VETCT
CONSULTANTS IN TELEMEDICINE

REPORTING SERVICE: CT

Report number: VETCT-1234 Report date: 10/01/2018

Referring Veterinarian:

Referring Practice: South Devon Referrals

Email address:

Owner: Patient:

Species: Canine Breed: Staffordshire Bull Terrier Sex: Female Neutered Age:

Associated cases:

Clinical History:

Subjective (Hx): Started in about Oct noticing was squatting to urinate for longer than normal. Gradually got worse - taking longer to urinate, squiatting more frequently, also faeces looser. Had urinalyis, antibiotics, pro biotics/ symptomatic treatment for D+, intestinal food. Nothing made any difference. Continuing to worsen - bloody and mucus discharge from vulva. Now having accidentis in house too. Eating adn drinking OK, keen to go on walk - but then is just frequent pattern of squatting to urinate for 2 or 3 minutes. Not on any medication at present (stopped at Christmas time). Otherwise been a healthy dog - not vaccinated since being a puppy - not been o vet since. Keen to try and move things forward, rule things in or out, have budget limt of approx £2k more (on top of what spent so far). Referring practice has advised CT may be helpful.

Objective (CSx): M.ms pale pik, Crt < 2 sec, HR 110, NAD ausc. Resentled mid-caudl abdo palp to some degree and ??? could be mass. T38.6. Can see inflamed mucosa in vagina when part lips and bloody discharge - smear taken. On rectal exam thickened structure avbout 1cm dimater and irregular below rectum - suspect is urethra.

Questions to be answered:

Transitional cell carcionoma suspected? Other differentials? Any signs metastasis?

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Number of series / images: 4 / 1297

Series: [2MM BODY 2.0 BODY STD. VOLUME CE, 2.0, 2MM BODY 1.0 BODY STD. VOLUME, 1MM LUNG 1.0 BONE HI RESOLUTION]

Study dated: 10/01/2018

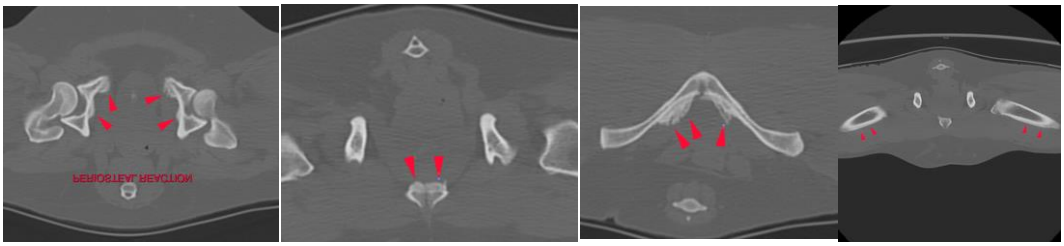
Study received: 10/01/2018

Anatomic regions: Abdomen

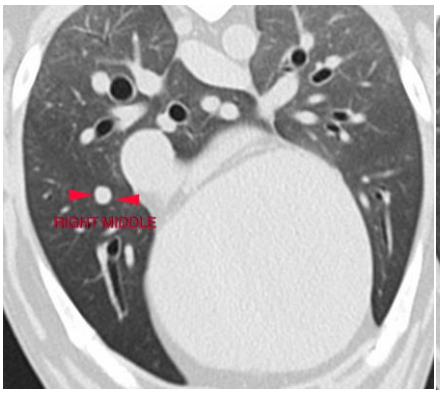
Details of study and technical comments: Pre-and postcontrast CT of the abdomen was performed.

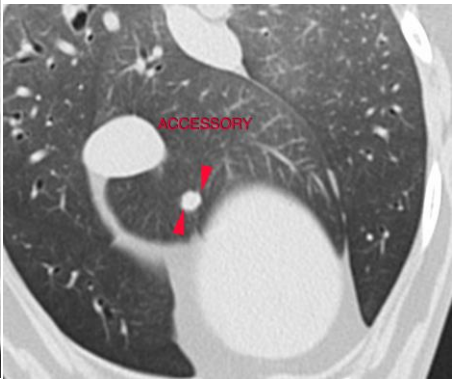
Diagnostic interpretation:

Musculoskeletal: The vertebral column is unremarkable. The paraspinal musculature is unremarkable. The visible ribs are unremarkable. The caudal extent of the sternum is unremarkable. There is mild smooth new bone formation along the lateral aspect of the left iliac wing. There is no evidence of underlying bony lysis. There is moderate palisading periosteal reaction of the pelvis at the level of the hip joints in the intrapelvic region and along the length of the dorsal surface of the pelvic floor. This is seen to lesser extent along the ventral aspect of the right ilial body. There is moderate bilateral stifle DJD. There is mild smooth periosteal reaction of the femoral diaphyses bilaterally without underlying bony lysis. Inguinal lymph nodes are normal. There are no distinct inguinal sac lesions.

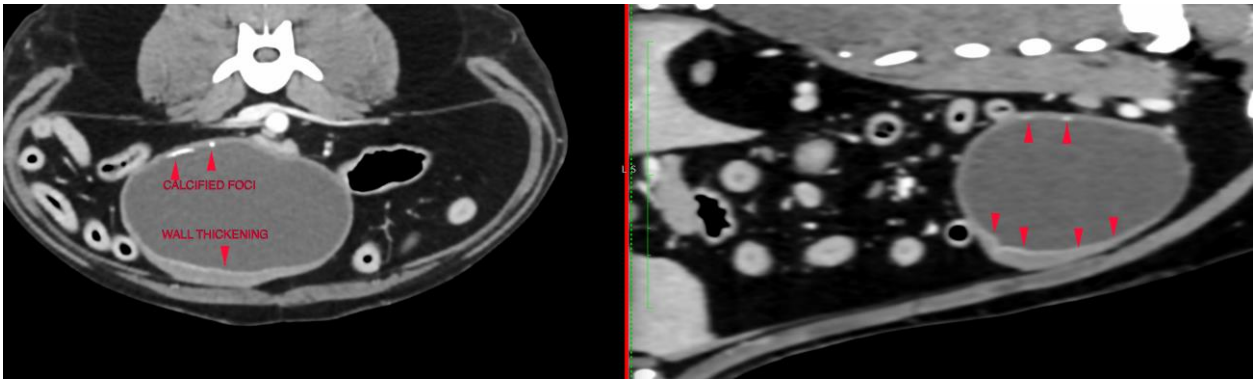


Limited caudal thoracic cavity: There is mild gravity dependent atelectasis. There is a well-circumscribed rounded soft tissue attenuating pulmonary nodule measuring 6.8 mm within the ventral aspect of the accessory lung lobe. There is a 5.7 mm rounded soft tissue attenuating pulmonary nodule within the caudal aspect of the right middle lung lobe. There is a poorly defined 5.9 mm rounded soft tissue attenuating focus within the ventral extent of the right middle lung lobe. There is a punctate soft tissue attenuating nodule within the peripheral/dorsal aspect of the left caudal lung lobe. A similar focus is seen within the ventral extent at the same level. See below.

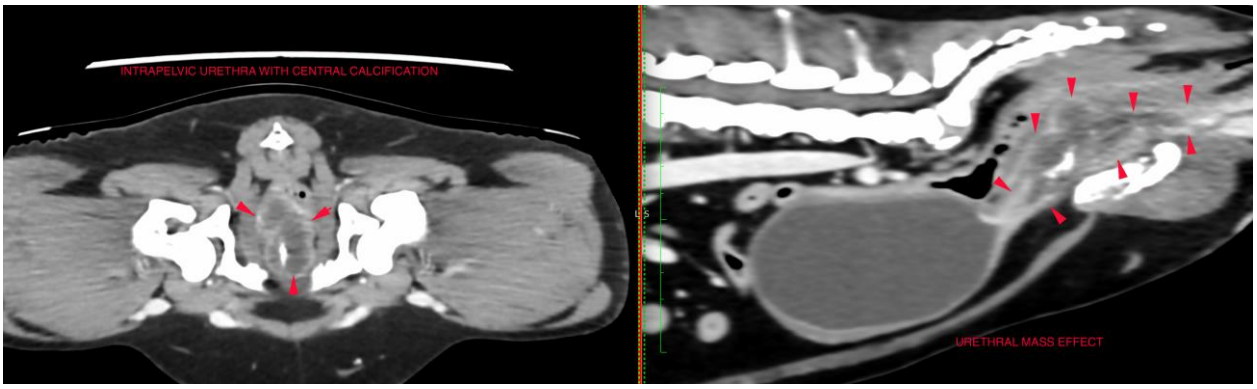




Abdominal cavity: There is no evidence of peritoneal free air. There is no evidence of peritoneal effusion. There are multifocal variably sized poorly and well-defined hypoattenuating hepatic nodules measuring up to 1.2 cm in maximum dimension. At least 1 or 2 of these nodules demonstrate a subtle ring type enhancement pattern. The gallbladder and common bile duct are unremarkable. The spleen is unremarkable. There is subtle caudal retroperitoneal fat stranding. There is a small wedge-shaped cortical defect within the ventral aspect of the left kidney. The ventral border of the cranial pole of the right kidney is slightly blunted. The ureters are unremarkable. Punctate calcified foci are seen lining the dorsal urinary bladder mucosa to the right of midline at the level of the mid bladder. The cranial 1/2-2/3 of the ventral urinary bladder wall shows variable thickening with contrast enhancement. This region of wall thickening shows a wedge-shaped mucosal defect at its cranial extent. Maximum wall thickness is approximately 7.7 mm.



There is asymmetric, predominantly hypoattenuating, urethral thickening with a dorsally lobulated border and central calcification affecting the length of the urethra. At its maximum dimension the urethra measures 3.4 cm in height by 2.5 cm in maximum width. This results in mild dorsal colonic displacement/compression in the intrapelvic region. There is also circumferential asymmetric caudal trigonal/proximal urethral thickening that is contrast-enhancing. The cervix is not easily differentiated from the urethral pathology described.



There is a mixed attenuating nodule involving the cranial pole of the right adrenal gland measuring up to 1.3 cm in width. The adrenal glands are otherwise normal. There is mild bulging of the gastric fundus towards the esophageal hiatus. The stomach is otherwise normal. The pancreas is unremarkable. The small and large bowel are normal. The right medial iliac lymph node is minimally rounded when compared to the left. Hypogastric and sacral lymph nodes are also minimally rounded without overt enlargement. There is a mildly enlarged jejunal lymph node. Otherwise unremarkable.

Conclusions:

-Primary urethral malignancy with urinary bladder seeding/involvement (such as transitional cell carcinoma) is considered most likely (urinary bladder changes may alternatively be inflammatory). Mural calcification vs. luminal calcified debris. Displacement of cervix is considered more likely than involvement of this region.
-Likely reactive lymph nodes (early metastasis cannot be completely excluded).
-Lung: Probable metastatic disease.
-Liver: Metastatic disease vs. nodular regeneration.
-Pelvis, femurs: Hypertrophic vs. metastasis.
-Right adrenal nodule.
-Left and possible right renal infarct.
-Trace caudal retroperitoneal effusion.
-Moderate stifle DJD may be due to chronic cruciate ligament injury.

Additional comments:

-If initial swab reported does not yield a diagnosis, traumatic catheterization may be attempted. Urine collection with centrifugation may also yield a diagnosis at times.

-Consider full thoracic imaging given presence of pulmonary nodules.

-Ultrasound-guided liver FNA may be considered if clinically indicated.

Reporting Radiologist:

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