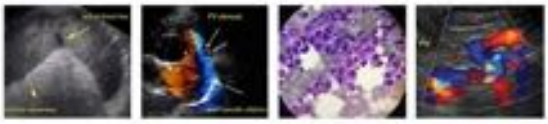


PATIENT

Westin Curry

SPECIES

Canine

BREED

Australian Shepherd

SEX

Neutered Male

AGE

13 Years

WEIGHT

36.2 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT

HOSPITAL NAME

Alpine AH

REFERRING VET

Dr. Sjloin

INVOICE

13145

DATE

3/21/22

PRESENTING CLINICAL SIGNS

History: Species: Canine Gender(altered?) M Age: 13Y Weight in #: 36.2 Breed: Australian Shepherd History: History of sensitive stomach that has worsened with age. Had severe episode of suspected HGE. Physical exam findings: Anxious, BAR. Mildly overweight. Mod. dental disease. Abnormal CBC values: Mild thrombocytosis. Otherwise NSF. Abnormal Chemistry Values: Mild elevation in ALT and ALP. Elevated Spec. cPL persistently, Too high to read TLI, too high to read folate. B12 WNL.

Reason for Ultrasound: Work up for GI and pancreatic changes.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are normal in thickness and the mucosal surface is smooth. The bladder lumen is moderately distended with mostly anechoic urine. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The prostate is normal in size (1.28 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal in size (5.49 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. Trace pyelectasia is present. There is no evidence of infarcts or hydroureter.

The right kidney is normal size (4.69 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 suspected. There is no evidence of nephroliths or hydroureter.

Adrenal Glands

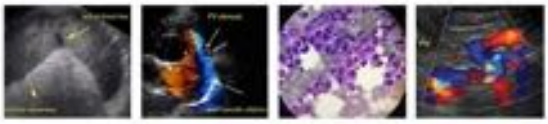
The left adrenal gland is upper limits of normal size (0.67 cm at cranial pole) (0.71 cm at caudal pole) (2.52 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is upper limits of normal size (0.97 cm at cranial pole) (0.72 cm at caudal pole) (2.55 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 normal in size (xxx cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A small amount (approximately 0.40 cm) hyperechoic nodule is observed. Splenic vasculature is normal.

Liver



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The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed. The gall bladder lumen is moderately distended. The wall is thin and smooth. A scant amount of suspended echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

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 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 ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

Pancreas

See *Other.*

Free Abdomen

There is no obvious evidence of free fluid.

Lymph Nodes

The abdominal lymph nodes are normal/not visible.

Other

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

A >9 cm irregular heterogeneous, cavitated mass is observed in the cranial abdomen just caudal to the stomach. The mesentery effacing the serosal surface is slightly hyperechoic.

ULTRASONOGRAPHIC FINDINGS

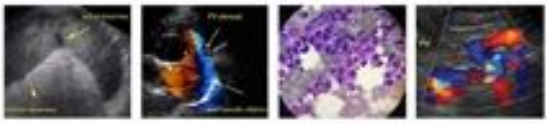
Primary Findings:

- Cranial abdominal mass, the origin of which is unclear. It is suspected to be arising from pancreas. Other possible origins include the caudate process of the liver, spleen, lymph node, mesentery, other. Neoplasia (i.e., sarcoma, adenocarcinoma) is suspected. Mild regional peritonitis is present.

Secondary Findings:

- Minor, age-related renal changes with dystrophic mineralization.
- The hyperechoic splenic nodule likely represents a benign myelolipoma or focus of lymphoid hyperplasia with low potential for emerging neoplasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS



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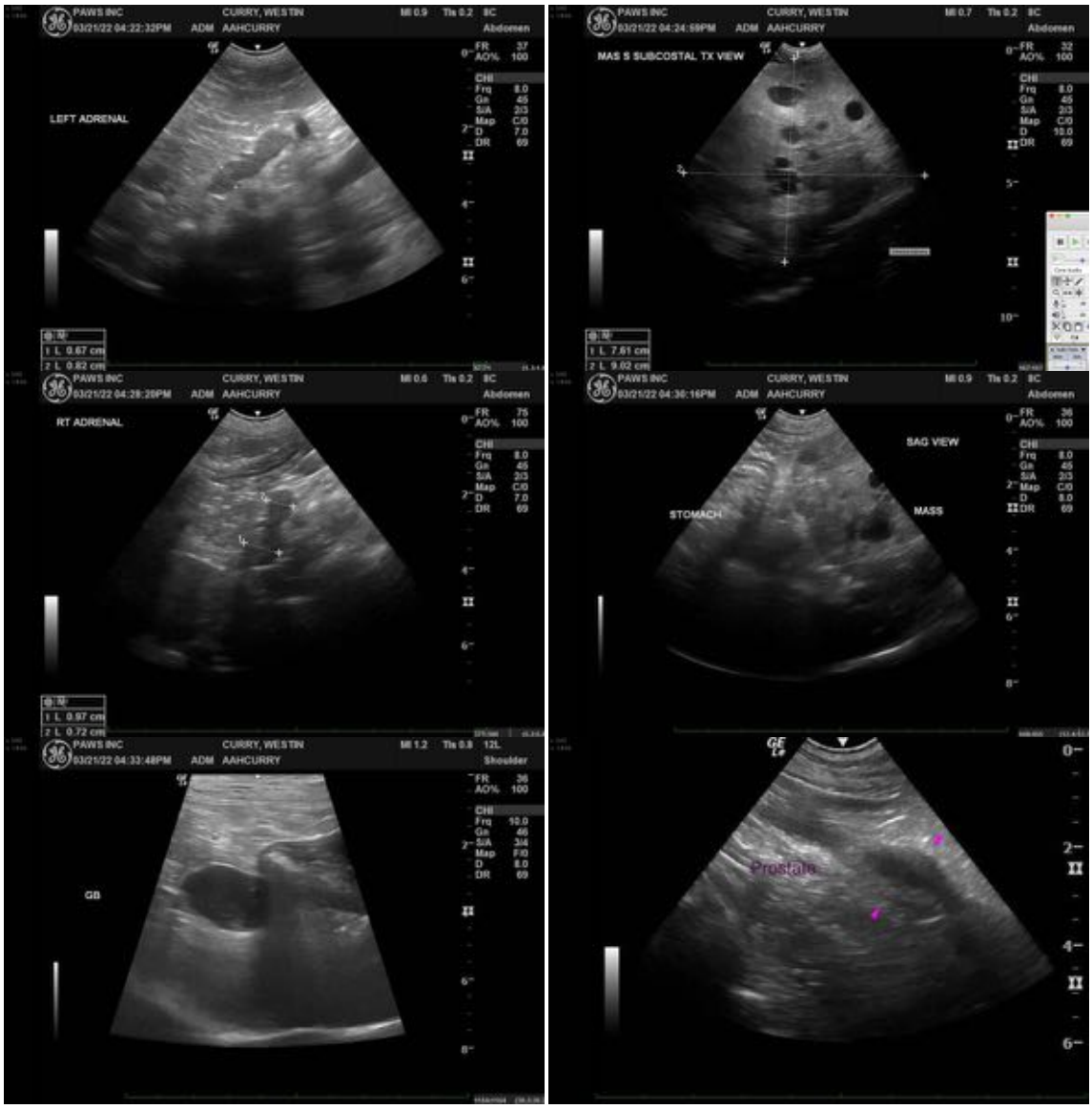
- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
- If there is no evidence of pulmonary metastatic disease and an aggressive approach is desired, consider referral to a board-certified surgeon to discuss mass removal with submission for histopathology. An abdominal CT scan would be useful in pre-surgical planning, particularly in helping to identify the origin of the mass. If a more conservative approach is desired, a fine needle aspirate of the mass can be considered (if clotting status is appropriate). However, there is risk of potential iatrogenic hemorrhage into the abomen with aspiration.



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.

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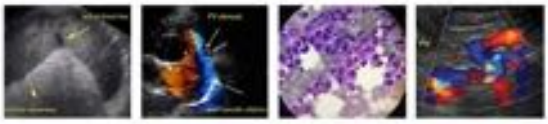

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pawsonography@gmail.com 530-786-8340

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

andrea.nicastro@sonopath.com