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Clinical Sonography & Telecytology
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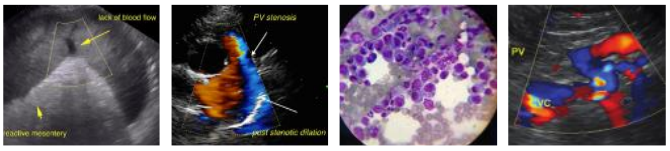

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Chewy Roman

SPECIES
Canine

BREED
Chihuahua

SEX
Neutered Male

AGE
7.5 years

WEIGHT
8.4 lbs

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

IMAGING PERFORMED BY
Potomac Mobile Veterinary Ultrasound

HOSPITAL NAME
Leesburg VH

REFERRING VET
Dr. Cathy Jarrett

INVOICE
10185

DATE
1/21/22

PRESENTING CLINICAL SIGNS

History: Inappetance for two weeks. Labwork is normal. Radiographs suggest general intestinal ileus. Concern for mottled enlarged spleen. Getting Mirtazipine.
Abnormal PE/Chem/CBC/UA Results: Increased monocytes 1428, Increased platelets 700,000, Anaplasma positive.

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 mostly 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 normal in size (1.49cm in length) (0.86 cm in width) with a normal shape and smooth peripheral contours. Parenchyma is mostly homogenous with a few pinpoint mineralizations. The prostatic urethra is not overtly dilated.

The left kidney is normal in size (3.50 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. An ill-defined hyperechoic medullary band is observed adjacent to the corticomedullary junction.

The right kidney is normal in size (3.26 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. An ill-defined hyperechoic medullary band is observed adjacent to the corticomedullary junction.

Adrenal Glands

The left adrenal gland is normal size (0.31 cm at cranial pole) (0.35 cm at caudal pole) (1.08 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 (0.36 cm at cranial pole) (0.36 cm at caudal pole) (1.42 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 normal in size with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver

A 6.5 x 3.46 cm irregular heterogenous vascular mass is arising from the caudal aspect, via a stalk (near the gall bladder). The mesentery effacing the serosal surface of the mass is hyperechoic. A 0.89 x 0.87 cm hypoechoic nodule is also observed on the left side. The remaining hepatic parenchyma is hypoechoic relative to the spleen and slightly mottled in appearance. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

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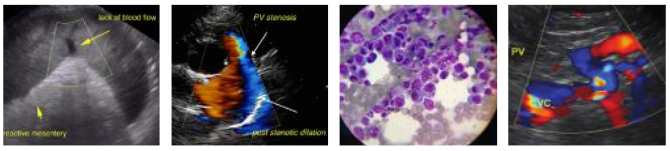

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The gall bladder lumen is moderately distended. The wall is thin and smooth. A small amount of aggregated echogenic suspended debris is observed within the lumen. The cystic and common bile ducts are normal.

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 colonic wall is normal. No obstructive or overt infiltrative disease is noted.

Pancreas
A portion of the pancreas is obscured by the hepatic mass. In the visualized portion of the right limb, the pancreas is prominent in size with minimal deviation from the normal peripheral contours. The parenchyma is largely isoechoic relative to surrounding omental fat and mottled in appearance. No distinct focal lesions are observed. The pancreatic duct is not overtly dilated.

Free Abdomen
The peritoneal cavity is normal. There is no evidence of inflammation or effusion. A few prominent jejunal lymph nodes are visualized, the largest measuring 1.12 cm in length.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

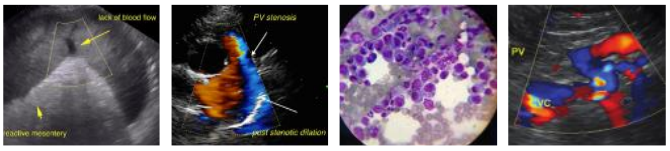
- A large hepatic mass. Neoplasia (i.e., adenocarcinoma, adenoma, round cell tumor) is considered likely, with a lower possibility of benign pathology. Regional peritonitis is present. The left hepatic nodule could be consistent with a metastatic lesion or a benign process (i.e., regenerative nodule).
- Bilateral non-specific chronic age-related renal changes with 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.
- The lymph node changes are most consistent with reactive lymphadenitis or lymphoid hyperplasia.

Secondary Findings

- The pinpoint mineralizations within the prostatic parenchyma may be an incidental finding, however, mineralization can be associated with prostatic neoplasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
- If there is no evidence of pulmonary metastatic disease and an aggressive approach is desired, an abdominal exploratory with hepatic mass removal and biopsy of the left hepatic nodule can be considered. The client should be warned, however, of the possibility of metastatic disease.



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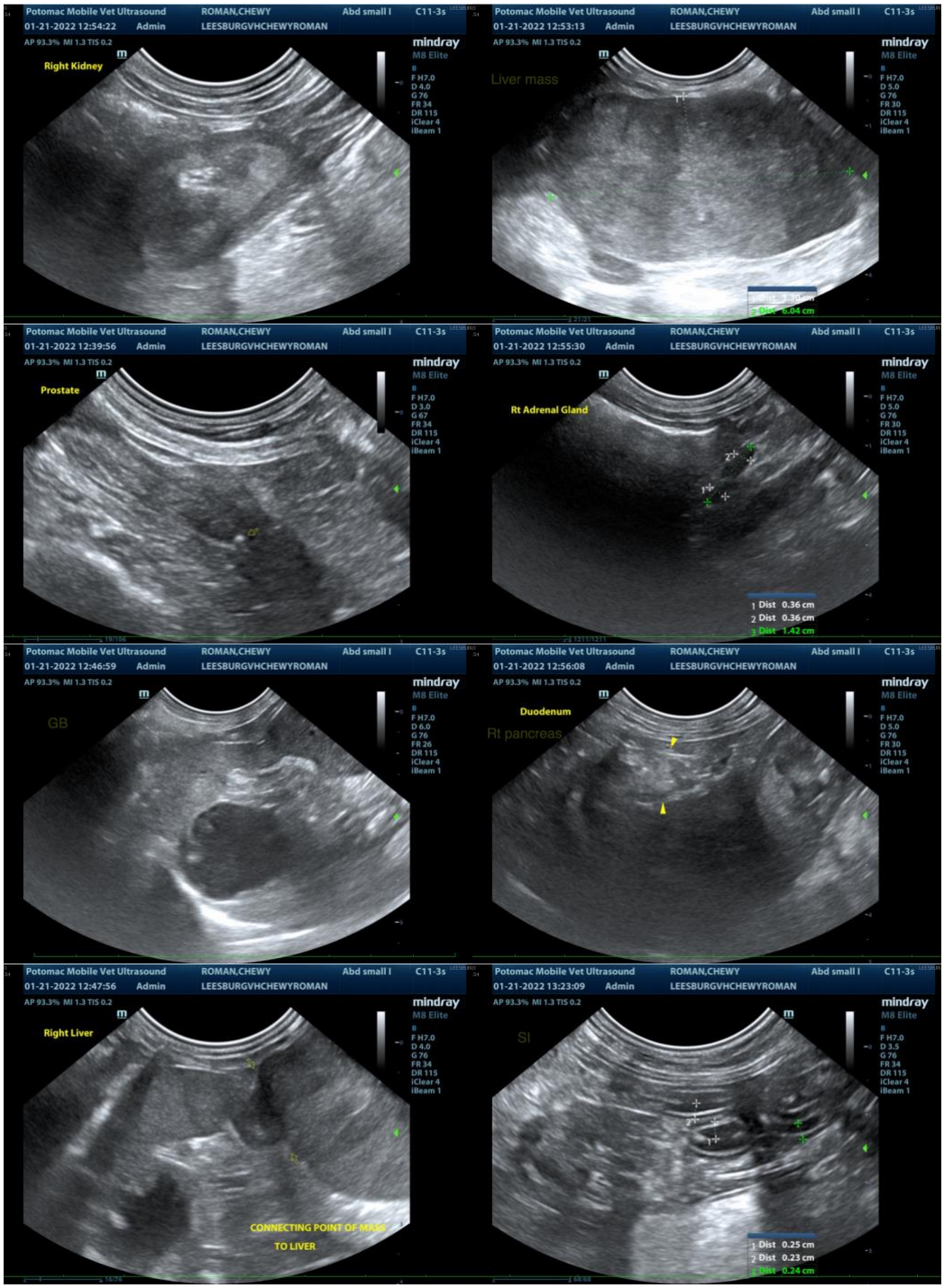
A fine-needle aspirate of the hepatic mass can be considered prior to surgery. However, cytology results from primary hepatic tumors are often inconclusive.

- If a more conservative approach is desired, palliative care is recommended.



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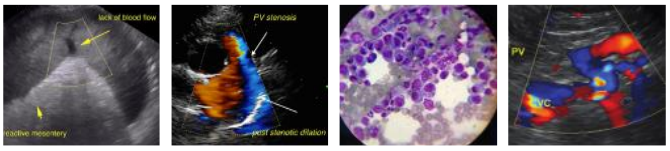

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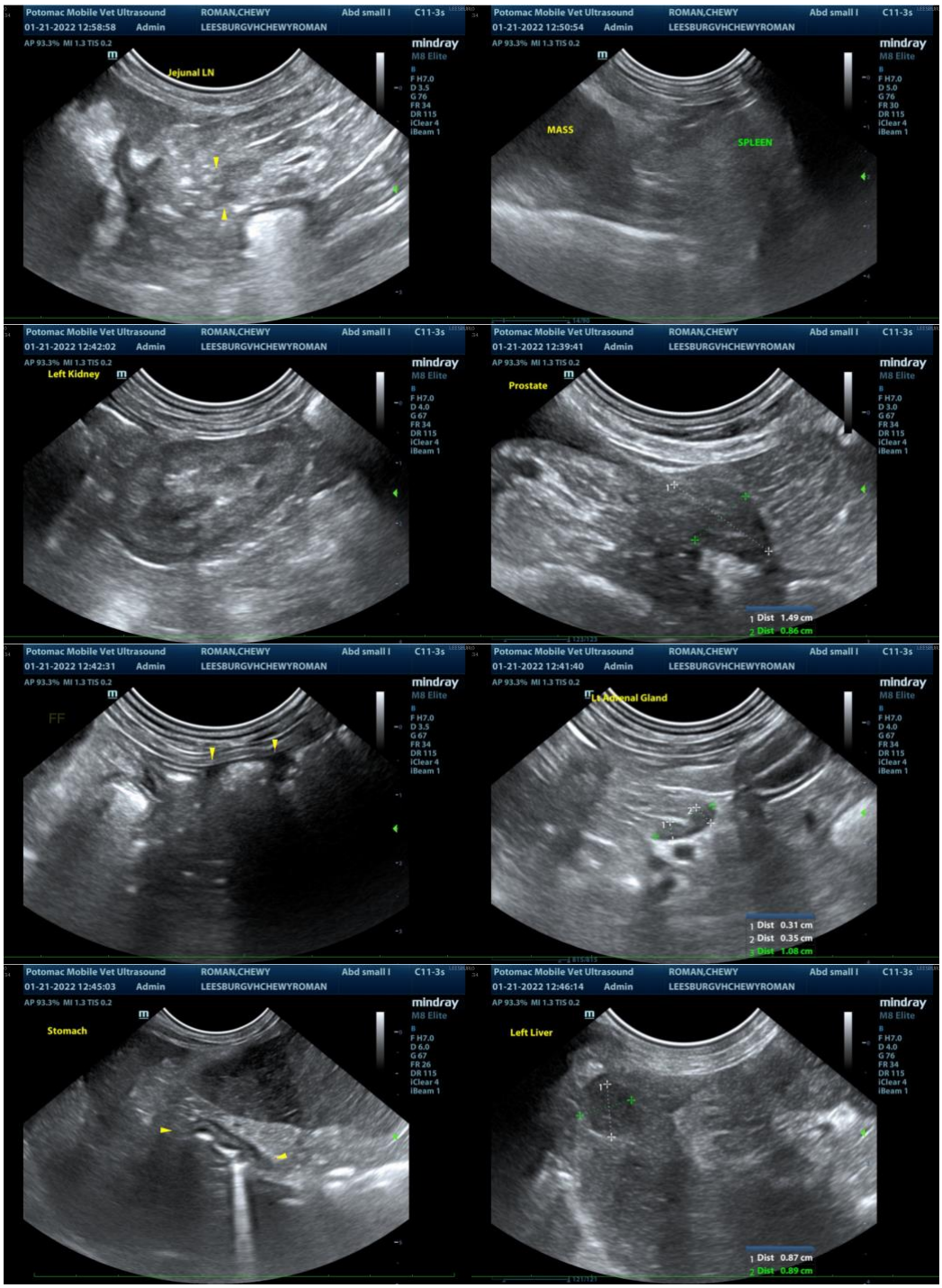

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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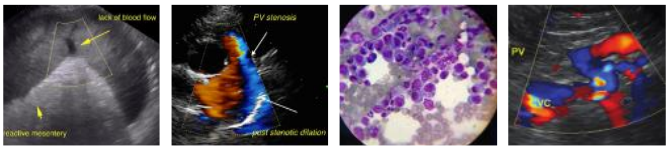

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Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance, please contact me.

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