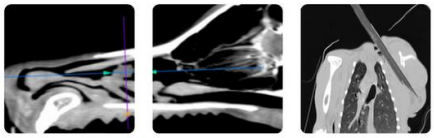

PATIENT

Berkley Caless

SPECIES

Canine

BREED

Labrador Retriever Mix

SEX

MN

AGE

14Y, 5M, 22D

WEIGHT

46kg

INTERPRETED BY

Tilde Rodrigues Froes, DMV, MSc., Dr. Med Vet., Dipl. CBraRVet

IMAGING PERFORMED BY

Byrony Tomic-Beard, BS, CVT

HOSPITAL NAME

Westford Veterinary Emergency and Referral Center

REFERRING VET

Mallory Watson, DVM

INVOICE

72690

DATE

11-20-25

PRESENTING CLINICAL SIGNS

Reason for presentation: CT scan chest/pelvis Reason for CT scan: Met Check/AGASACA PE: CV: no murmur or arrhythmia; HR: 90 RESP: normal lung sounds, no stridorous breathing; RR: pant EENT: pink gums, moderate dental tartar LN: no peripheral lymphadenopathy INTEG: multiple SQ masses ABD: comfortable on palpation MS: bilaterally thickened stifles with evidence of chronic CCL disease, bowlegged; generalized arthritis NEURO: normal mentation RECTAL: large left sided anal gland mass, extending ventral to the anus (soft ball sized) Other medical history: Bilateral CCL tears, chronic Possible laryngeal paralysis Possible seizure like episode after dental procedure 2023 Abnormal PE/Chem/CBC/UA Results: Previous Diagnostics: 11/14/25: CBC: Retic Hemo 23.7 (23.8-28.3), WBC 4.3 (5.8-16.2), Lymph 0.598 (0.98-4.2), PLT 418 (120-412); all else WNL Chem: K 5.5 (4.0-5.4), NA:K Ratio 27 (28-37), AST 14 (16-55), Choles 357 (131-345); all else WNL T4: 0.9 (1.0-4.0) 11/7/25 AUS: Impressions: -Mild renal architectural changes -Left adrenal nodule, caudal pole-r/o adenoma (functional v. non-functional) v. pheochromocytoma v. carcinoma v. other -Perineal swelling would appear consistent with mass-r/o possible anal sac tumor that has become inflammed/necrotic v. other tissue source. Fluid obtained does not appear purulent Cytology: Apocrine gland adenocarcinoma of the anal sac

COMPUTED TOMOGRAPHIC STUDY OF THORAX AND PELVIS

PELVIS

A large, amorphous, heterogeneously enhancing soft-tissue mass occupies the left perineal region, corresponding to the left anal sac topography. The mass effect measures approximately 7.4 × 6.5 × 5.8 cm. The mass causes mild distortion of the terminal rectal lumen and extramural compression; however, the retained fecal material in this region remains moderate in quantity and normal in attenuation.

The left medial iliac lymph node is mildly enlarged (2.4 × 0.8 cm) compared with the contralateral right medial iliac lymph node (2.1 × 0.7 cm).

The sacral lymph nodes are unremarkable.

There are multifocal complete and incomplete spondylosis deformans affecting the thoracic, lumbar, lumbosacral, and coccygeal vertebral endplates, with lesions most pronounced at the lumbosacral junction, where irregular endplates with a few small osteolytic foci are seen.

The caudal articular processes show variable degenerative changes.

The coxofemoral joints are incongruent with moderate periarticular ossification.

The sacroiliac joints bilaterally show sclerosis and irregular subchondral surfaces.

THORAX

The trachea and main bronchi are within normal limits.

There are few scattered subpleural mineral hyperattenuating foci in the pulmonary parenchyma. The right caudal lung lobe shows peripheral consolidation and reduced volume expansion in the gravity-dependent region, consistent with passive pulmonary atelectasis.

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The remaining lung parenchyma shows normal attenuation, with no pulmonary micronodules, nodules, or masses.

The bronchial tree has normal branching, tapering, and bronchus-to-artery ratios.

The heart and pulmonary vessels are normal.

The sternal, cranial mediastinal, and tracheobronchial lymph nodes are unremarkable.

The pleural space, diaphragm, ribs, thoracic wall, and esophagus are normal.

There are multifocal degenerative changes of the costochondral cartilages.

COMPUTED TOMOGRAPHIC DIAGNOSIS

- Large left perineal/anal sac soft-tissue mass. Differential diagnosis includes perianal neoplasia (e.g., apocrine gland adenocarcinoma of the anal sac based on the patient's history). The left perineal/anal mass causes mild extramural rectal compression, and partial obstruction.
- Mild enlargement of the left medial iliac lymph node. Differential diagnosis includes reactive lymphadenitis or early phase metastatic lymphadenopathy (given AGASACA).
- Multifocal spondylosis deformans, most pronounced at L7–S1, with irregular endplates and small osteolytic foci. Due to the osteolytic changes in the L7-S1 endplates, concurrent discospondylitis is suspected.
- The spinal caudal articular processes exhibit variable degenerative changes.
- Bilateral coxofemoral degenerative joint disease with joint incongruity.
- Bilateral sacroiliac degenerative joint disease.
- Pulmonary osteomas and right caudal passive pulmonary atelectasis, clinically incidental. No evidence of pulmonary or mediastinal metastatic disease.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The tomographic study identifies a large left perineal/anal sac mass, consistent with the previously diagnosed apocrine gland adenocarcinoma of the anal sac (AGASACA). The mass exerts mild extramural compression on the terminal rectum but does not currently produce a complete obstructive pattern. Continue monitoring for changes in defecation, discomfort, or progression of perineal swelling due to mass effect.

The left medial iliac lymph node is mildly enlarged, and although this change may represent reactive lymphadenitis, early metastatic lymphadenopathy cannot be excluded, particularly in the context of AGASACA.

The axial skeleton demonstrates multifocal spondylosis deformans, most pronounced at L7–S1, where irregular endplates and small osteolytic foci are present. These findings raise suspicion for concurrent discospondylitis, especially given the osteolytic appearance. Clinical correlation and, if indicated, empirical treatment is suggested.

Additional findings of bilateral coxofemoral and sacroiliac degenerative joint disease are consistent with chronic osteoarthritis.

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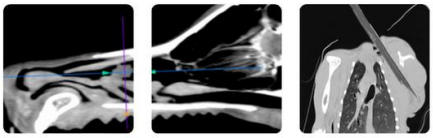

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Educational Teleconsultation Services™

SonoPath.com info@sonopath.com 1.800.838.4268

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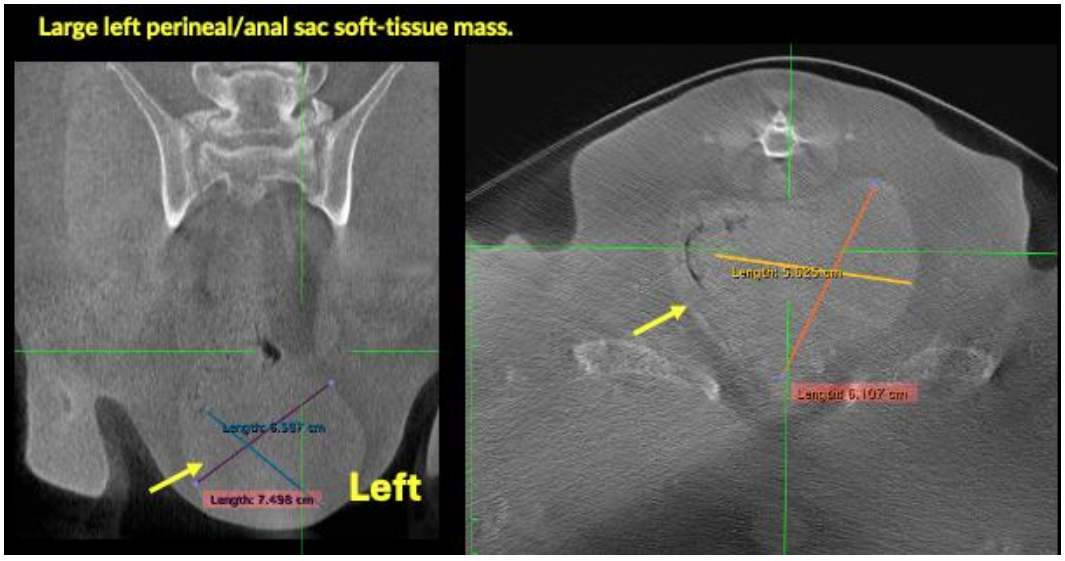

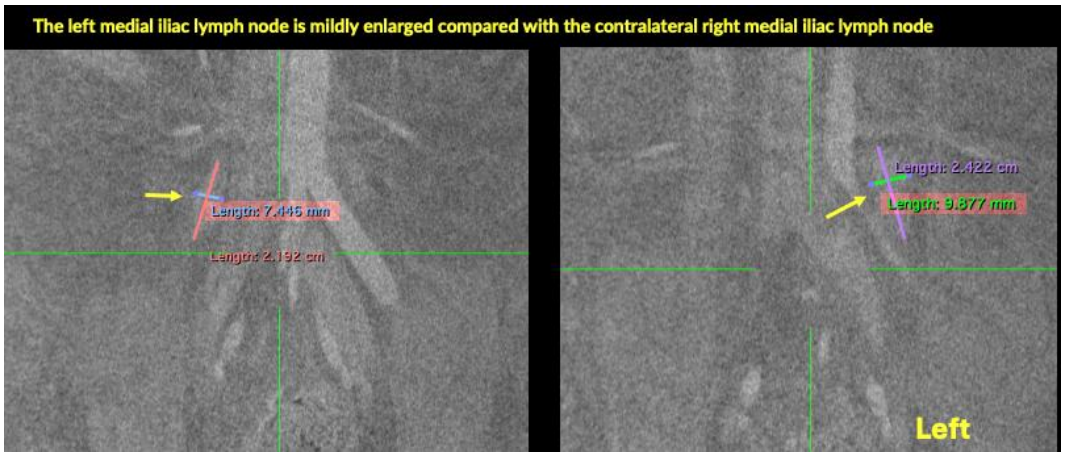

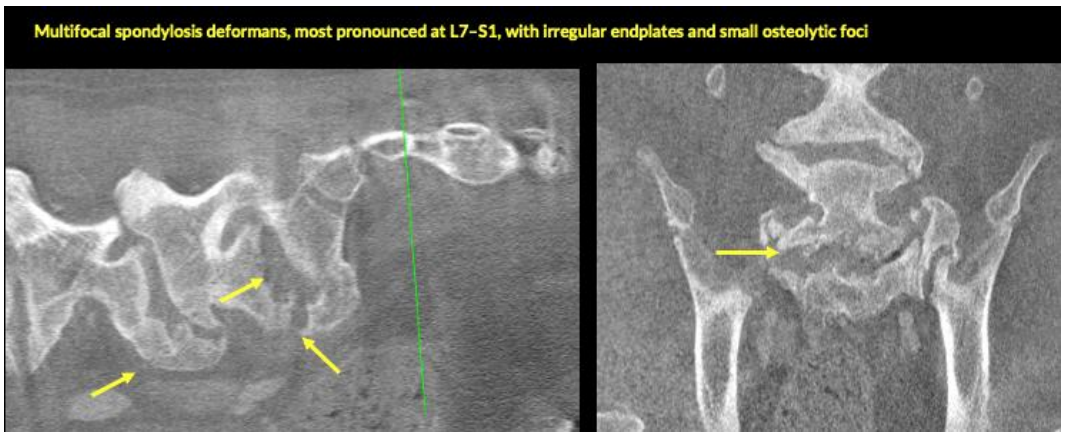

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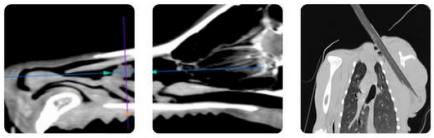

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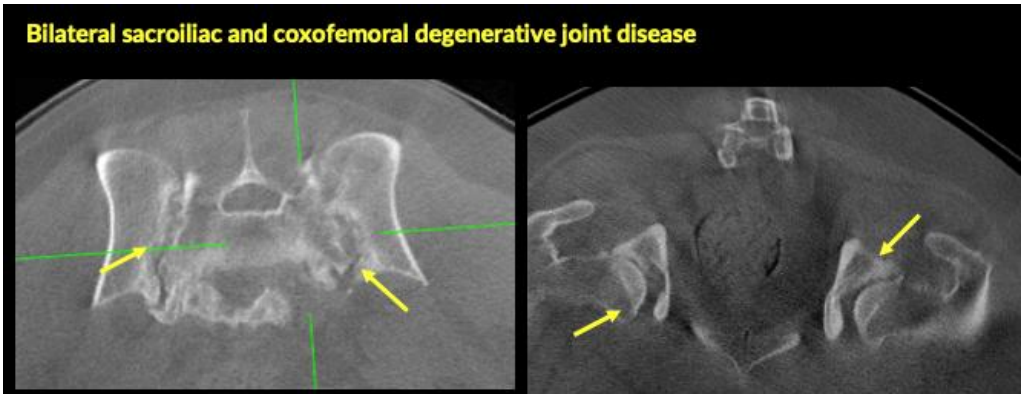

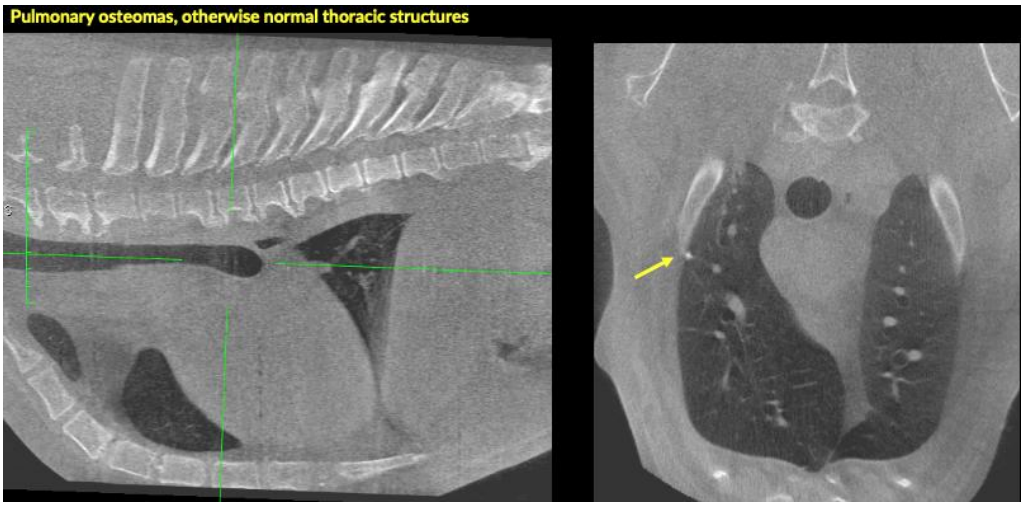

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance, please contact me.

Tilde Rodrigues Froes, DMV, MSc., Dr. Med.Vet., Dipl.CBraRVet
info@sonopath.com