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Intrapelvic Leiomyomas in two dogs treated via dorsal perineal approach

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Keywords: leiomyoma, dog, intrapelvic mass, surgery.

Introduction: Intrapelvic masses are rare in dogs. Few reports address their frequency, origin, diagnostics, and treatment (Katamoto et al. 2003; Tobias & Johnston 2012; Ferraris et al. 2021). Possible origins include colorectal, reproductive, urinary, neural or adipose tissues (Ferraris et al. 2021). Leiomyomas are benign smooth muscle tumors, uncommon in the colorectal region. Their slow growth allows them to reach substantial sizes before clinical signs like tenesmus or deformed faeces appear (Santos et al. 2021). Surgical approaches include ventral laparotomy (with or without pubic osteotomy), lateral and dorsal perineal (McKeown et al. 1984).

Case Reports: Two dogs presented with progressive tenesmus and abnormal defecation. Exams were unremarkable, though rectal palpation revealed firm, immobile masses dorsal to the rectum.

Case 1: A 12-year-old spayed female Parson Russell Terrier had a 6-month history of tenesmus and flat faeces. CT showed a $5.2 \times 3.4 \times 3.3$ cm soft tissue-attenuating mass dorsal to the rectum with mineral foci and minimal homogeneous contrast enhancement (Fig. 1A). The rectum was ventrally compressed. No signs of metastatic disease were found. FNA was non-diagnostic. Exploratory coeliotomy revealed a mass adherent to the dorsal rectum, which was bluntly excised via a dorsal perineal approach (Fig. 2). Histopathology confirmed leiomyoma.

Case 2: A 12-year-old intact male mixed breed had a 5-week history of tenesmus and an episode of constipation. CT revealed a $4.7 \times 3.6 \times 3.4$ cm non-contrast-enhancing, soft tissue mass in the dorsal pelvic inlet, with severe rectal lumen narrowing (Fig. 1B). The scan showed no signs of metastasis. Ultrasound guided FNA yielded insufficient cells for a diagnosis. The mass

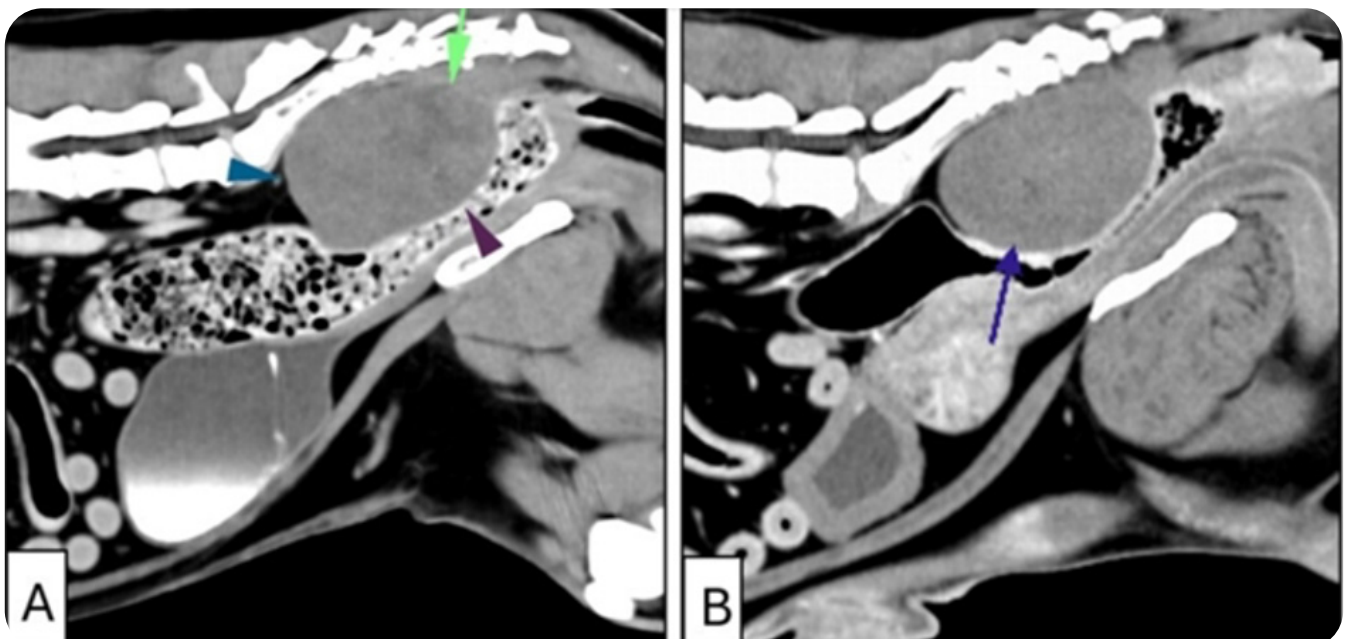


Fig. 1: CT scans of case 1 (A) and 2 (B); arrows indicate the tumorous masses

was removed via dorsal perineal approach and confirmed as leiomyoma histologically.

Postoperative recovery was uneventful in both dogs, with no complications. Follow-up via telephone at 178 days for Case 1 and 32 days for Case 2 confirmed that both dogs were in good health with normal defecation.

Discussion: CT was essential for mass identification (Fig. 1) and surgical planning but failed to define their tissue origin. Both FNAs were non-diagnostic, consistent with leiomyomas being poorly exfoliative and yielding low-cellularity samples (Katamoto et al. 2003; Ferraris et al. 2021). In both cases, minimal invasive surgical access through the dorsal perineal approach allowed blunt dissection and removal (Fig. 2). This approach provides good exposure to the caudal rectum while preserving critical structures such as caudal rectal nerve and pelvic plexus (McKeown et al. 1984).

Conclusion: These cases highlight the challenge of diagnosing intrapelvic leiomyomas. CT is useful for localization but not definitive for origin. FNA often yields inconclusive results due to poor exfoliation. The dorsal perineal approach enabled safe and curative mass removal and should be considered prior to exploration through coeliotomy in these specific cases.

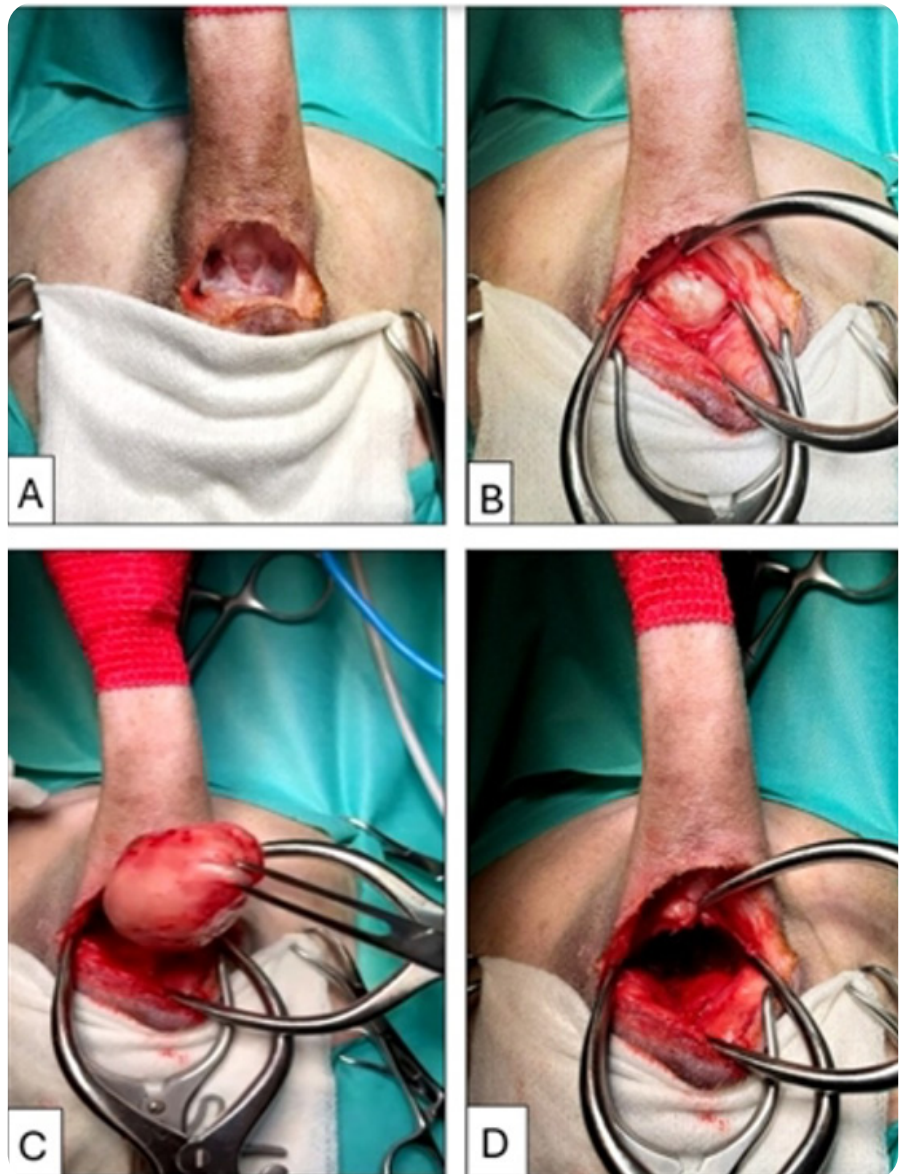


Fig. 2: Dorsal perineal approach; (A) U-shaped incision; (B) view after dissecting; (C) extraction of the mass; (D) view after removal of the mass

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