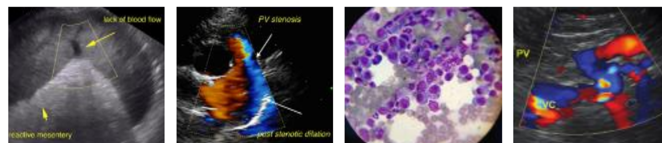
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Maya Suarez

SPECIES
Canine

BREED
Pomeranian

SEX
Female

AGE
11 years

WEIGHT
26 lb

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

IMAGING PERFORMED BY
Dr. G. Ferrer, DVM

HOSPITAL NAME
Paseos Veterinary Center

REFERRING VET
Dr. Franco Ortiz

INVOICE
10176

DATE
1/20/22

PRESENTING CLINICAL SIGNS

Presented as a referral for another clinic for severe anemia. The anemia had a Hematocrit of 9%. Pt presented with a treatment plan including Prednisone 5mg and enalapril. At presentation pt was very weak and lethargic and a blood transfusion was given yesterday and hematocrit increased to 28%. Currently in Unasyn, and was given Dexamethasone yesterday (1-19-22) when getting transfusion. Abdominal ultrasound was done to determine if there is any abnormalities or bleeding that will explain the severe anemia.

Abnormal PE/Chem/CBC/UA Results: Hematocrit 8%

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 is distended. A small amount of suspended echogenic debris is observed within the lumen. 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 presented normal size (5.09 cm in length); with a relatively normal shape. The cortex is diffusely thickened, hyperechoic to heterogenous, with several small cortical cysts. There is moderate loss of corticomedullary distinction. Trace pyelectasia (to 0.21 cm in the transverse plane) is present. At least one small non-obstructive nephrolith is visualized. There is no evidence of infarcts or hydroureter.

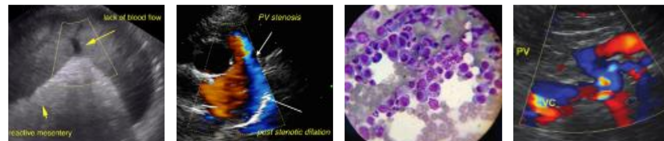
The right kidney presented normal size (6.29 cm in length); with a relatively normal shape. The cortex is variably thickened and hyperechoic to heterogenous with moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Hyperechoic shadowing diverticular foci are visualized. A few cortical cysts are seen. There is trace pyelectasia (0.19 cm in the transverse plane). There is no evidence of hydroureter.

Adrenal Glands
The left adrenal gland is enlarged (0.72 cm at cranial pole) (0.65 cm at caudal pole) (2.17 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 mildly enlarged (0.62 cm at cranial pole) (0.65 cm at caudal pole) (2.35 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 subjectively normal in size (1.13 cm in width at the level of the hilus) with normal curvilinear peripheral contours. The parenchyma is subjectively hypoechoic and slightly mottled in appearance. No distinct focal lesions are observed. Splenic vasculature appears normal with no evidence of thrombosis.

Liver
The liver is subjectively enlarged with slightly irregular peripheral contours. The parenchyma is hyperechoic relative to the spleen. Several varying-sized hyperechoic to heterogenous nodules/masses are observed throughout the organ, the largest measuring 3.68 cm in length. The larger lesion causes slight capsular expansion. A 0.96 cm ill-defined hypoechoic nodule is also seen.



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Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

The gall bladder is moderately distended. The wall is thickened (up to 0.32 cm) and edematous with a “double-walled” effect. A moderate amount of aggregated echogenic suspended debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is not distended. 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 ileocecocolic junction and colonic wall are 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 hyperechoic 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

The peritoneal cavity is normal. There is no evidence of inflammation or effusion. The abdominal lymph nodes are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

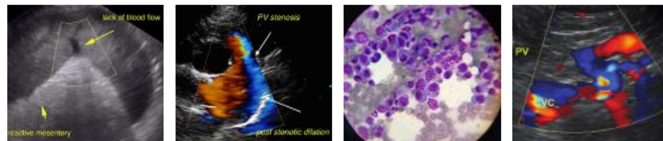
- The hepatic nodules/masses could be consistent with a neoplastic process. Alternatively, benign regenerative nodular hyperplasia may be present.
- The gall bladder wall changes could be consistent with immune-mediated disease, cholecystitis, recent blood transfusion, increased hydrostatic pressure, or less likely, anaphylaxis. The luminal debris/sludge could be consistent with a developing mucocele, cholestasis or fasting.

Secondary Findings

- Age-related pancreatic remodeling/fibrosis. Concurrent low-grade pancreatitits may also be present, particularly if the patient is painful on cranial abdominal palpation.
- The splenic parenchymal changes are most consistent with extramedullary hematopoiesis or lymphoid hyperplasia. Infiltrative neoplasia is possible but considered unlikely.
- Mild bilateral adrenomegaly.
- Bilateral chronic nephropathy with left nonobstructive nephrolithiasis, right dystrophic mineralization and bilateral cortical cysts.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for neoplasia in the chest.



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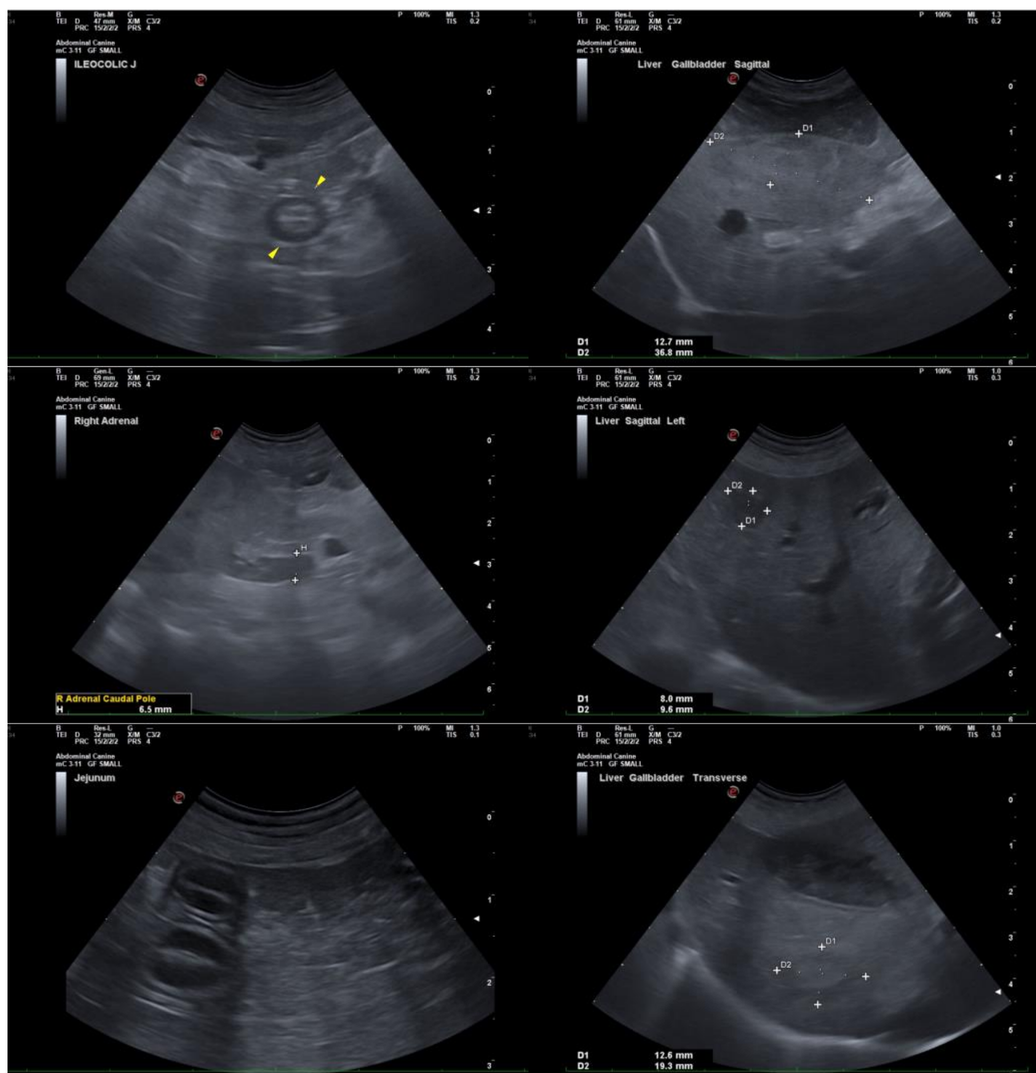
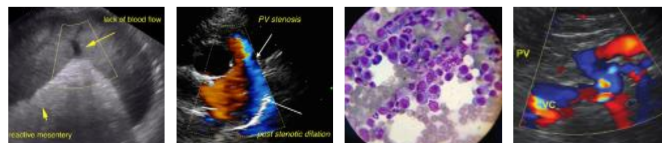
- If clotting status is appropriate, consider fine-needle aspirates of the hepatic nodules. Hepatic cytology is often inconclusive for primary hepatic tumors. However, it can be useful to assess for round cell neoplasia.
- Given the severe anemia, a reticulocyte count is recommended to assess for a regenerative response. If non-regenerative, a bone-marrow aspirate may be warranted. Also consider further testing for tick-borne diseases.
- Serial monitoring of the gall bladder is recommended to assess for progression/resolution of the wall changes and the presence of debris.





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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. 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.

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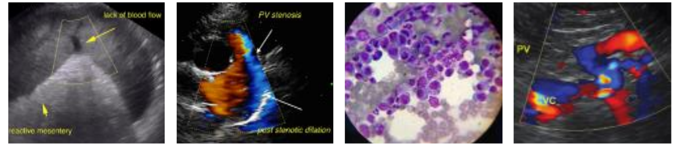

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