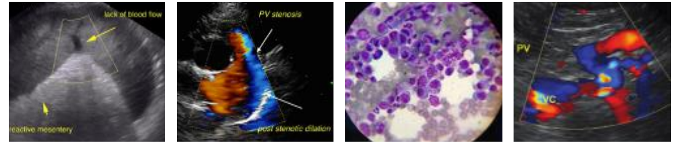
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™




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

**PATIENT**
Josephine Gomber

**SPECIES**
Canine

**BREED**
Jack Russel/ Dachshund Mix

**SEX**
Spayed Female

**AGE**
14 years

**WEIGHT**
19 lbs

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

**IMAGING PERFORMED BY**
Dr. Scott

**HOSPITAL NAME**
Ho Ho Kus VH

**REFERRING VET**
Dr. Eisenberg

**INVOICE**
10475

**DATE**
3/3/22

## PRESENTING CLINICAL SIGNS

History: Hematuria for the first time ever- 2 recent bouts of it. Unresponsive to Ab chosen based on culture, hx of increased ALT. Is on denamarin
Abnormal PE/Chem/CBC/UA Results: PE WNL CBC/Chem WNL UA 3+ blood Chest rads WNL

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*
The urinary bladder is mildly to moderately distended. The ventral wall is thickened and irregular with a mass effect, which extends into the cystourethral junction, trigone area, and proximal urethra. The proximal urethra is thickened (up to 0.59 cm in diameter). Foci of mineralization are observed within the thickened regions. A small amount of echogenic debris is suspended within the lumen. No cystic calculi are observed.

The left kidney is normal size (5.63 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. At least one small cortical cyst is observed at the caudal pole. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney is normal size (5.20 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. At least one small cortical cyst is observed at the caudal pole. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

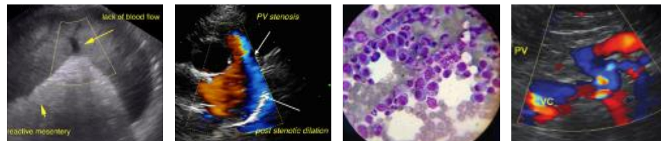
### *Adrenal Glands*
The left adrenal gland is mildly enlarged (0.64 cm at cranial pole) (0.79 cm at caudal pole); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.95 cm at cranial pole) (0.53 cm at caudal pole) (2.06 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 normal in size (1.33 cm in width at the level of the hilus) with normal curvilinear peripheral contours. The parenchyma is diffusely mottled, with numerous small, ill-defined hypoechoic nodules/areas throughout the organ. Numerous pinpoint hyperechoic to mineralized foci are also observed. Splenic vasculature is normal with no evidence of thrombosis.

### *Liver*
The liver is subjectively prominent in size with swollen curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and exhibits mild heterogeneity. A 2.39 x 1.96 cm irregular cyst is observed on the right side. Hepatic vasculature and biliary tracts are of normal volume with no evidence of congestion.

The gall bladder is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. The cystic and common bile ducts are normal/not seen.



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### *Gastrointestinal*

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is minimally fluid-distended. The gastric wall and pylorus are 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 or overt infiltrative disease is noted.

### *Pancreas*

The region of the pancreas is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional inflammation or effusion.

### *Free Abdomen*

A trace amount of free fluid is observed in the caudal retroperitoneal space. The abdominal lymph nodes are normal/not visible.

## ULTRASONOGRAPHIC FINDINGS

### Primary Findings

- Urinary bladder mass effect at the caudal aspect with suspected extension into the urethra. Neoplasia (i.e., transitional cell carcinoma), is suspected with a lower possibility of a severe inflammatory process. The trace retroperitoneal fluid is likely secondary to mild focal peritonitis.

### Secondary Findings

- Mild left adrenomegaly
- The diffuse splenic parenchymal changes trend toward the benign (i.e., lymphoid hyperplasia or extramedullary hematopoiesis), with a lower possibility of emerging neoplasia. The dystrophic mineralization of the spleen is also present. This finding is typically secondary to endocrinopathy.
- 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. Right hepatic cyst, likely incidental.
- Gall bladder debris, non-mucocele.

## 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 evaluate for lower urinary tract neoplasia. If confirmed, consider referral to a board-certified oncologist to discuss chemotherapy options. Otherwise, palliative care can be considered (see below):

1. Piroxicam at 0.3 mg/kg PO every 24 hours (may need to be compounded in smaller patients)
2. Misoprostol (stomach protectant) at 2 mcg/kg PO every 12 hours
3. Baseline renal values should be performed then repeated every 4 weeks to monitor for nephrotoxicity

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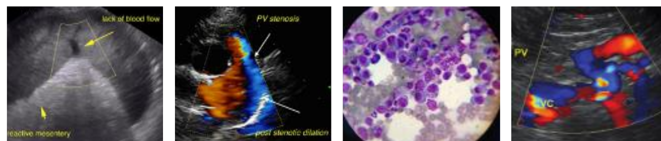

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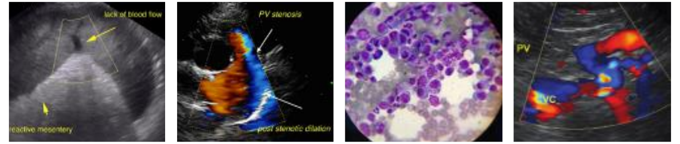

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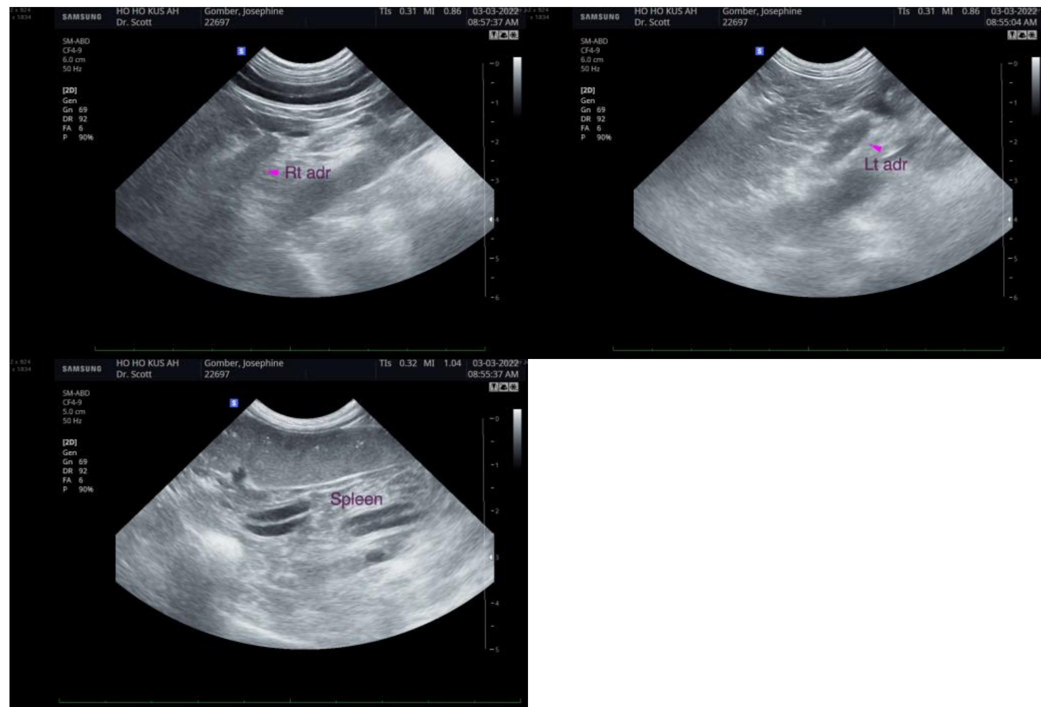


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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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