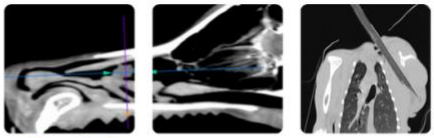


PATIENT

Rambo Duffy

SPECIES

Canine

BREED

Rottweiler

SEX

Neutered Male

AGE

8

WEIGHT

63.4

INTERPRETED BY

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

IMAGING PERFORMED BY

David

HOSPITAL NAME

Animal Surgical Center- Oceanside

REFERRING VET

Dr. Kim

INVOICE

14049

DATE

03/04/26

PRESENTING CLINICAL SIGNS

- parapesis on both hind limbs, CP deficits on both hind limbs, positive motor and deep pain on both hind limbs. patient was ambulatory, thoracic limbs WNL
- weakness on both hind limbs, slight plantigrade stand on both hind limbs.
- painful on palpation of sacrum region

COMPUTED TOMOGRAPHIC STUDY OF THE THORAX, ABDOMEN & SACRAL SPINE

A pre- and post-contrast CT study of thorax, abdomen and sacral spine are provided for review totaling 3 series. One pre-contrast series of the thorax, bone algorithm. One pre-contrast series of the sacral spine, bone algorithm. One post-contrast series of the abdomen (delayed), bone algorithm.

COMPUTED TOMOGRAPHIC FINDINGS

SACRAL SPINE

There is an aggressive mixed osteolytic and proliferative lesion centered in the left portion of the sacrum involving the left-wing aspect, and sacroiliac joint.

The affected sacral bone demonstrates extensive osteolysis with areas of mottled medullary sclerosis. An irregular, amorphous to spiculated periosteal reaction is present adjacent to the lesion.

There is enlargement of the left L7–S1 intervertebral foramen with associated widening of the vertebral canal at this level. Despite these changes, the L7 vertebra does not demonstrate evidence of aggressive osseous destruction.

Associated with the osseous lesion, there is a soft tissue mass effect involving the adjacent paraspinal musculature and gluteal musculature, more pronounced on the left side.

Multifocal, mild sclerosis of the dorsal articular surfaces of the vertebral bodies is noted.

Incomplete bridging spondylosis deformans is present at L3–L4 and L5–L6.

The coxofemoral joints are bilaterally incongruent (> right) with mild periarticular bone production.

THORAX

The trachea and main bronchi are within normal limits.

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

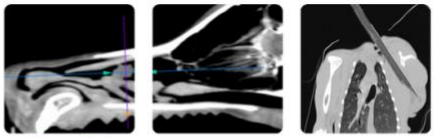
At least three soft tissue pulmonary micronodules are identified within the pulmonary parenchyma, measuring approximately 5.7 mm to 7.4 mm.

Additionally, multiple scattered subpleural hyperattenuating mineral foci are observed.

There is mild reduction in pulmonary expansion with areas of increased attenuation in the gravity-dependent regions of the lungs, compatible with dependent atelectasis.

The bronchial tree demonstrates normal branching and tapering. Bronchial walls are thin and smooth with a normal bronchus-to-artery ratio.

The cardiac silhouette and pulmonary vessels are within normal limits.



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

Mineralization foci and mild enthesophyte formation are noted at the insertion sites of the supraspinatus and subscapularis muscle tendons bilaterally.

ABDOMEN

The medial iliac and sacral lymph nodes are mildly enlarged.

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

The urinary bladder is moderately distended with hypoattenuating fluid admixed with contrast material. The bladder wall thickness is normal.

The visible gastrointestinal tract is normally distended and anatomically distributed, without evidence of severe mural thickening or mass effect.

The colon contains gas admixed with a moderate volume of heterogeneous fecal material.

No large mass effect is identified within the liver or spleen.

The serosal fat demonstrates normal attenuation. There is no evidence of peritoneal effusion or peritonitis.

The prostate gland is within normal limits.

COMPUTED TOMOGRAPHIC DIAGNOSIS

Aggressive mixed osteolytic and proliferative lesion centered in the left sacrum and sacroiliac joint, associated with marked bone destruction, irregular periosteal reaction, enlargement of the left L7–S1 intervertebral foramen, and adjacent soft tissue mass effect involving the paraspinal and gluteal musculature. Differential diagnoses include primarily neoplasm, osteosarcoma, soft tissue sarcoma or other soft tissue neoplasm with bone involvement, chondrosarcoma, undifferentiated sarcoma. Baixa probabilidade infectious osteomyelitis.

Mild enlargement of the medial iliac and sacral lymph nodes, which may represent reactive lymphadenopathy or metastatic involvement.

Multiple small pulmonary nodules (5.7–7.4 mm) suspicious for pulmonary metastases.

Incomplete bridging spondylosis deformans at L3–L4 and L5–L6.

Bilateral coxofemoral incongruency (> right side) with mild osteoarthrosis.

Bilateral supraspinatus and subscapularis tendon mineralization foci, incidental or possible correlated with enthesopathy.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The CT examination confirms the presence of a highly aggressive destructive lesion centered in the left sacrum and sacroiliac region, with associated periosteal reaction, medullary bone destruction, and regional soft tissue extension. The lesion also results in expansion of the left L7–S1 intervertebral foramen and widening of the vertebral canal, which may explain the patient's neurological deficits affecting the pelvic limbs.

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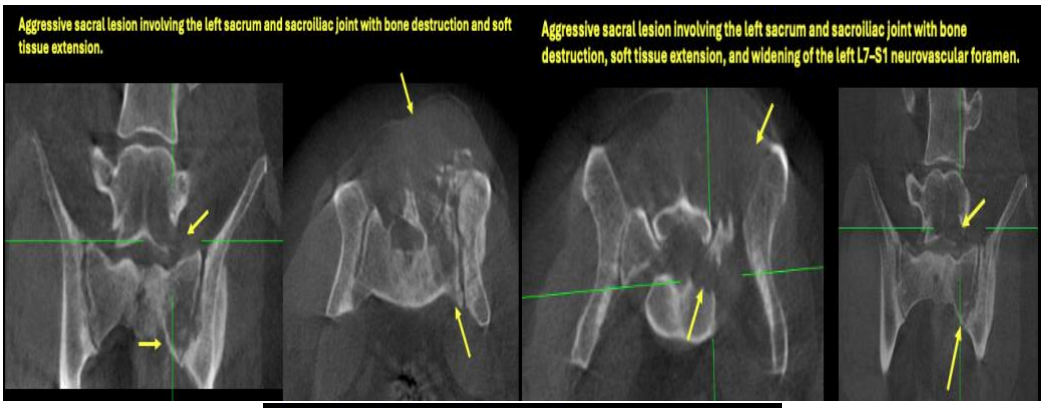
Based on the imaging characteristics, the primary differential diagnosis is a malignant primary bone tumor, particularly osteosarcoma. Other sarcomas, such as chondrosarcoma or undifferentiated sarcoma, remain differential considerations. A soft tissue neoplasm with secondary bone invasion is also considered possible. Osteomyelitis is considered less likely.

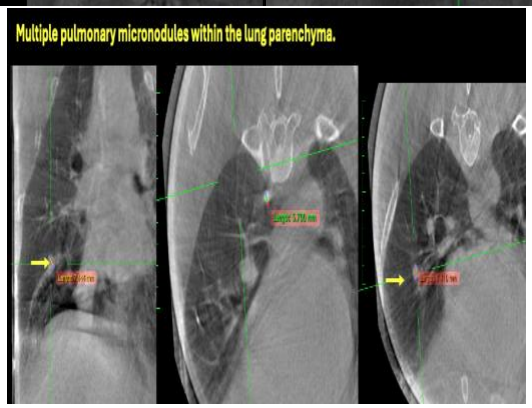
Additionally, multiple small pulmonary nodules are identified, raising concern for metastatic pulmonary disease.

Mild enlargement of the medial iliac and sacral lymph nodes may represent reactive lymphadenitis or possible metastatic involvement.

Image-guided biopsy (ultrasonography) or fine-needle aspiration of the sacral lesion is recommended for definitive histopathological diagnosis. An oncologic consultation is recommended for staging and treatment planning.

Technical notes: Image quality is mildly limited by motion artifacts, beam-hardening artifacts, and suboptimal contrast enhancement.





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

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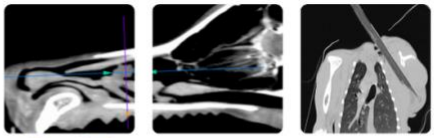

Teleradiology
Educational Teleconsultation Services™

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