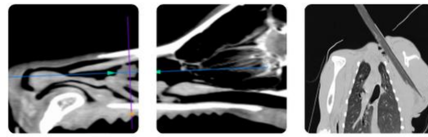


PATIENT

Charlie Susca

SPECIES

Canine

BREED

Mix

SEX

Neutered Male

AGE

8Y

WEIGHT

31.0kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Victoria Bradshaw

HOSPITAL NAME

Gulf Shore Veterinary Specialty Surgery

REFERRING VET

Dr. Byron Young DVM, MS, DACVS

INVOICE

74346

DATE

3-24-26

PRESENTING CLINICAL SIGNS

Charlie presents for medium firm 10x 8 x 6 cm subcutaneous mass left lateral ventral thorax. FNA submitted, reported as soft tissue sarcoma. CT for surgical planning.

COMPUTED TOMOGRAPHIC STUDY OF THE THORAX AND ABDOMEN

A pre- and post-contrast CT study of the whole-body is provided for review totaling 2 series. One pre-contrast series of the whole-body, soft tissue algorithm. One post-contrast series of the whole-body, soft tissue algorithm.

COMPUTED TOMOGRAPHIC FINDINGS

Thorax and Thoracoabdominal Wall

There is a large, heterogeneously contrast-enhancing soft tissue mass centered within the left ventral thoracoabdominal wall, predominantly involving the subcutaneous tissues and extending between the internal and external rectus sheath layers and the external abdominal oblique musculature. The mass measures approximately 12.8 × 7.8 × 12.1 cm.

The cranial aspect of the lesion is more poorly marginated relative to the adjacent soft tissues and musculature, with associated mild regional soft tissue swelling and thickening. The lesion extends from approximately the level of the 5th intercostal space caudally to the xiphoid region.

There is mild inward displacement/distortion of the adjacent body wall toward the thoracic/abdominal cavity; however, there is no CT evidence of cavitary invasion. There is no evidence of adjacent rib involvement or osseous lysis.

The trachea and main bronchi are within normal limits.

A single sternal lymph node is mildly enlarged.

The cranial mediastinal and tracheobronchial lymph nodes are within normal limits.

The pulmonary parenchyma is normally aerated, with no evidence of pulmonary nodules, micronodules, or masses.

The bronchial tree is unremarkable.

Cardiac silhouette and pulmonary vasculature are within normal limits.

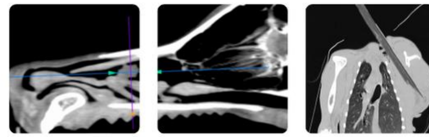
The pleural space, diaphragm, ribs, and thoracic esophagus are unremarkable.

Abdomen

The liver is within normal limits in size, shape, attenuation, and contrast enhancement.

The gallbladder contains fluid attenuation material with mild gravity-dependent hyperattenuating sediment, compatible with mild biliary sludge. The cystic duct and common bile duct are within normal limits.

The right pancreatic lobe is mildly enlarged, with preserved attenuation. The left pancreatic lobe is unremarkable.



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The spleen is mildly and diffusely enlarged, with regular margins and homogeneous attenuation and contrast enhancement.

The kidneys are within normal limits in size, shape, contour, and attenuation. The renal pelves and ureters are unremarkable.

The urinary bladder is moderately distended and has normal wall thickness.

The gastrointestinal tract is within normal limits in distribution and distension, with no focal mural mass effect identified.

The colon and rectum contain fecal material and gas.

The abdominal lymph nodes and adrenal glands are within normal limits.
The serosal fat is unremarkable.

The prostate is unremarkable.

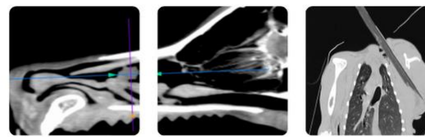
There is multifocal complete and incomplete spondylosis deformans affecting multiple vertebral endplates, with multifocal in situ intervertebral disc mineralization.

There is bilateral coxofemoral subluxation with moderate periarticular osteophytosis/ossification, consistent with coxofemoral osteoarthrosis.

There are mild bilateral sacroiliac degenerative changes.
There is bilateral periarticular new bone formation involving the elbow joints, consistent with elbow osteoarthrosis.

COMPUTED TOMOGRAPHIC DIAGNOSIS

- Large left ventral thoracoabdominal wall soft tissue mass, heterogeneously contrast-enhancing, centered within the subcutaneous and fascial/muscular body wall tissues, extending from the 5th intercostal space to the xiphoid region. Differential diagnoses include soft tissue neoplasia, compatible with the reported soft tissue sarcoma.
- The cranial margin is less well defined, raising concern for local infiltrative extension into adjacent soft tissues/musculature.
- Mild enlargement of a sternal lymph node. Differential diagnoses include reactive lymphadenopathy versus possible early metastatic lymph node involvement.
- No CT evidence of pulmonary metastatic disease.
- Mild splenomegaly, nonspecific, possibly incidental or secondary to congestion (including anesthetic-related change) or lymphoid hyperplasia; infiltrative disease is considered less likely.
- Mild enlargement of the right pancreatic lobe, nonspecific; may reflect mild/reactive pancreatic change.
- Mild biliary sludge.
- Multifocal spondylosis deformans and intervertebral disc mineralization.
- Bilateral hip dysplasia with secondary coxofemoral osteoarthrosis.
- Mild bilateral sacroiliac osteoarthrosis
- Bilateral elbow osteoarthrosis



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

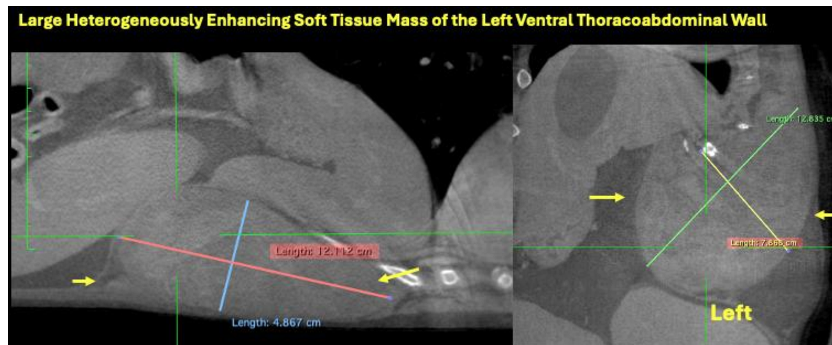
The CT examination demonstrates a large left ventral thoracoabdominal wall mass with imaging features consistent with the previously diagnosed soft tissue sarcoma. The lesion appears primarily confined to the body wall soft tissues, including the subcutaneous tissues and fascial/muscular planes, with mild distortion of the adjacent body wall contour, but without convincing CT evidence of rib invasion or extension into the thoracic or abdominal cavities.

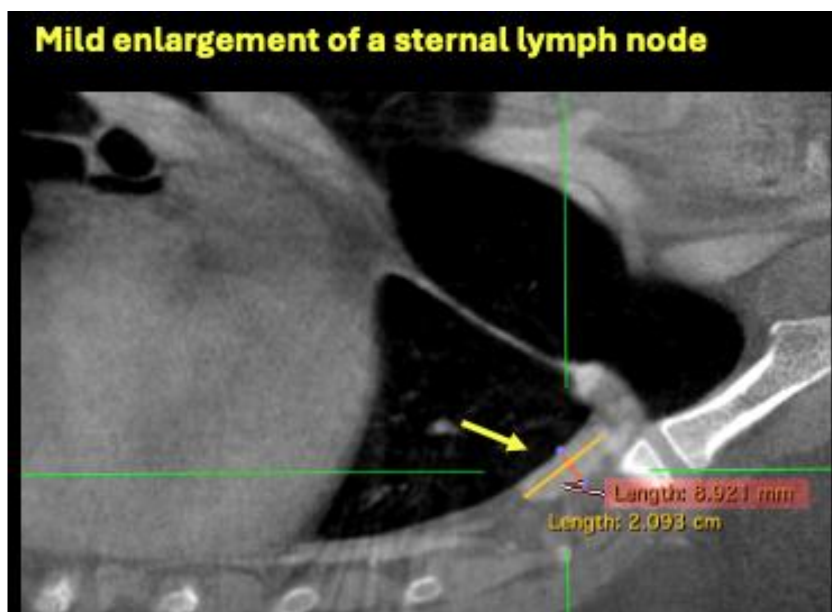
The cranial aspect of the mass is more poorly marginated, which may indicate more infiltrative local behavior than is grossly appreciable externally.

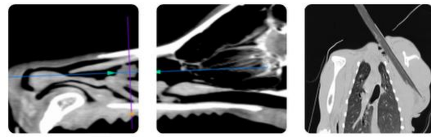
Histopathology of the excised mass is suggested for definitive grading and margin assessment.

A mildly enlarged sternal lymph node is present. Differential diagnoses include reactive lymphadenopathy versus possible early metastatic lymph node involvement.

The mild right pancreatic lobe enlargement is nonspecific and of uncertain clinical relevance in the absence of compatible clinical/laboratory findings. Mild biliary sludge is likely incidental.







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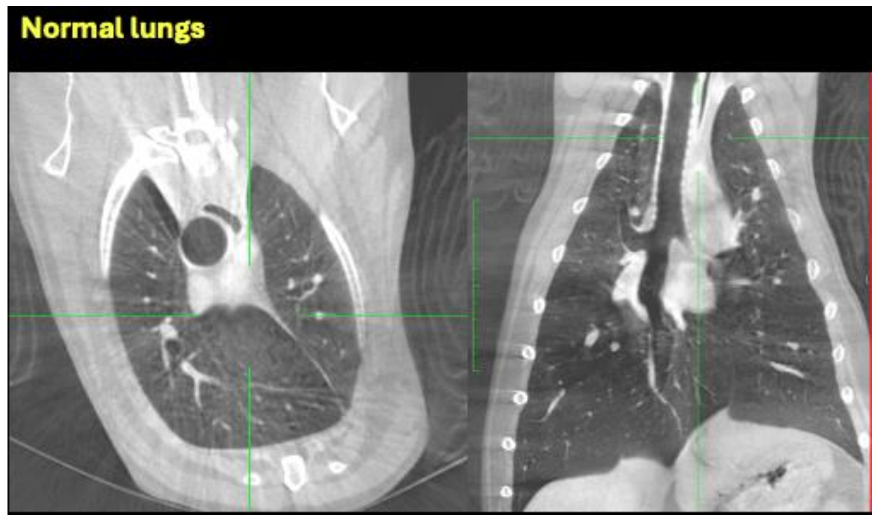

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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