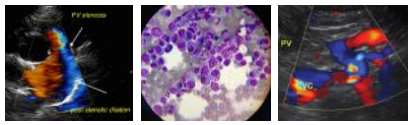
IMAGING PERFORMED BY

IntraPet.com



SonoPath
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DATE

1/20/2022

PATIENT

Roger Cross

SPECIES

Canine

BREED

Pitbull Terrier

SEX

Neutered Male

AGE

4-15-2006

WEIGHT

82 lbs

INTERPRETED BY

Andrea Nicastro, DMV, Diplomate DACVIM (Small Animal Internal Medicine)

HOSPITAL NAME

Eastern Animal Hospital

REFERRING VET

Dr. Haviland

INVOICE

10167

PRESENTING CLINICAL SIGNS

History: Present for hematochezia after eating chicken bones. Rads performed.

Current Medications: Metronidazole 750 mg po bid 10 d, Proviable, Carprofen 100 mg am, 50 mg pm.
Lab Results: BW pending (prev elevation ALT, ALP, Cholesterol). Attached separately.
Radiographs: Concerns for cranial abdominal mass. Attached separately.
Date of Previous IntraPet Ultrasound: No previous IntraPet scans.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

Imaging Performed By: Andi Parkinson, RDMS.

Additional history: Mild thrombocytosis. ALP 898.

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 prostate is not definitively visualized due to its pelvic location.

The left kidney is normal size (8.96 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. A 2.30 x 2.05 cm irregular cortical cyst is observed at the cranial medial aspect. The cyst does not cause significant capsular expansion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney is normal size (8.47 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is enlarged (1.19 cm at cranial pole) (1.45 cm at caudal pole) (3.69 cm in length); with a slightly irregular shape. The parenchyma is subtly heterogenous with some loss of glandular detail. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is enlarged (1.33 cm at cranial pole) (1.65 cm at caudal pole) (3.31 cm in length); with a slightly irregular shape. The parenchyma is subtly heterogenous with some loss of glandular detail. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (2.35 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A 0.75 cm irregular anechoic cyst is observed at the cranial medial aspect. Splenic vasculature is normal.

Liver

The liver is subjectively prominent in size with slightly irregular peripheral contours. The parenchyma is isoechoic relative to the spleen and somewhat heterogenous in appearance, with at least one ill-defined hyperechoic nodule/area. In addition, a 5.15 x 2.63 cm irregular cystic lesion is observed deep on the right

side, adjacent to the diaphragm. 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. A moderate amount of mostly gravity dependent aggregated echogenic debris/sludge is observed within the lumen. The cystic and common bile ducts are normal.

Gastrointestinal
The gastric lumen is distended with ingesta. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is segmentally dilated with gas and chyme. 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 region of the pancreas is isoechoic relative to surrounding omental fat. There is no evidence of regional inflammation or effusion. See "*Other*" category

Free Abdomen
There is no evidence of free fluid.

Lymph Nodes
See "*Other*" category

Other
A 1.08 x 0.93 cm hypoechoic to heterogenous nodule is observed in the right cranial quadrant.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory and infiltrative disease are considered less likely. The cystic hepatic lesion on the right side likely represents a benign incidental finding, with a lower possibility of an emerging neoplastic process.

- Bilateral adrenomegaly

- The presence of ingesta in the gastric lumen despite fasting is suggestive of delayed gastric emptying.

- The origin of the nodule in the right cranial quadrant is unclear. It may be arising from pancreas, mesentery, lymph node, other. Differentials include benign change versus emerging neoplasia.

  *There is no obvious evidence of a cranial abdominal mass.

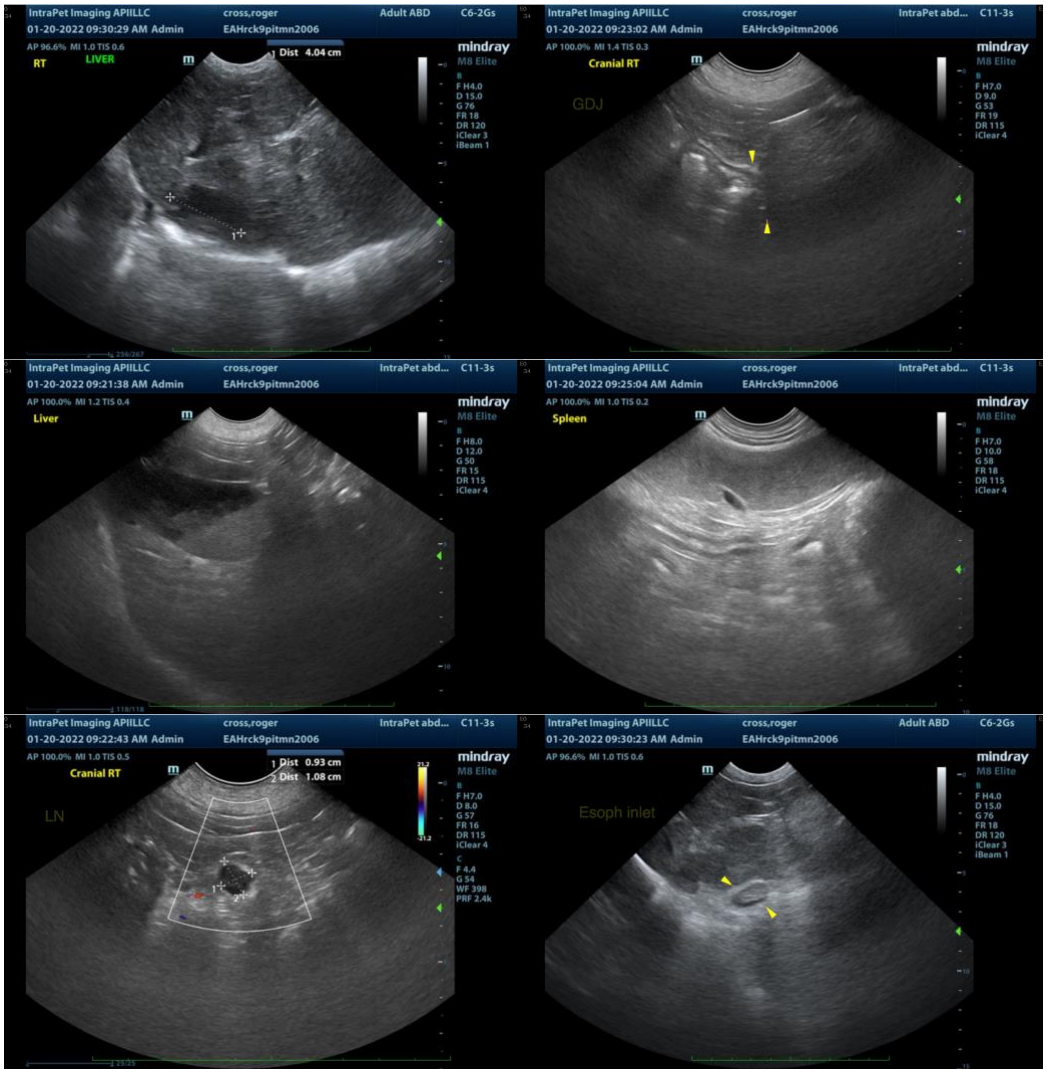
Secondary Findings

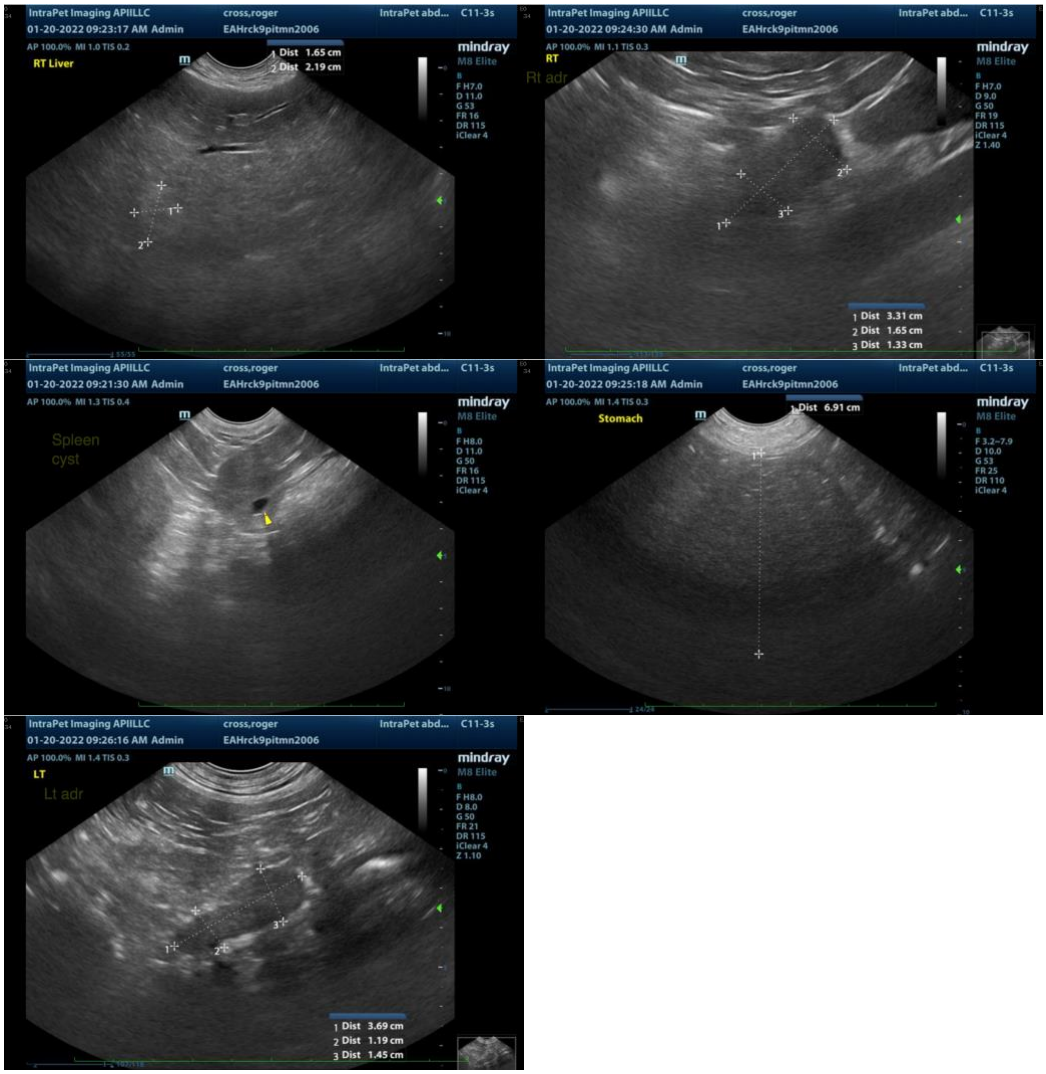
- Bilateral age-related renal changes with a left cortical cyst

- The small cystic lesion within the splenic parenchyma trends toward the benign with a lower possibility of emerging neoplasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Consider testing for hyperadrenocorticism with a low-dose dexamethasone suppression test or ACTH stimulation test if clinical signs (i.e., PU/PD) develop in the future.
- Consider a repeat ultrasound in 4-6 weeks to reevaluate the cystic splenic and hepatic lesions and cranial abdominal nodule for growth/progression.
- Given the patient's age, consider thoracic radiographs to assess cardiopulmonary status





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.

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