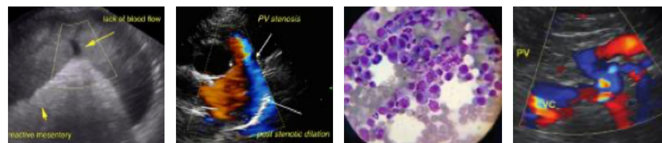

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1-800-838-4268 info@sonopath.com

PATIENT

Cakes Murphy

SPECIES

Canine

BREED

Yorkie

SEX

Female, spayed

AGE

12.5 Yrs.

WEIGHT

5.3 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Barnes

HOSPITAL NAME

Westview VH

REFERRING VET

Dr. Barnes

INVOICE

14415

DATE

1/9/23

PRESENTING CLINICAL SIGNS

History: Repeat AUS, LAst scan Sep, 2022. Previous Primary Findings: 1) The hepatic parenchymal changes are most concerning for infiltrative neoplasia (i.e., lymphoma or other round cell tumor), however a multifocal inflammatory process cannot be excluded. 2) The gallbladder changes are consistent with an emerging mucocele. 3) The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely. Previous Secondary Findings: 1) Bilateral minor degenerative renal changes with non-obstructive nephrolithiasis. 2) Borderline bilateral adrenomegaly. Histo and FNA of the liver:TDX: Vacuolar Hepatopathy

Abnormal PE/Chem/CBC/UA Results: Dog doing well, R/C scan and bloods pending. Previous BA panal Normal

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder and visible portion of the pelvic urethra are normal for the degree of luminal distension. The urine is anechoic with no evidence of debris. Cystic calculi and discrete masses are not observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The left kidney is normal size (3.88 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. Pinpoint hyperechoic to mineralized foci are observed within the cortex. Several non-obstructive nephroliths are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. 1-2 small cortical cysts are seen.

The right kidney is normal size (3.76 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. Pinpoint hyperechoic to mineralized foci are observed within the cortex. Several non-obstructive nephroliths are visualized. There is no evidence of pyelectasia, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is borderline enlarged (0.55 cm at cranial pole) (0.60 cm at caudal pole) (1.65 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.

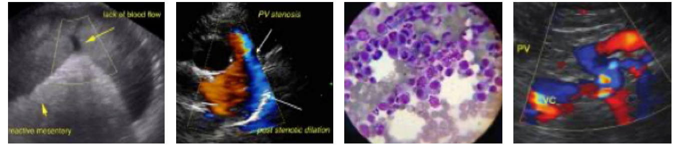
The right adrenal gland is mildly enlarged (0.67 cm at cranial pole) (0.67 cm at caudal pole) (2.08 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (1.21 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. Several ill-defined myelolipomas are observed in the region of the hilus. Splenic vasculature is normal.

Liver

The liver is enlarged with swollen to slightly irregular peripheral contours. The parenchyma is isoechoic relative to the spleen and diffusely and severely mottled in appearance with numerous hypoechoic



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nodules throughout the organ. A 2.4 cm well circumscribed hypoechoic mass is observed adjacent to the diaphragm, on the right side. Vascular and biliary tracts are of normal volume with no evidence of congestion. The gall bladder lumen is distended. The wall is normal in thickness. A moderate amount of gravity-dependent echogenic to mineralized debris/sludge is observed within the lumen. In addition, a small amount of debris is adhered to the luminal surface. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is not distended. 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 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 disease is noted.

Pancreas

The region of the pancreas is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional 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:

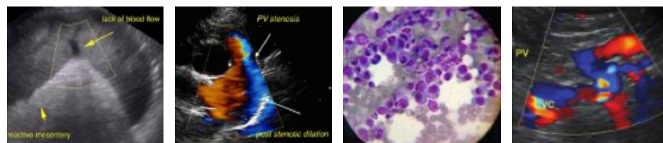
- The hepatic parenchymal changes are concerning for infiltrative neoplasia. However, severe inflammatory disease, excessive regenerative nodular hyperplasia, hepatotoxicosis (i.e., copper) or other hepatopathy cannot be completely excluded, particularly given that the patient has been doing well since the previous scan. Changes are similar to the previous sonogram.
- Gallbladder sludge, non-mucocele. Changes have improved since the previous sonogram.

Secondary Findings:

- Bilateral chronic age-related renal changes with non-obstructive nephrocalcinosis.
- Mild bilateral adrenomegaly.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Hepatic tissue sampling (i.e., fine needle aspirate or biopsies) can be considered at this time, if not already performed. If biopsies are pursued, hepatic copper quantitation should be performed, and aerobic and anaerobic bile cultures obtained.
- If hepatic tissue sampling is not pursued at this time, consider serial monitoring of the patient's liver values and hepatic sonographic appearance.



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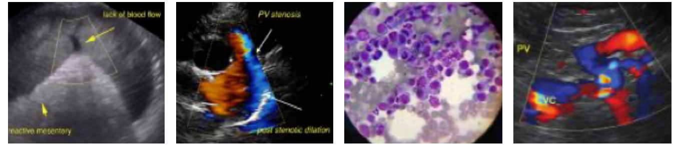
- Consider testing for hyperadrenocorticism with a low-dose dexamethasone suppression test or ACTH stimulation test if clinical signs (i.e., PU/PD) develop.

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



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