

PATIENT

Lucy Pearce

PRESENTING CLINICAL SIGNS

Weight loss, decreased appetite. Pt resents abdominal palpation on physical exam. Weight loss of 7 lb since august. Brief u/s- mass on spleen, no ascites. Inflammation/hazy area noted caudal to stomach. Radiograph thorax and abdomen- Radiographic Findings Seven images of Lucy are available for evaluation. The cardiopulmonary and other thoracic structures are unremarkable. The stomach is filled with ingesta. The small bowel is diffusely gas-filled but no segments are visibly distended or thickened. The colon contains semi formed feces and the wall of the colon is mildly thickened and hypermotile. No spinal abnormalities evident. The cranial tip of the spleen has a rounded appearance but the overall splenic size is normal. The other abdominal parenchymal structures are unremarkable and the serosal detail is adequate. Conclusion Unremarkable thorax with no evidence pulmonary metastasis. Mild colitis suspected. Small 3 cm mass suspected at the cranial aspect of the spleen. No evidence of recent peritoneal hemorrhage. Craig Long, DVM, DACVR Soft feces noted while in hospital Blood panel results will be available tomorrow Started ID low fat diet and visbiome probiotic.

SPECIES

Canine

BREED

Lab X

SEX

Spayed Female

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

AGE

10 Years

Urinary System

The urinary bladder is moderate distended. The wall is normal in thickness with a smooth mucosal surface. Luminal contents are mostly anechoic. There is no evidence of cystic calculi. The region of the trigone is normal. In the region of the proximal urethra, an approximately 1.0 cm area of irregular tissue is visualized in the region of of the lumen. However, there is no obvious evidence of luminal dilation.

WEIGHT

68 Pounds

The left kidney presented normal size (6.46 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

INTERPRETED BY

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

The right kidney presented normal size (6.26 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT

Adrenal Glands

The left adrenal gland is normal size (0.63 cm at cranial pole) (0.62 cm at caudal pole); 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.

HOSPITAL NAME

Brighton Greens VH

The right adrenal gland is normal size (0.77 cm at the cranial pole) (0.67 cm at caudal pole) (2.42 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.

REFERRING VET

Dr. Robin Janeway

Spleen

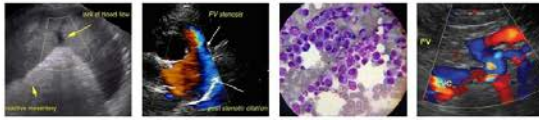
The spleen is subjectively normal in size overall (1.74 cm) with slightly irregular peripheral contours. A 2.74 cm hypoechoic mass is observed at the craniomedial aspect. The lesion causes mild capsular expansion. the remainder of the spleen, the parenchyma is heterogeneous with curvilinear peripheral margins. Splenic vasculature appears normal with no evidence of thrombosis. The mesentery effacing the serosal surface of the medial aspect of the spleen is hyperechoic. In

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33914

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Lucy Pearce **Liver**

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WEIGHT

68 Pounds

The liver is subjectively prominent in size with swollen curvilinear peripheral contours. The parenchyma is hyperechoic relative to the spleen and exhibits mild heterogeneity. No focal distinct lesions are observed. Hepatic vasculature and 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 aggregated, echogenic, partially dependent debris/sludge is observed within the lumen. The cystic and common bile ducts are normal.

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 small intestinal lumen is not dilated. The small intestinal wall thickness is normal (xxx cm) 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 right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely isoechoic to 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.

Free Abdomen

There is no evidence of free fluid.

1-2 prominent to enlarged medial iliac lymph nodes are visualized, the largest measuring 2.98 cm in length. In addition, at least one sublumbar lymph node measuring 3.60 cm in length is seen.

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PRIMARY FINDINGS

- Splenic mass. Neoplasia (i.e., round cell tumor, sarcoma) is considered likely with a lower possibility of benign pathology (i.e., focus of lymphoid hyperplasia or extramedullary hematopoiesis). Regional peritonitis is present.
- The lymphadenopathy could be secondary to lymphoid hyperplasia, reactive lymphadenitis, or infiltrative neoplasia.
- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory and infiltrative disease are considered unlikely. However, correlation with the patient's lab values is recommended.

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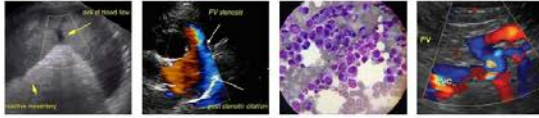
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SECONDARY FINDINGS

- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.



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- The significance of the tissue in the proximal urethral lumen is unclear. It may be artifactual and/or a normal variant for this patient. Alternatively, inflammation or emerging neoplasia is possible. Correlation with clinical findings is recommended.

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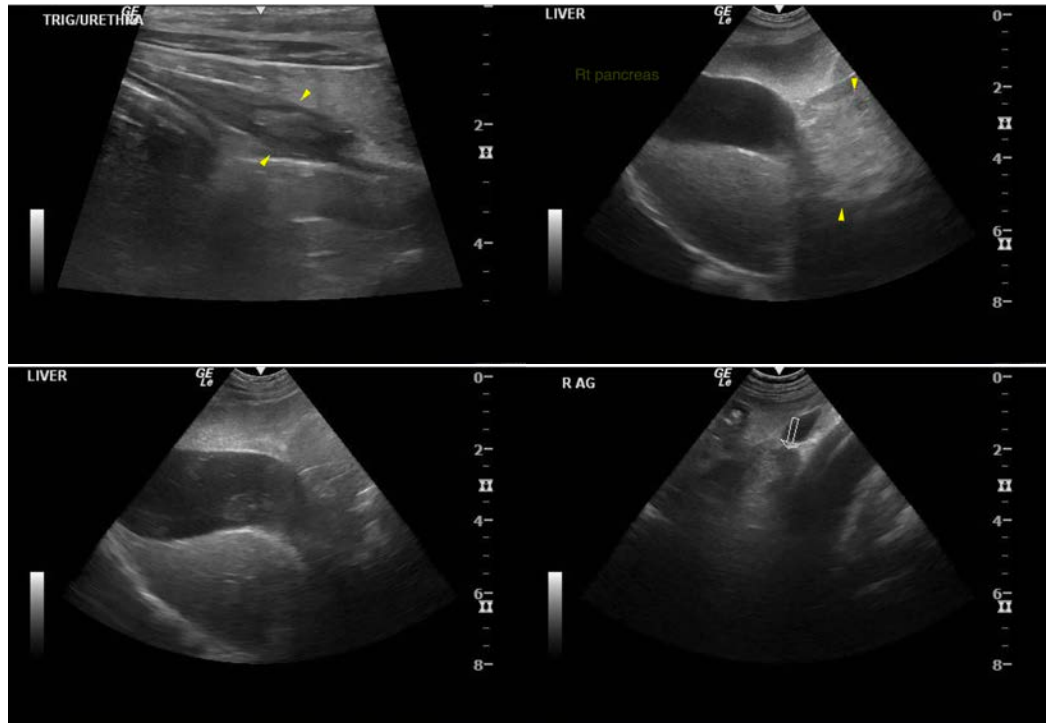
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- 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, consider a splenectomy with submission of the spleen for histopathology.
- A liver biopsy should also be obtained at the time of surgery to assess for micrometastatic disease. The caudal abdominal lymph nodes should also be biopsied.
- Given the patient's clinical signs, also consider a malabsorption panel including serum cobalamin, folate, TLI and PLI +/- GI biopsies.
- If the patient is experiencing lower urinary tract signs, consider a urine BRAF test to screen for neoplasia (given the urethral findings). Alternatively, consider a recheck ultrasound in 3-4 weeks.



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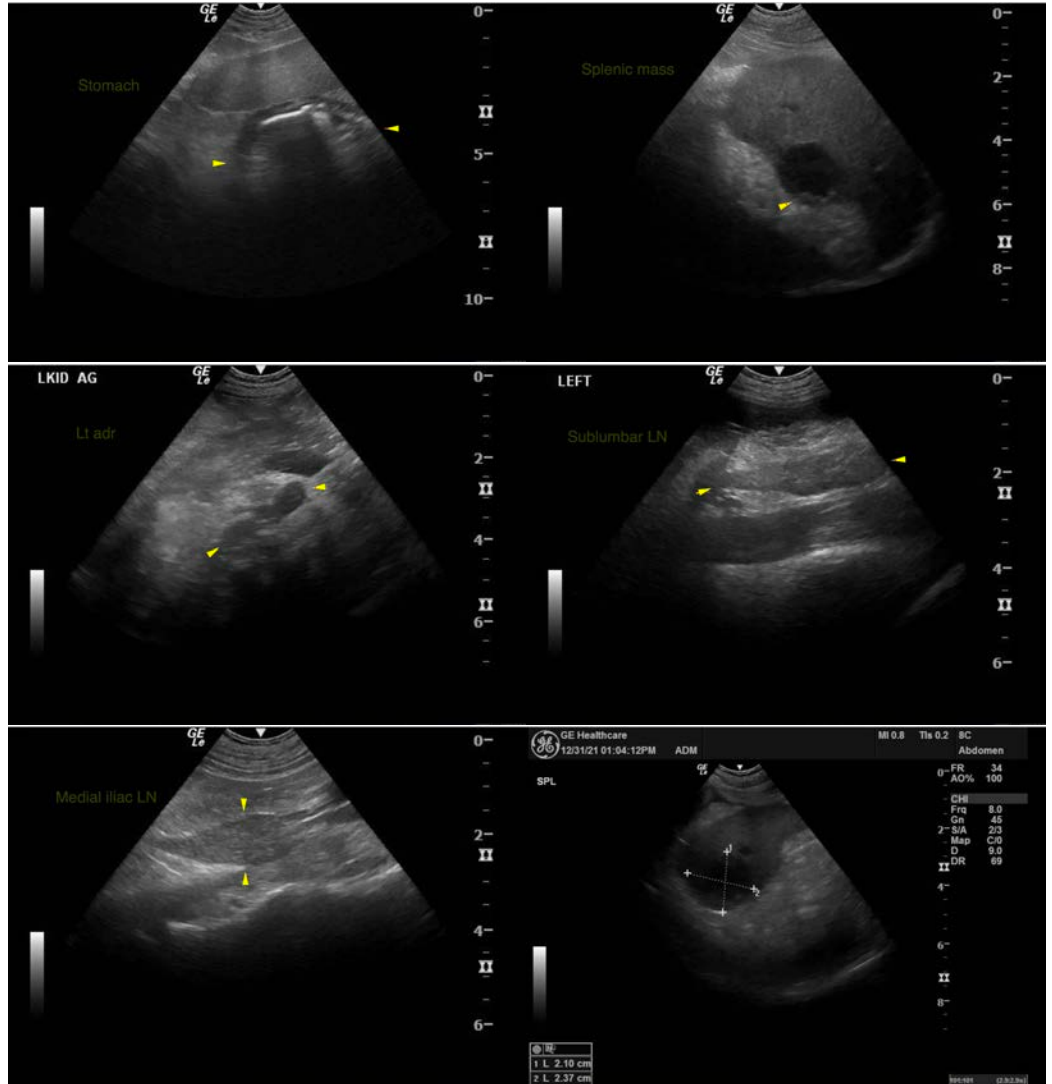
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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