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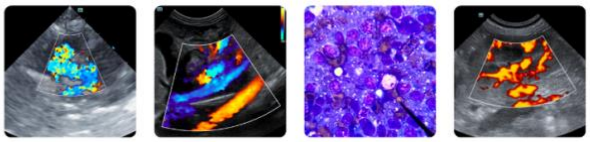

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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PATIENT

Levi Buck

SPECIES

Canine

BREED

Beagle

SEX

Neutered Male

AGE

11 years 1 mo

WEIGHT

49.8 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Katelyn Mazzochette DVM

HOSPITAL NAME

Airpark AH

REFERRING VET

Ben Kable, DVM

INVOICE

22255

DATE

11-13-25

PRESENTING CLINICAL SIGNS

History: Seen recently at local ER for vague clinical signs, 4cm splenic mass identified on ultrasound. Bloodwork was performed at ER and was wnl, 4dx neg. O has since indicated an interest in a higher-level ultrasound prior to surgical splenectomy.

Abnormal PE/Chem/CBC/UA Results: BW WNL, 4dx neg

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness. The mucosal surface is smooth. The bladder is moderately distended. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The prostate is normal in size (1.01 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal in size (5.96 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (5.88 cm in length) with an irregular shape. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. There is a questionable cortical infarct at the lateral aspect. Trace pyelectasia is present. At least one, small, cortical cyst is seen at the cranial pole. There is no evidence of nephroliths, or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.70 cm at cranial pole) (0.63 cm at caudal pole) with a normal shape and 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 in size (0.69 cm at cranial pole) (0.60 cm at caudal pole) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

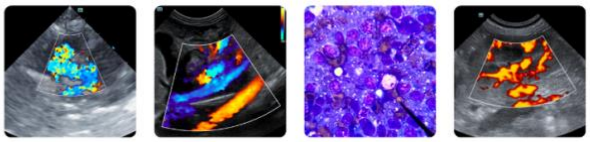
Spleen

A 5.2 x 4.3 cm hypoechoic expansile mass appears to be arising from the splenic parenchyma. In addition, a, 0.83 cm hypoechoic nodule is observed at the medial aspect. In the remainder of the spleen, the margins are curvilinear, and the parenchyma is of appropriate echogenicity and echotexture. Splenic vasculature is normal with no evidence of thrombosis.

Liver

The liver is subjectively normal in size with normal peripheral contours. The parenchyma is hypoechoic relative to the spleen and subtly mottled in appearance. Severa, small, hyperechoic nodules are observed throughout the organ. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

The gallbladder lumen is moderately distended. The wall is thin and smooth. A small amount of echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.



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Gastrointestinal

The gastric lumen is mildly 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 not dilated. The small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. There is no evidence of an obstructive pattern.

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.

Lymph Nodes

The abdominal lymph nodes are normal/not visible.

Free Abdomen

There is no obvious evidence of free fluid.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Abdominal mass, suspected to be of splenic origin. Neoplasia (i.e., round cell tumor, sarcoma) is suspected, with a low possibility of a non-neoplastic process. The hypoechoic splenic nodule at the medial aspect may represent a metastatic lesion or a benign focus (i.e., lymphoid hyperplasia or similar).

Secondary Findings

- The hyperechoic hepatic nodules trend toward the benign (i.e., myelolipomas, regenerative nodules) with a lower possibility of more insidious hepatic pathology. The diffuse hepatic parenchymal changes are most consistent with benign age-related remodeling, with a lower possibility of metastatic disease, an inflammatory hepatopathy, hepatotoxicosis, and/or other hepatopathy.
- Bilateral age-related renal changes with trace right pyell, and a possible right cortical infarct
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Minor retained gastric ingesta

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for pulmonary metastases
- Consider fine-needle aspiration of the splenic mass (if accessible and if clotting status is appropriate). A 25-gauge needle should be used. If the mass is not accessible or cytology results are inconclusive, consider a splenectomy with submission of the spleen for histopathology. Liver biopsies should also be obtained at the time of surgery to assess for micrometastatic disease.

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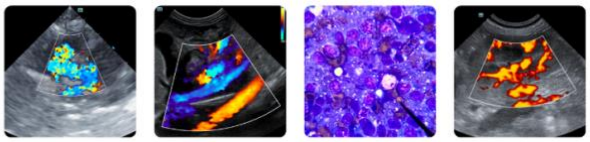

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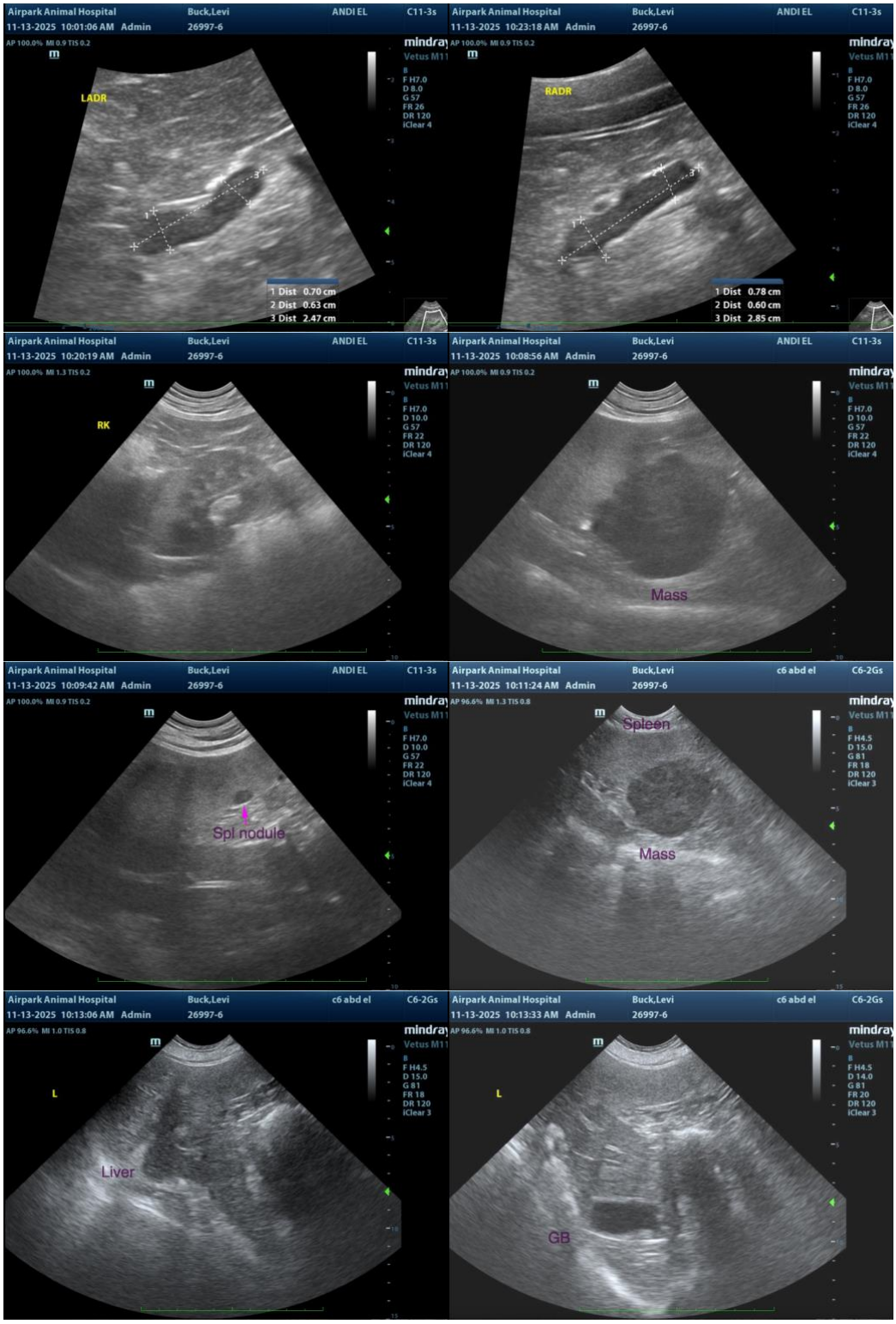

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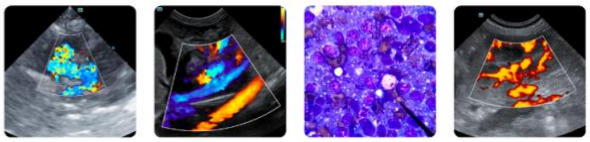

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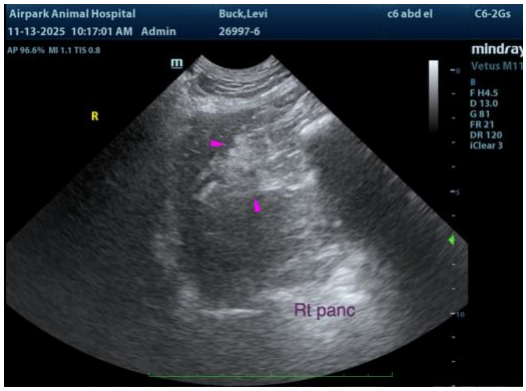

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
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