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Clinical Sonography & Telecytology
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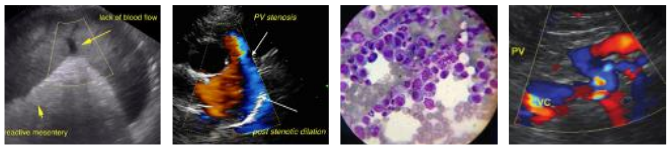


SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Sophie Spalluto-Hued

SPECIES

Canine

BREED

Havanese

SEX

Spayed Female

AGE

13 Years

WEIGHT

22.5 Lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Shari Reffi, CVT

HOSPITAL NAME

Whippany VH

REFERRING VET

Dr. Smith

INVOICE

12805

DATE

12/2/21

PRESENTING CLINICAL SIGNS

History: Recurrent E. Coli bladder infections. Current meds: Enrofloxacin 68mg sid at night. RC SO. Hx of cystotomy 2/2021.

Abnormal PE/Chem/CBC/UA Results: C&S E. Coli, WBC 37-50/HPF, USG 1.032

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended. The wall in the region of the apex is mildly thickened (up to 0.44 cm) with a slightly irregular mucosal surface. A 0.37 cm cystic calculus is observed within the lumen as well as a small amount of echogenic debris. The region of the trigone and the proximal urethra, visible to a depth of 2.0 cm, are normal.

The left kidney presented normal size (5.06 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. Moderate pyelectasia is present (0.47 cm in the longitudinal plane). A few non-obstructive nephroliths are visualized. A few small cortical cysts are observed. There is no evidence of infarcts or hydroureter. Renal vasculature is normal.

The right kidney presented normal size (5.15 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. Trace pyelectasia is present. Several non-obstructive nephroliths are visualized. A few small cortical cysts are visualized. There is no evidence of infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.55 cm at cranial pole) (0.78 cm at caudal pole) (1.96 cm in length); with a 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 (0.79 cm at cranial pole) (0.74 cm at caudal pole) (2.16 cm in length); with a 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.

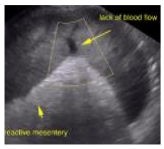
Spleen

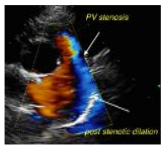
The spleen is normal in size (1.51 cm at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

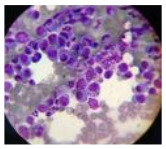
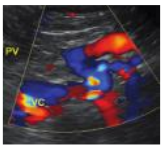
Liver

The liver is subjectively normal in size. The parenchyma is isoechoic relative to the spleen. A 3.98 cm x 3.74 cm slightly hyperechoic to heterogeneous mass is observed approximately mid liver. The mass causes slight expansion of the caudal margins. 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 small amount of





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partially dependent echogenic debris is observed within the lumen. The cystic and common bile ducts are normal.

Gastrointestinal

The gastric lumen is mildly to moderately 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 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. No obvious parenchymal abnormalities are observed. There is no evidence of regional inflammation or effusion.

Free Abdomen

There is no evidence of free fluid. A 1.94 cm x 0.58 cm medial iliac lymph node is visualized.

Other

A 1.98 cm x 1.68 cm septated cystic lesion is observed just caudal to the left renal artery.

A brief echocardiogram (no charge) reveals no evidence of pericardial effusion or obvious right atrial/auricular mass.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

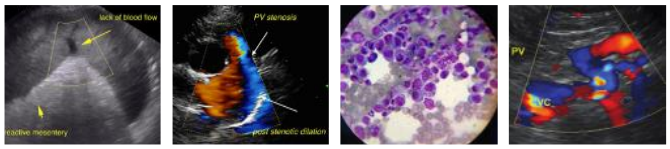
- Cystic calculus with bladder wall changes suggestive of cystitis
- Hepatic mass (mid liver). Neoplasia (i.e., adenoma, adenocarcinoma) is suspected. However, benign pathology (i.e., regenerative nodular hyperplasia) cannot be completely excluded.

Secondary Findings

- Bilateral age-related renal changes with non-obstructive nephrolithiasis
- Mild bilateral adrenomegaly
- The prominent medial iliac lymph node likely represents reactive lymphadenitis or lymphoid hyperplasia.
- The origin of the cystic lesion, caudal to the left adrenal gland, is unclear. It may be arising from mesentery, lymph node, other. Differentials include benign cyst, hematoma, emerging neoplasia (i.e., hemangioma, hemangiosarcoma), other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
- If an aggressive approach is desired, consider and abdominal exploratory with cystotomy and submission of the cystic calculus for analysis and culture. Hepatic mass removal and



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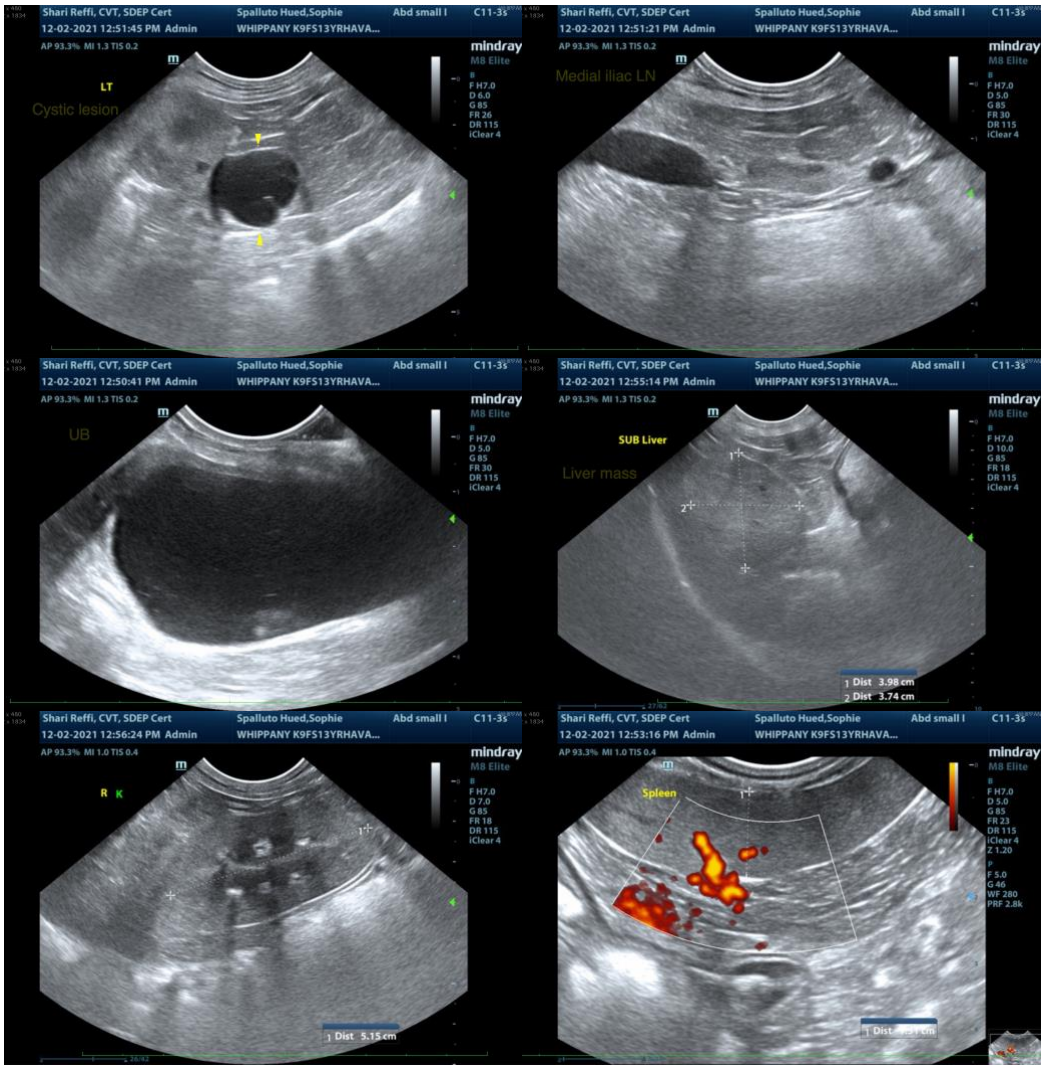
submission of the liver mass for histopathology can also be performed concurrently. An abdominal CT scan would be useful in presurgical planning. Consider referral to a board-certified surgeon if the potential for perioperative complications associated with hepatic mass removal.

- 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.



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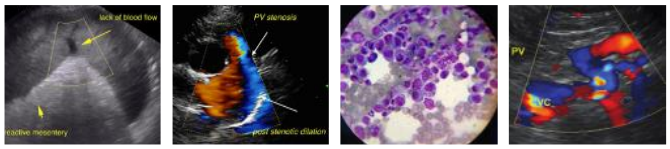

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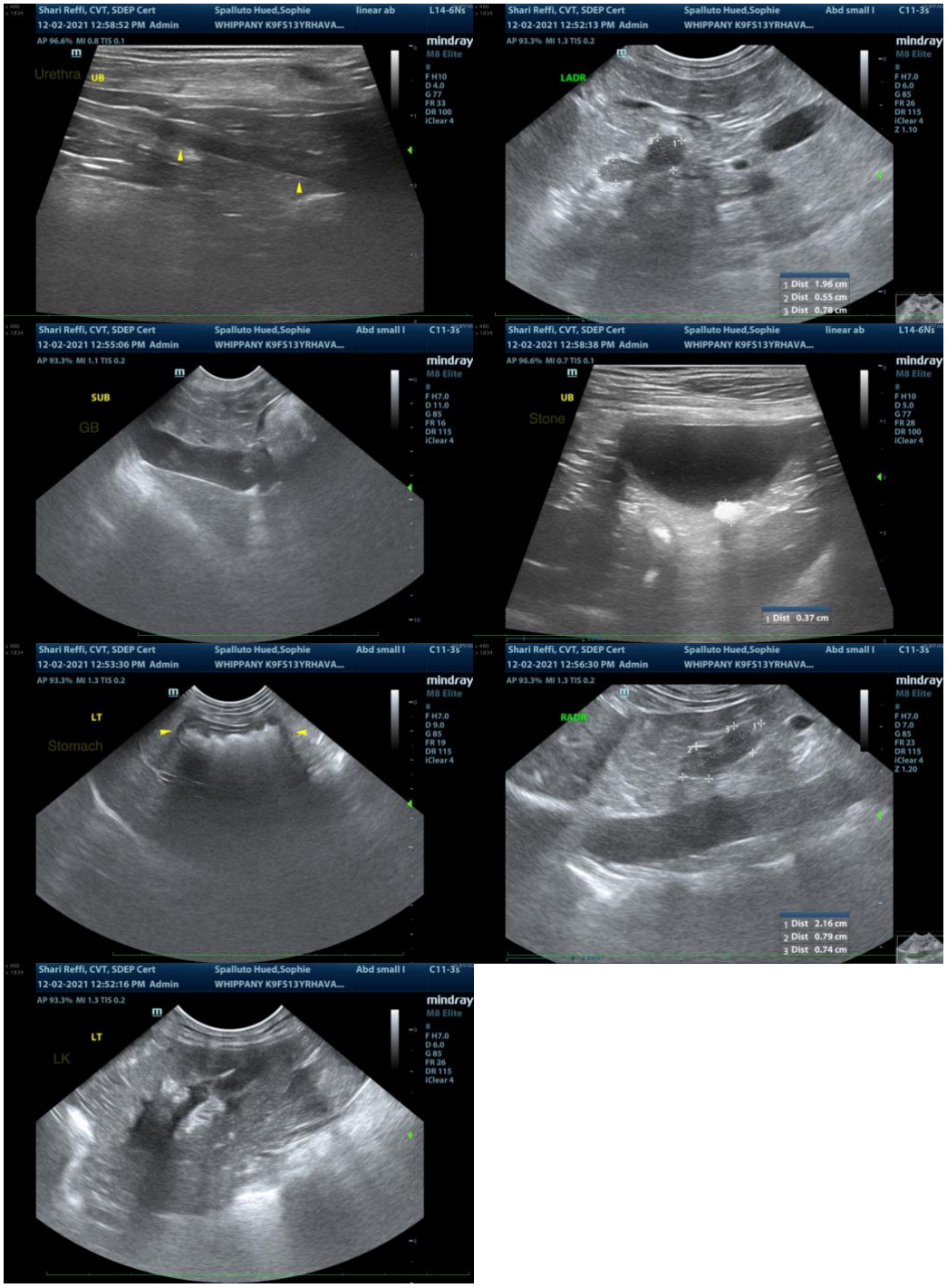

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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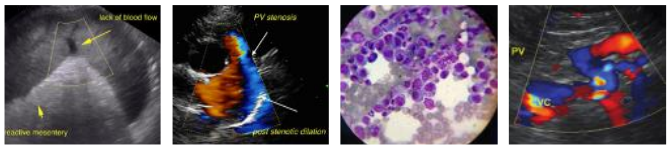

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