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Clinical Sonography & Telecytology
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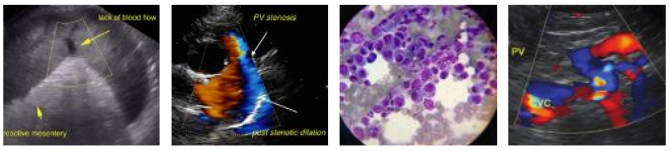

SonoPath.com
1-800-838-4268 info@sonopath.com

**PATIENT**

Nina Maguire

**SPECIES**

Canine

**BREED**

Mixed

**SEX**

Spayed Female

**AGE**

15 years

**WEIGHT**

Not provided

**INTERPRETED BY**

Andrea Nicastro, DVM, Diplomate ACVIM (*Small Animal Internal Medicine*)

**IMAGING PERFORMED BY**

Potomac Mobile Veterinary Ultrasound

**HOSPITAL NAME**

Heritage Animal Hospital

**REFERRING VET**

Dr. Jarrett

**INVOICE**

10153

**DATE**

1/14/22

## PRESENTING CLINICAL SIGNS

History: Suspected Cushing's and high liver enzymes.
Abnormal PE/Chem/CBC/UA Results:

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder, trigone, and pelvic urethra are normal in thickness and the mucosal surface is smooth. The bladder lumen is moderately distended with anechoic urine. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal in size (5.64 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild to moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal in size (6.89 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild to moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

### *Adrenal Glands*

The left adrenal gland is normal size (0.82 cm at cranial pole) (0.83 cm at caudal pole) (2.41 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (078 cm at cranial pole) (0.58 cm at caudal pole) (2.50 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

### *Spleen*

The spleen is overall normal in size (1.72 cm in width at the level of the hilus) with slightly irregular peripheral contours. At the caudal aspect, two coalescing, isoechoic-to-slightly heterogenous masses, one measuring 2.88 x 2.52 cm, the other measuring 2.10 x 2.09, are observed. The lesions are causing slight capsular expansion. The remaining parenchyma is homogenous in appearance. Splenic vasculature is normal with no evidence of thrombosis.

### *Liver*

The liver is enlarged with irregular peripheral contours. A >8 cm irregular isoechoic to slightly heterogenous vascular mass is observed on the left side with extension to the right side. The mass causes capsular expansion. The remaining parenchyma is isoechoic relative to the spleen and slightly heterogenous in appearance. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

The gall bladder lumen is moderately distended. The wall is thin and smooth. An excess amount of aggregated echogenic suspended sludge is observed within the lumen. The cystic and common bile ducts are normal.

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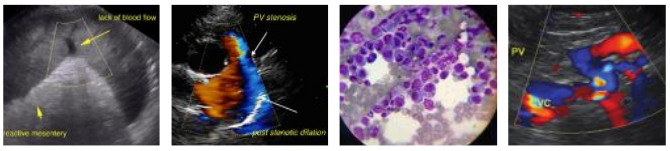


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***Gastrointestinal***

The gastric lumen is mildly distended with ingesta and hard shadowing material. The gastric wall is normal in thickness with a normal layering pattern. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. No obstructive or overt infiltrative disease is noted.

***Pancreas***

The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely isoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

***Free Abdomen***

There is no obvious evidence of free fluid. The abdominal lymph nodes are normal/not visible.

***Other***

A >5 cm well-circumscribed heterogenous mass with fat opacities and cavitated areas is observed in the right cranial to mid-abdomen. Surrounding mesentery is hypoechoic.

## ULTRASONOGRAPHIC FINDINGS

### Primary Findings

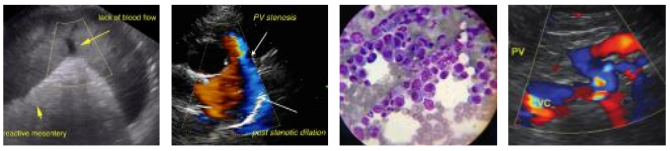
- Splenic masses. Neoplasia (i.e., round cell tumor, sarcoma), is favored with a lower possibility of benign pathology.
- Large hepatic mass. Top differentials include adenocarcinoma, adenoma, and round cell tumor with a low possibility of benign pathology.
- The gall bladder changes could be consistent with a developing mucocele, cholestasis, or less likely, fasting.
- The mass in the right abdomen is most consistent with a necrotic lipoma or liposarcoma, however, other pathology cannot be completely excluded.

### Secondary Findings

- The gastric luminal contents are consistent with ingesta and foreign material. There is no obvious evidence of obstruction.
- Bilateral age-related renal changes with left dystrophic mineralization
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.

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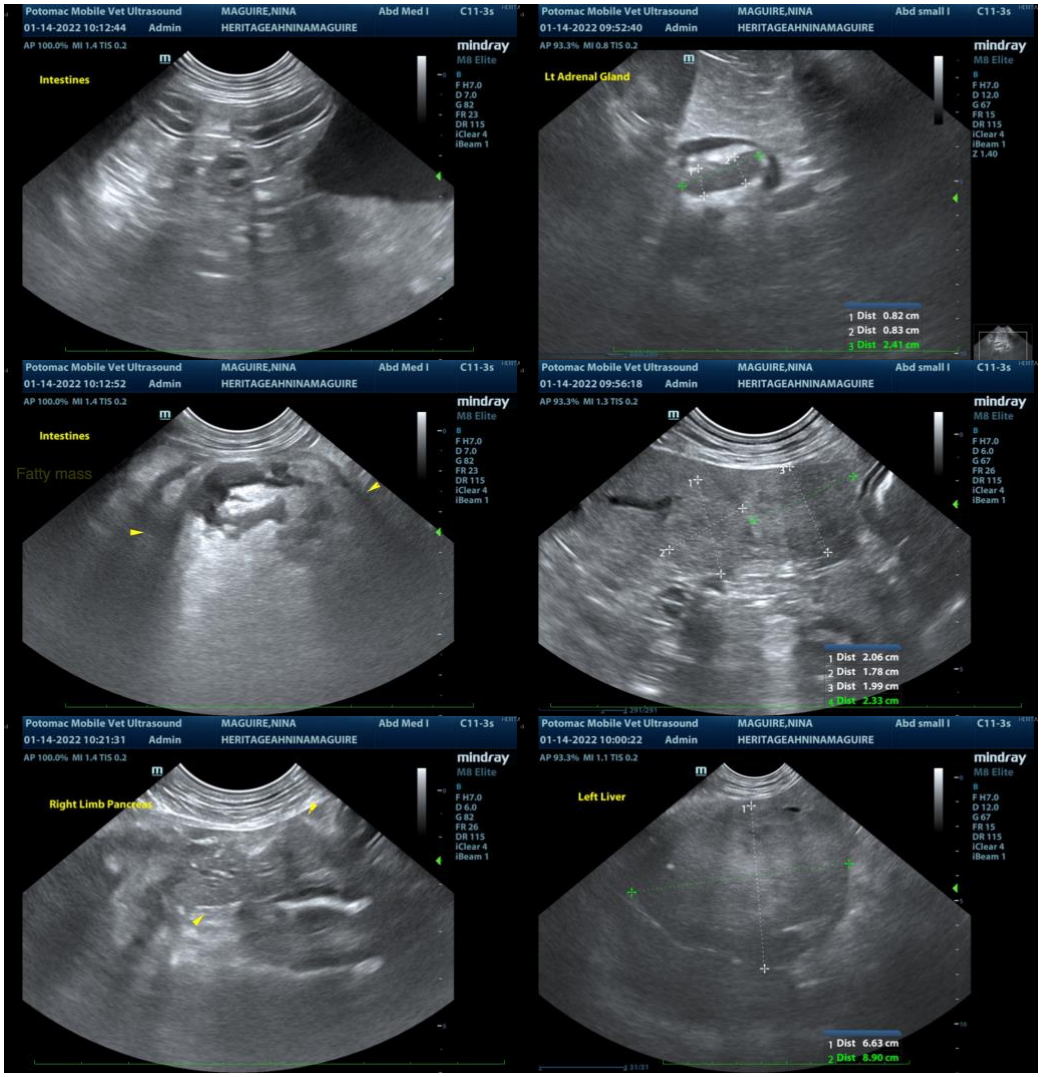
- Fine-needle aspirates at the hepatic and splenic masses can be considered (if clotting status is appropriate). If cytologic evaluations are inconclusive, and aggressive approach is desired, and abdominal exploratory with splenectomy, hepatic mass removal or debulking, and removal of the fatty right abdominal mass can be considered. If surgery is pursued, referral to a board-certified surgeon is recommended. An abdominal CT scan would be useful in presurgical planning. Given the multitude of masses, however, palliative care should be considered in lieu of aggressive treatment.



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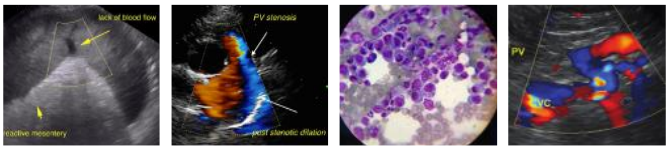

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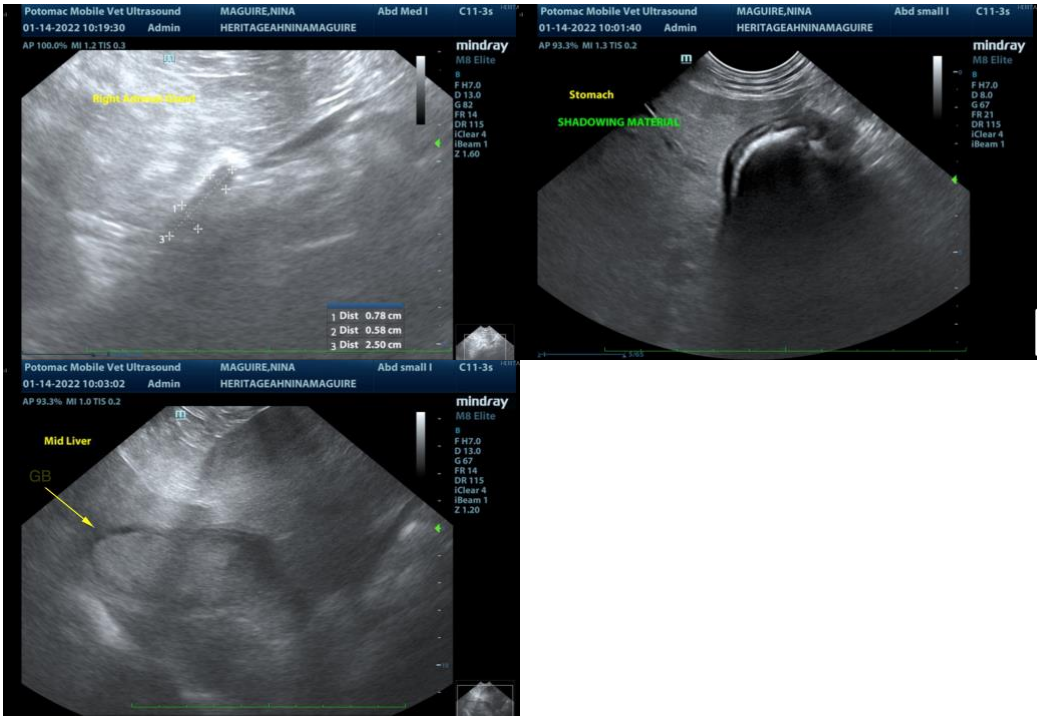


**The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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.

**Andrea Nicastro**, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com