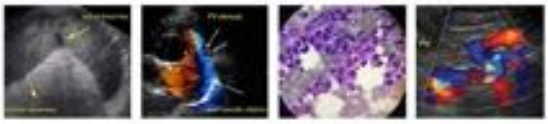


PATIENT

Conan Macias

SPECIES

Canine

BREED

Lab/Retriever mix

SEX

Neutered Male

AGE

11/5/2014

WEIGHT

85 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT

HOSPITAL NAME

Roundhill AH

REFERRING VET

Dr. Carl Kelly

INVOICE

14762

DATE

3/20/23

PRESENTING CLINICAL SIGNS

History: Brought in for routine checkup for mobility. IDEXX results show probably liver inflammation. Cholangeohepatitis? Pre/post bile acids show probably liver disfunction and possibly worsening inflammation. Because of the pre/post bile acid we performed today, there is food in the stomach. We also used 1.4cc dolorex for sedation Urine was concentrated (S.G. =1.032) Not concerned about Cushings. Xrays show NAF in lungs/chest Current medications (as of 3-7-2023) Amoxi 500mg, 1 BID. Denamarin 425mg, 1 SID. Ursodiol 250mg 1.5 tabs SID

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 0.66 cm) with an irregular mucosal surface. The wall tapers to a normal thickness as it extends toward the cystourethral junction. A scant amount of echogenic debris is observed within the lumen. No cystic calculi are observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The prostate is not definitively visualized due to its pelvic location.

The left kidney is normal size (7.31 cm in length); normal shape and architecture with 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.

The right kidney is subjectively normal size); normal shape and architecture with 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.

Adrenal Glands

The left adrenal gland is normal size (0.89 cm at cranial pole) (0.77 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.

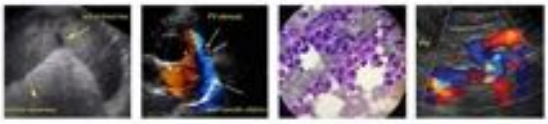
The right adrenal gland is normal size (0.81 cm at cranial pole) (0.71 cm at caudal pole); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is subjectively normal in size (1.78 cm in width at the level of the hilus) with normal curvilinear peripheral contours. The parenchyma is diffusely mottled with ill-defined hypoechoic areas, the largest measuring 1.62 cm in diameter. Splenic vasculature appears normal with no evidence of thrombosis.

Liver

The liver is normal to slightly enlarged with irregular peripheral contours. The parenchyma is hypoechoic to isoechoic relative to the spleen and diffusely heterogeneous in appearance. An approximately 4.4 cm heterogeneous mass is observed adjacent to the gallbladder, approximately mid-



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liver. Smaller heterogeneous nodules/masses are also seen. Ill-defined mineralized foci are also observed throughout the organ. On the left side, a 0.96 cm multi-septated cystic lesion is also visualized. Vascular is of normal volume with no evidence of thrombosis. The gall bladder lumen is moderately distended. The wall is normal in thickness. Several polypoid like lesions are arising from the mucosal surface. A moderate to large amount of suspended echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is mildly distended with ingesta. The gastric wall is normal in thickness with a normal layering pattern. The small intestinal lumen is segmentally dilated with chyme. 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 disease is noted.

Pancreas

See *Other.*

Free Abdomen

A focal area of reactive mesentery is observed in the left cranial to mid-abdomen. Trace free fluid is observed.

Lymph Nodes

See *Other.*

Other

In the cranial abdomen, a 3.2 cm heterogeneous mass is visualized. Surrounding mesentery is hyperechoic.

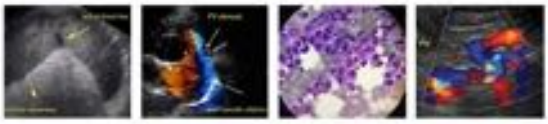
ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- Hepatic masses/nodules. Neoplasia (i.e., round cell tumor, adenocarcinoma) is the top differential. However, multifocal inflammatory disease or benign regenerative nodules cannot be completely excluded. Diffuse mineralization is also observed throughout the liver. The cystic hepatic lesion could be consistent with a benign cyst, focal abscessation or an emerging tumor.
- The origin of the mass in the left cranial quadrant is unclear. It may be arising from lymph node, mesentery, liver, other. Again, neoplasia is considered likely with a lower possibility of a focal inflammatory process or granuloma. Adjacent peritonitis is present.

Secondary Findings:

- The urinary bladder wall changes are suggestive of cystitis.



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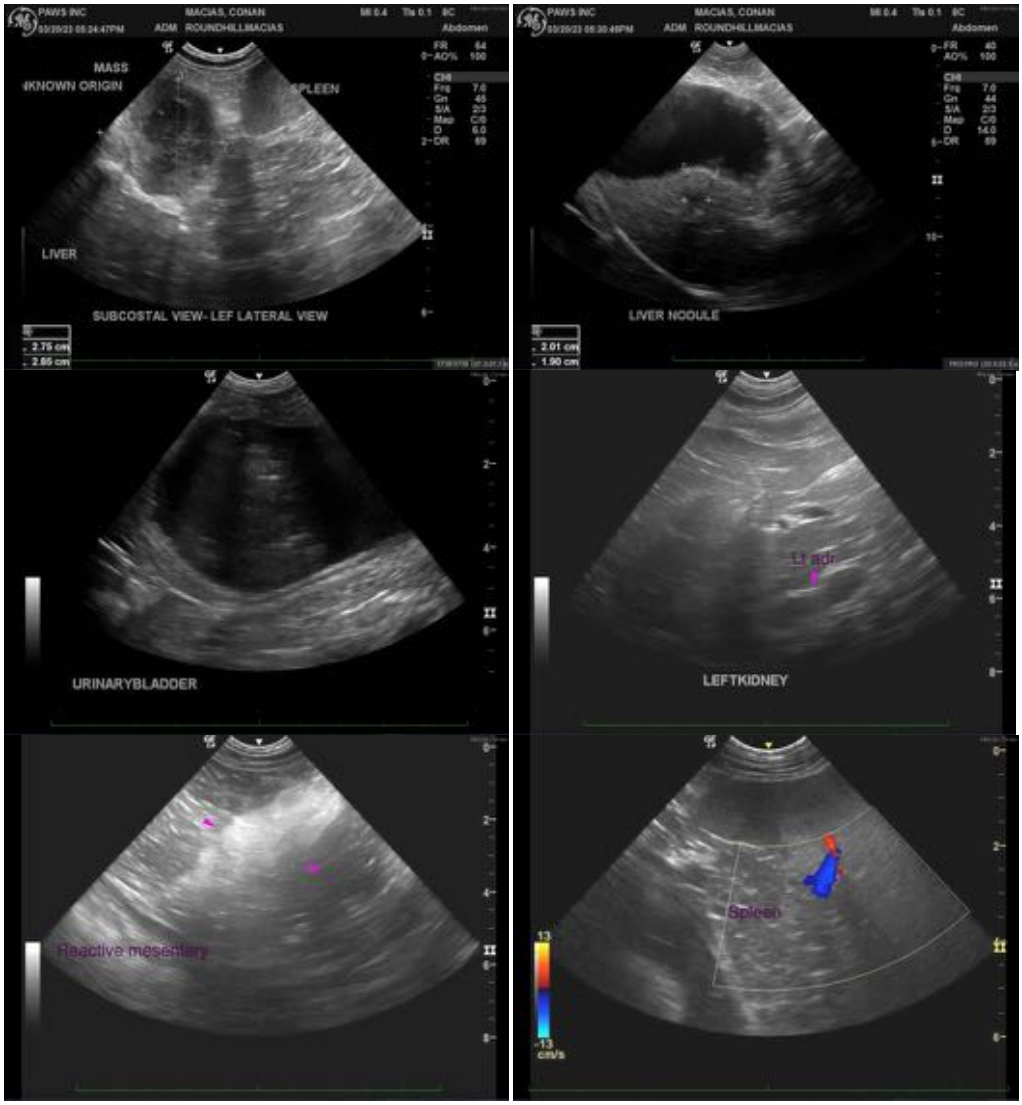
- The splenic parenchymal changes could be consistent with a benign process (i.e., lymphoid hyperplasia or similar). Alternatively, emerging neoplasia is possible. A benign process is favored.
- The gallbladder changes could be consistent with cholestasis, an emerging mucocele or less likely, fasting.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Fine needle aspirates of the hepatic and left cranial abdominal mass can be considered (if clotting status is appropriate). 25-gauge needles should be used. If cytology results are inconclusive, surgical biopsies may be necessary to get a definitive diagnosis.



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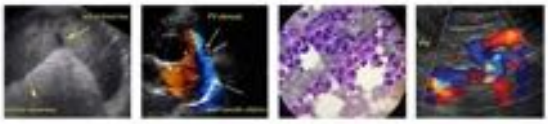

IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

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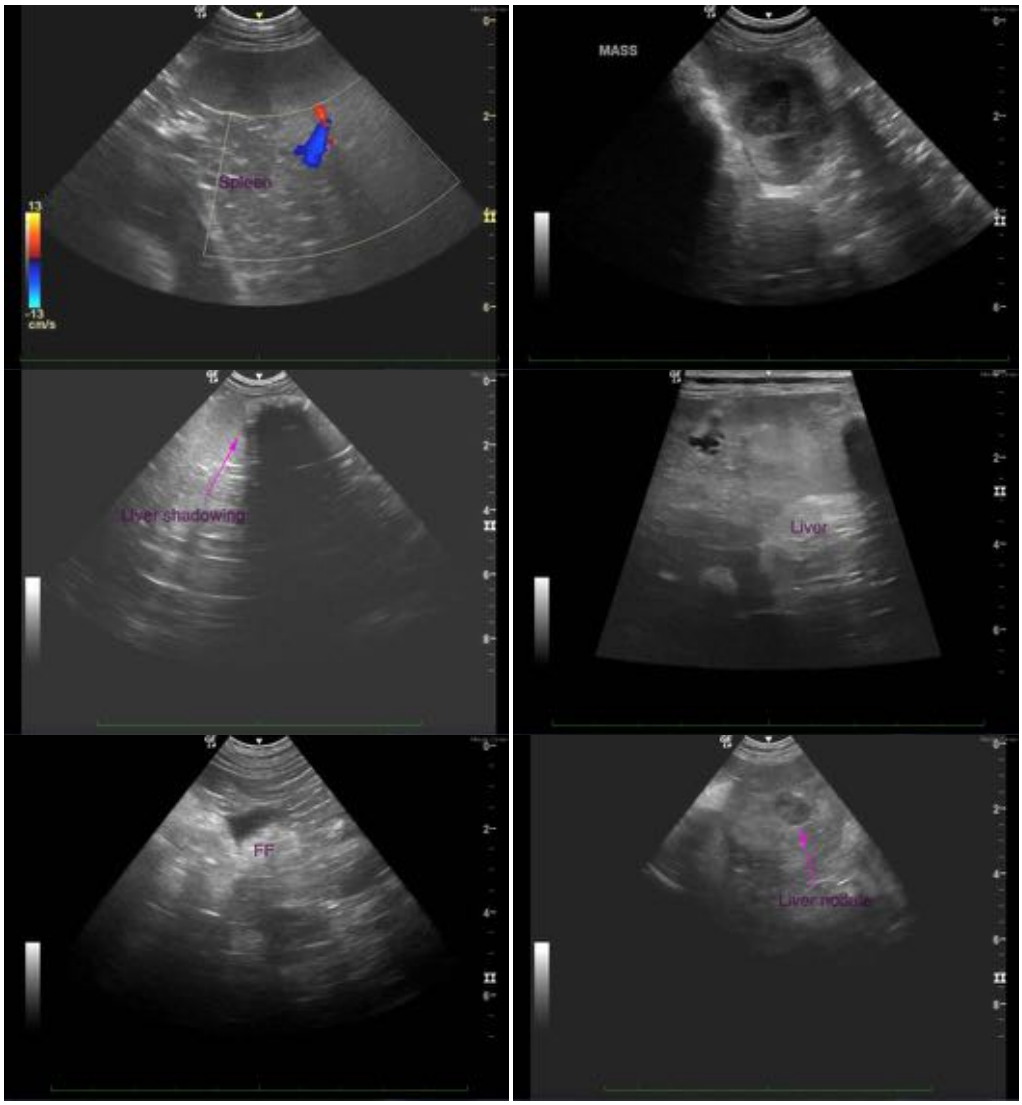

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@SonoPath.com