SonoPath
Clinical Sonography & Telecytology
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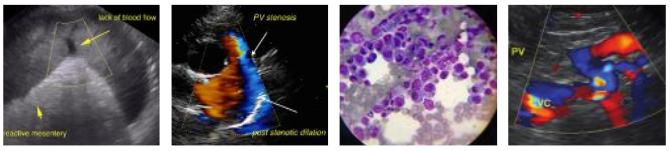

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Jacob Schlosser

SPECIES

Canine

BREED

Retriever Mix

SEX

Neutered Male

AGE

11 years

WEIGHT

30 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Callihan/AEC

HOSPITAL NAME

Animal Emergency Care

REFERRING VET

Dr. Johnson/AEC

INVOICE

10337

DATE

2/13/22

PRESENTING CLINICAL SIGNS

History: Presented for hematuria, large amounts dilute urine with blood. No prior urinary issues, nothing remarkable on radiographs; serum chemistries are normal. CBC shows normal WBC but monocytes are quite elevated at 7K (slide was reviewed by pathologist). His previous UA did not show any bacteria. There were a lot of epithelial cells, but morphology not remarked on.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly distended with mostly anechoic. The wall is diffusely thickened and irregular with a suspected mass effect (3.70 cm along the caudal dorsal wall). No cystic calculi are observed. The proximal urethra is not overtly dilated.

The prostate is normal in size (1.74 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal size (6.74 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. A hyperechoic medullary band is observed adjacent to the corticomedullary junction. A small cortical cyst is observed at the caudal pole. Trace pyelectasia is present. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (6.43 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. A hyperechoic medullary band is observed adjacent to the corticomedullary junction. Trace pyelectasia is present. There is no evidence of nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is normal size (0.74 cm at cranial pole) (0.72 cm at caudal pole) (2.63 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 normal size (0.64 cm at caudal pole) (2.63 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 subjectively prominent in size (2.31 cm in width at the level of the hilus) with a slightly swollen peripheral margins and a folded contour. A light micronodular pattern (bordering on a “moth-eaten” appearance), is observed throughout the parenchyma. Splenic vasculature is normal with no evidence of thrombosis.

Liver

The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is slightly mottled in appearance. No distinct focal lesions are observed. Vascular 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. Luminal contents are anechoic. The cystic and common bile ducts are normal.

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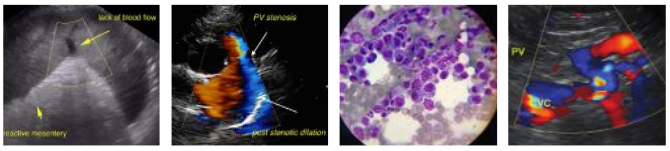

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Gastrointestinal
The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal 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 left limb and base of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely hypoechoic 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. Several prominent to enlarged lymph nodes are observed at the aortic trifurcation, the largest measuring 4.12 cm in length. A 1.23 cm jejunal lymph node is also seen, just medial to the spleen. Several prominent lymph nodes are also observed in the right cranial quadrant. A few sublumbar lymph nodes are also visualized.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

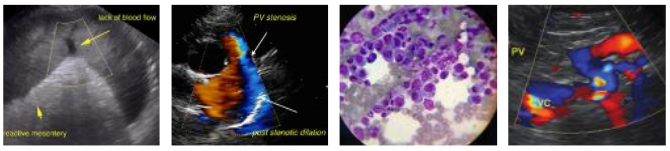
- Thickened urinary bladder wall with suspected mass effect at the caudal dorsal aspect. Differentials include infiltrative neoplasia (transitional cell carcinoma), versus severe cystitis.
- The splenic parenchymal are concerning for infiltrative neoplasia (i.e, lymphoma). However, a benign process such as lymphoid hyperplasia or extramedullary hematopoiesis cannot be excluded.
- The abdominal lymphadenopathy can be considered with infiltrative neoplasia, reactive lymphadenitis or lymphoid hyperplasia.

Secondary Findings

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

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
- A urine BRAF test is recommended to further assess for lower urinary tract neoplasia.



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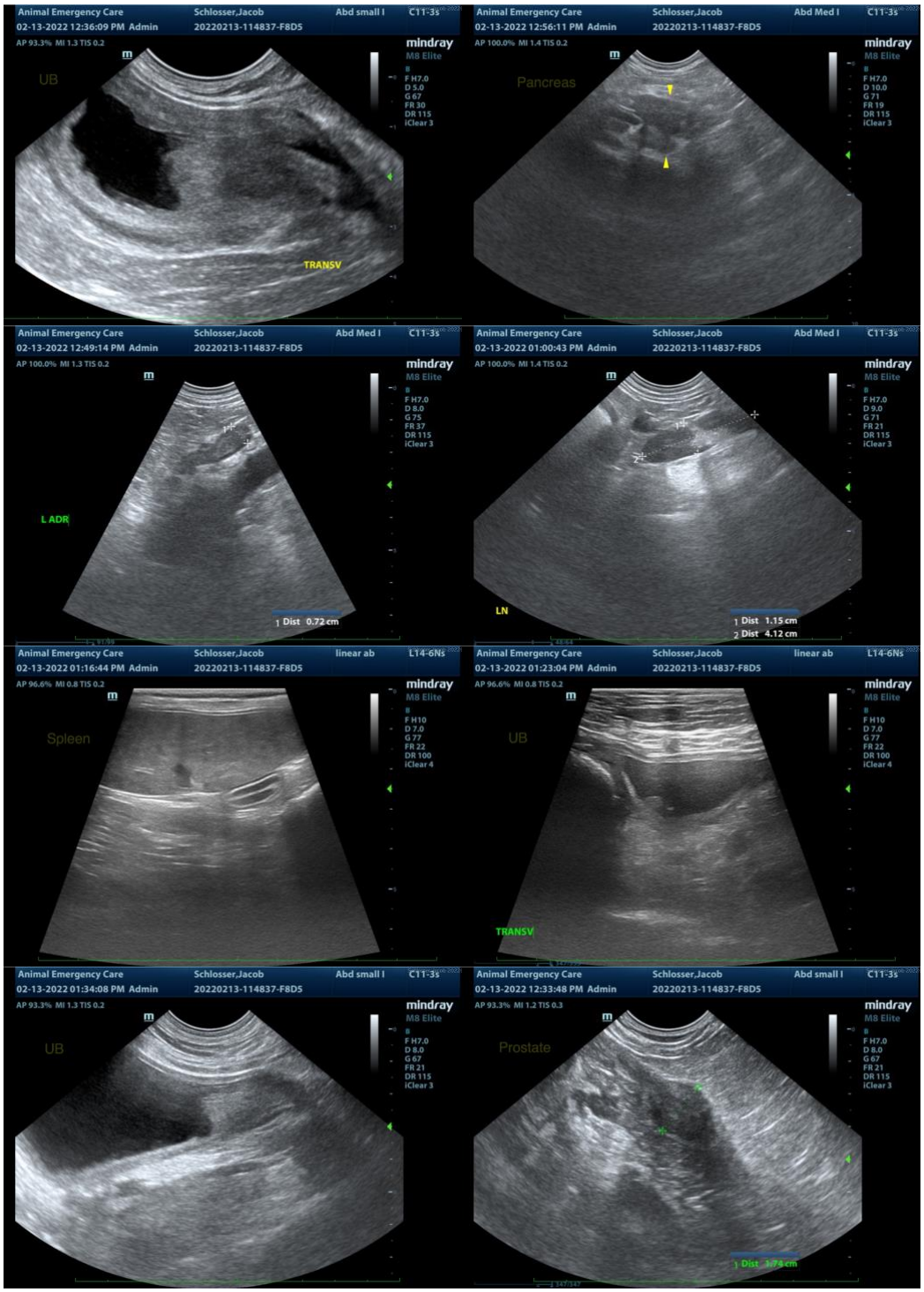
- Depending on the splenic and urinary bladder cytology results, consultation with a board-certified oncologist may be warranted.



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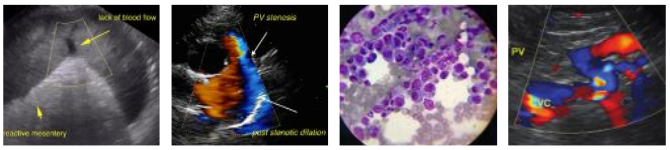

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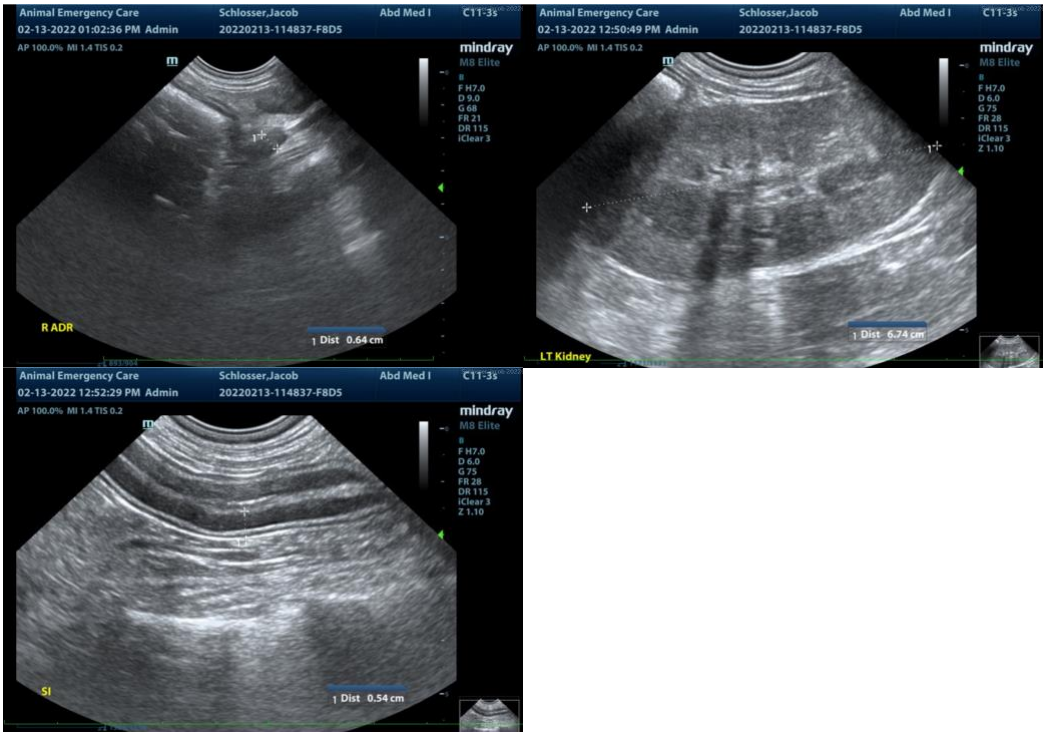

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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