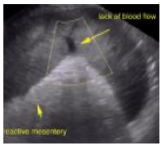
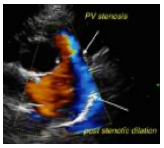
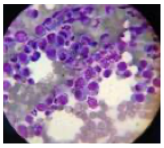
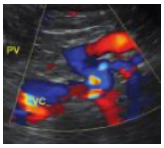
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

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

PATIENT

Abby Dennis

SPECIES

Canine

BREED

Pug

SEX

Spayed Female

AGE

12 years

WEIGHT

16 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Tracy Nyberg

HOSPITAL NAME

Stuga North VS

REFERRING VET

Tracy Nyberg

INVOICE

11911

DATE

12.22.22

PRESENTING CLINICAL SIGNS

History: Appointment reason: vomiting at night for the last week or so, this has been a chronic issue, but worsening. Recent 2-week history of increased regurgitation of foamy liquid at random times (O originally would complain of vomiting, but she did it in the exam today and it was clearly regurgitation and O said that is how it has been over the last 2 years); weight loss over the last 2 years, but most dramatic over the last 2 months (down 1#); Down 5# from March 2022. She was seen 2 years ago for the start of vomiting (possibly regurgitation), started on metoclopramide, did not work per O; she was put on ZD diet 1 year ago, this has not had any effect of this symptom of vomiting. She also has a recent history of defecating passively in the house/fecal incontinence. Eating well, no diarrhea. Upon PE, BAR, wandering around the room, NS OU (mild ocular d/c), NND, audible upper respiratory noise, no HM, clear lung sounds; abdomen soft, non-painful. During examination she stood up and regurgitated a small amount of yellow, foamy liquid. She has hind end weakness but wearing on the claws. Rads were performed and also submitted previously to Sonopath for interp. Owner reports today since being on metoclopramide, famotidine, and omeprazole she has gained weight and is no longer having the regurgitation like she previously had.

Abnormal PE/Chem/CBC/UA Results: April 2022: Senior panel: Lyme +, UTI but

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is mildly to moderately distended. A small amount of suspended echogenic debris is observed within the lumen. No masses, inflammatory changes or calculi are observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The left kidney is normal size (3.65 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis.

The right kidney is normal size (4.39 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.64 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.

The region of the right adrenal gland is evaluated. No obvious pathology is observed.

Spleen

The tip of the cranial pole is visualized and appears normal in size with normal curvilinear peripheral contours and homogenous parenchyma.

Liver

The liver is overall normal in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the visualized portions of the spleen and mostly homogenous in appearance. A 2.79 cm mass appears to be arising from the cranial aspect on the right side, and is invading into the caudal vena cava. Hepatic vasculature and intrahepatic biliary tracts are otherwise of normal volume with no evidence of congestion.

The gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal
The gastric lumen is distended with ingesta. 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.

Pancreas
The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely isoechoic 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.

Free Abdomen
The peritoneal cavity is normal. There is no evidence of inflammation or effusion. The abdominal lymph nodes are normal/not visible.

Other
Pleural effusion is seen on brief visualized of the thorax. There is no obvious evidence of pericardial effusion.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

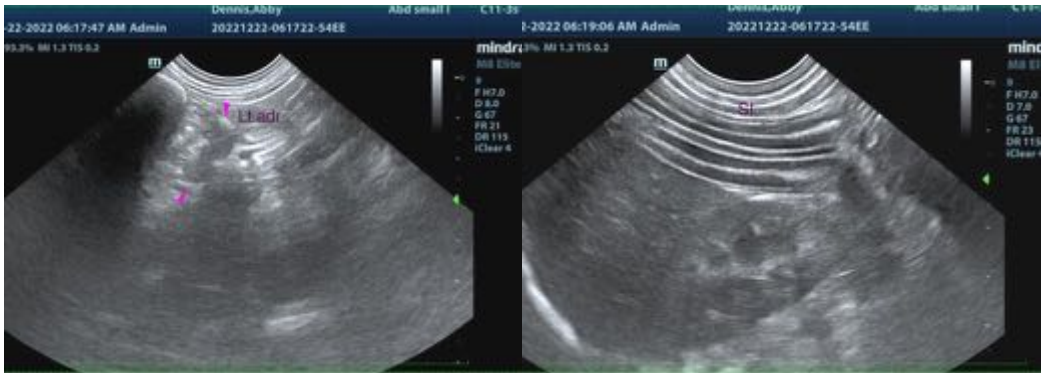
- Mass in thoracic caudal vena cava, which appears to be arising from hepatic parenchyma. Neoplasia (i.e., carcinoma, other) is suspected.
- Pleural effusion

Secondary Findings

- Mild bilateral age-related renal changes with left dystrophic mineralization
- Mild left adrenomegaly
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The presence of ingesta in the gastric lumen despite fasting is suggestive of delayed gastric emptying.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Repeat thoracic radiographs are recommended to assess for the development of pleural effusion since the last x-rays were taken.
- A thoracic/abdominal CT scan would be useful in further characterizing the mass in the thoracic vena cava.
- Depending on the results of the above diagnostics, a more advanced regurgitation work-up may be warranted.



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.

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