

BACKGROUND

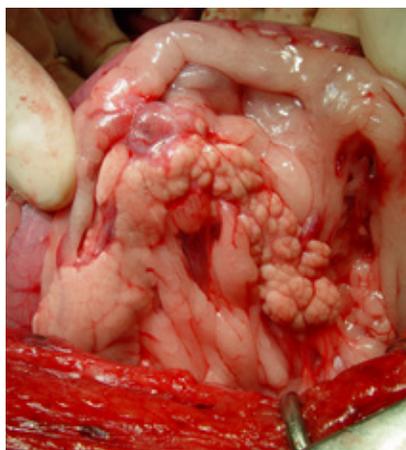
95%

Malignant in dogs



BLOODWORK

Low glucose -
 inappropriate insulin
 combination



WHIPPLE'S TRIAD

Signs of
 low glucose

Low glucose
 in blood



Reverse signs
 with glucose



CLINICAL SIGNS

- ▶ Seizures
- ▶ Weakness
- ▶ Collapse

DIAGNOSIS

Low cost

Ultrasound or surgery

Gold standard

Dual phase CT angiography

THERAPY

Surgery is considered the
 treatment of choice

Conservative Therapy

Feed multiple times a day
 Prednisolone 0,5-2 mg/kg PO 2dd
 Diazoxide 5-30 mg/kg PO 2dd
 Streptozotocin/Octreotide
 Toceranib 2.5-3 mg/kg MWF

STAGES & PROGNOSIS

Stage 1: >2 years *Only in pancreas*

Stage 2: 1-2 yrs *Pancreas & lymph nodes*

Stage 3: < 1 yr *Pancreas & distant*



BACKGROUND

- ▶ Sexually transmitted tumor with cells being transplanted through direct contact with an affected dog
- ▶ Most dogs are intact stray or free-roaming dogs



CLINICAL SIGNS

- ▶ Cauliflower-like, pedunculated, nodular, papillary, or multilobulated in appearance; with intermittent bleeding from prepuce/vulva area
- ▶ Size range from a small nodule (5 mm) to a large mass (> 10 cm) that is firm, often ulcerated and friable
- ▶ Location: most commonly genital, facial
- ▶ Paraneoplastic syndromes: erythrocytosis

DIAGNOSIS

- ▶ By cytology of fine needle aspiration, impression smear is less often diagnostic. Flushing in nasal TVT
- ▶ Histology is indicated if cytology is not diagnostic or the presentation is atypical



THERAPY

- ▶ Vincristine is treatment of choice - 0,5-0,7 mg/m² weekly for 3-8 weeks or 2 weeks after the complete resolution of the visible tumor
- ▶ Radiation therapy or other cytostatic agents such as doxorubicin, cyclophosphamide, methotrexate, vinblastine can be used in non-responsive cases
- ▶ Surgery less effective with recurrence rate above 60%



PROGNOSIS

Excellent. Dogs can be cured with chemotherapy.
More careful prognosis in immunocompromised dogs



BACKGROUND

- ▶ In the female cat, almost 90% of mammary tumors are malignant
- ▶ Early neutering (< 1 year old) reduces the risk later in life
- ▶ Contraceptives increase risk of both benign and malignant tumors
- ▶ Rare in males but they can develop malignant tumors after medroxyprogesterone treatments

CLINICAL SIGNS

- ▶ Mass in or near a mammary gland
- ▶ Typically, subcutaneous and painless; sometimes ulcerated and painful

Any mass located in the mammary glands, regardless its size, should be examined.

DIAGNOSIS

- ▶ Cytology of mass to rule out other tumors or non-neoplastic lesions
- ▶ Histology required for definitive diagnosis

STAGING

- ▶ 3-view thoracic radiographs
- ▶ Fine needle aspirate of enlarged lymph nodes
- ▶ Abdominal ultrasound or a total body CT scan (for staging/planning)

TREATMENT

- ▶ Bilateral or 2 x unilateral staged mastectomy (4-6 weeks apart)
- ▶ Potentially use adjuvant chemotherapy (carboplatin- or doxorubicin-based protocols) if high grade, if lymph node metastasis, or with histologic invasion
- ▶ Potentially, metronomic chemotherapeutic protocols (Cyclophosphamide plus Cox-2 inhibitors)



NEGATIVE PROGNOSTIC FACTORS

Tumor (> 3cm), distant or lymph node metastases, lymphatic and vascular invasion

PROGNOSIS

Variable. With smaller masses, rapid surgical removal of the mass may lead to cure.



BACKGROUND

- ▶ Mammary tumors are malignant in approximately 50% of cases
- ▶ Early spay (defined as the first two years) significantly decreases the risk of developing mammary tumors and the mortality associated with them
- ▶ Contraceptives increase the risk of benign tumors
- ▶ Rare in males

CLINICAL SIGNS

- ▶ Mass in or near a mammary gland
- ▶ Typically, subcutaneous and painless; sometimes ulcerated and painful

Any mass located in the mammary glands, regardless its size, should be examined.

DIAGNOSIS

- ▶ Cytology can be used to rule out other skin or subcutaneous tumors or non-neoplastic lesions
- ▶ Histology required for definitive diagnosis

STAGING

- ▶ 3-view thoracic radiographs
- ▶ Fine needle aspirate of enlarged lymph nodes
- ▶ Abdominal ultrasound or a total body CT scan (for staging/planning)

TREATMENT

- ▶ Surgery (nodulectomy, regional or ipsilateral mastectomy, depending on the size, number and distribution in the mammary chain)
- ▶ Potentially use adjuvant chemotherapy (carboplatin- or doxorubicin-based protocols) if high grade, if lymph node metastasis, and/or with lymphatic or vascular invasion
- ▶ Potentially, metronomic chemotherapeutic protocols (Cyclophosphamide plus Cox-2 inhibitors)



NEGATIVE PROGNOSTIC FACTORS

Tumor (> 3 cm), distant or lymph node metastases, lymphatic and vascular invasion; high histological grade

PROGNOSIS

Depends on clinical stage and grade. Smaller tumors without metastasis can often be cured by surgery alone

