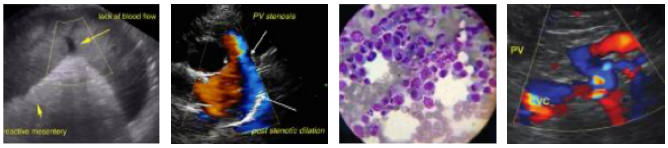
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Kahlua Ramos

SPECIES

Canine

BREED

Labrador Retr

SEX

Female Spayed

AGE

11 years

WEIGHT

80 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr Gabriel Ferrer DVM

HOSPITAL NAME

Pulse: Pet Ultrasound Svc

REFERRING VET

Dr. Javier Rodriguez

INVOICE

12596

DATE

PRESENTING CLINICAL SIGNS

History: The patient presented to the rDVM as pt has not been urinating or defecating. An abdominal ultrasound was done to further evaluate.

Abnormal PE/Chem/CBC/UA Results: PE: On rectal exam there was a mass palpated Radiographs: A mass effect on the neck of the bladder BW: CBC: Lymph 0.82(1-5), rest was unremarkable CHEM: ALP: 508 (23-212), rest was unremarkable.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is distended. The wall is normal in thickness with a smooth mucosal surface. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone and the visible portion of the proximal urethra are normal. (See also “Other” category).

The left kidney is normal in size (8.12 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney is normal in size (8.48 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is enlarged (1.18 cm at cranial pole) (0.90 cm at caudal pole) (3.50 cm in length) with a slightly irregular shape. At the cranial pole, a 1.28 x 1.30 cm hyperechoic nodule is present. Within this nodule a 0.46 x 0.43 cm more-hyperechoic nodule is present. Glandular echogenicity and detail at the caudal pole are normal. Surrounding vasculature appears normal.

The right adrenal gland is in normal size (1.35 cm at cranial pole) (0.75 cm at caudal pole) (2.69 cm in length) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature appear normal.

Spleen

A >6.00 cm hyperechoic-to heterogenous mass is arising from the parenchyma, just distal to the hilus. The lesion causes capsular expansion. A few ill-defined myelolipomas are also observed in the region of the hilus. In the remainder of the spleen, the parenchyma is homogenous. Splenic vasculature appears normal with no evidence of thrombosis.

Liver

The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen. Two small hyperechoic nodules are observed in the region of the right medial lobe (the largest measuring 1.15 cm in diameter). Hepatic vasculature and intrahepatic 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 moderate amount of echogenic debris is observed within the lumen (some of which is gravity-dependent and some of which is suspended). The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The lumen is not distended. The gastric wall is 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. There is no evidence of an obstructive pattern.

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

There is no obvious evidence of free fluid. Two enlarged lymph nodes are observed in the caudal abdomen, adjacent to the large mass. The larger node measures 5.59 cm in length, the smaller 5.36 cm in length. The nodes are irregular and slightly heterogenous in appearance.

Other

A >9.00 cm irregular heterogenous mass is observed in the caudal abdomen. The mass appears to extend into the pelvic inlet.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Large caudal abdominal mass, the origin of which is unclear. It may be arising from connective tissue/mesentery, urethra, lymph node, other. Neoplasia (i.e., sarcoma, round cell tumor) is suspected, with a low possibility of a focal inflammatory process. The regional lymphadenopathy is concerning for a metastatic disease with a lower possibility of reactive change.

- Splenic mass. Neoplasia (i.e., sarcoma, round cell tumor) is suspected, with a lower possibility of a benign process (i.e., lymphoid hyperplasia). It is unclear whether this lesion is associated with the caudal abdominal mass or if this represents a second primary tumor.

Secondary Findings

- Minor bilateral age-related renal changes

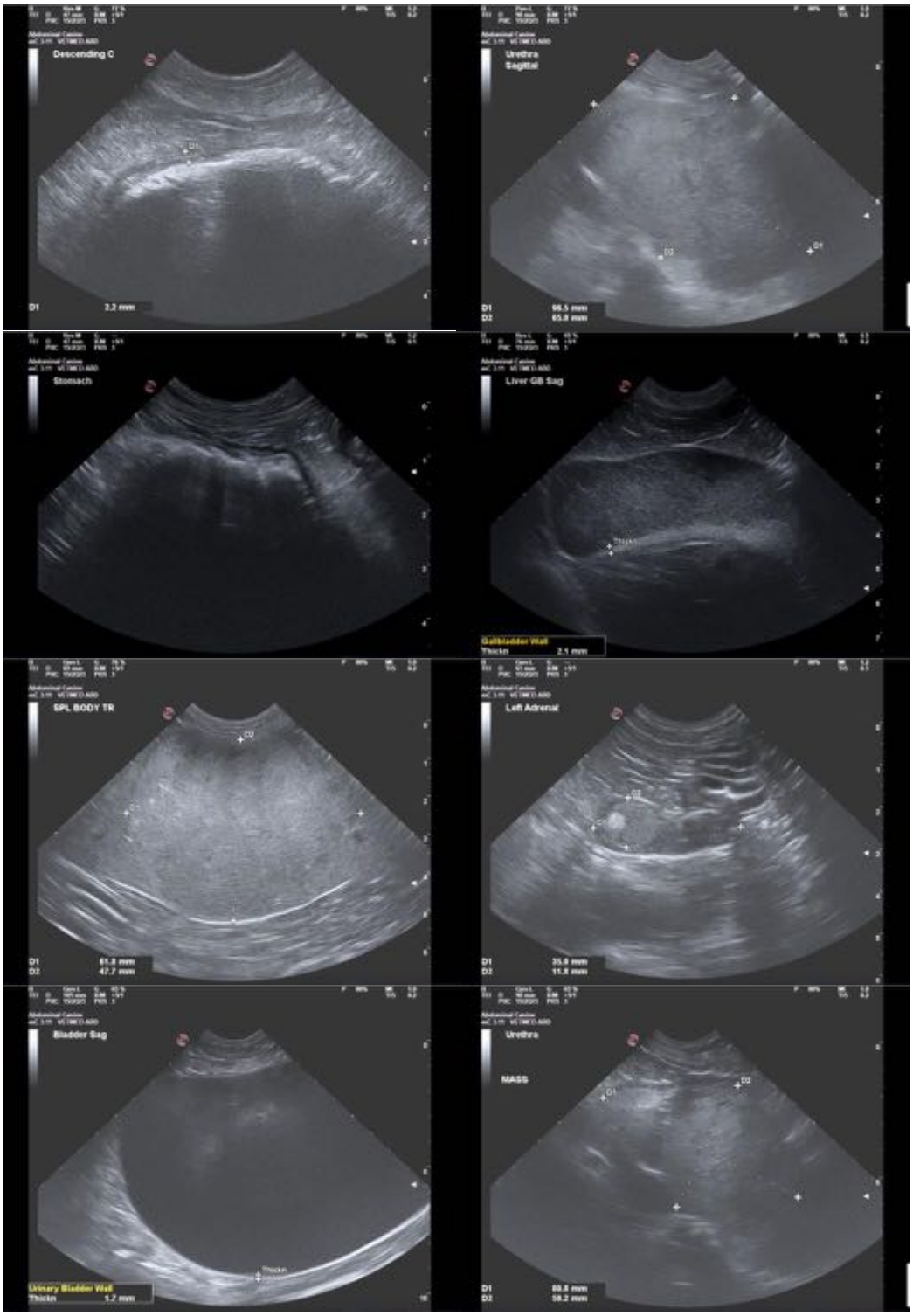
- The left adrenal nodule could be consistent with benign macronodular hyperplasia. Alternatively, an emerging tumor is possible.

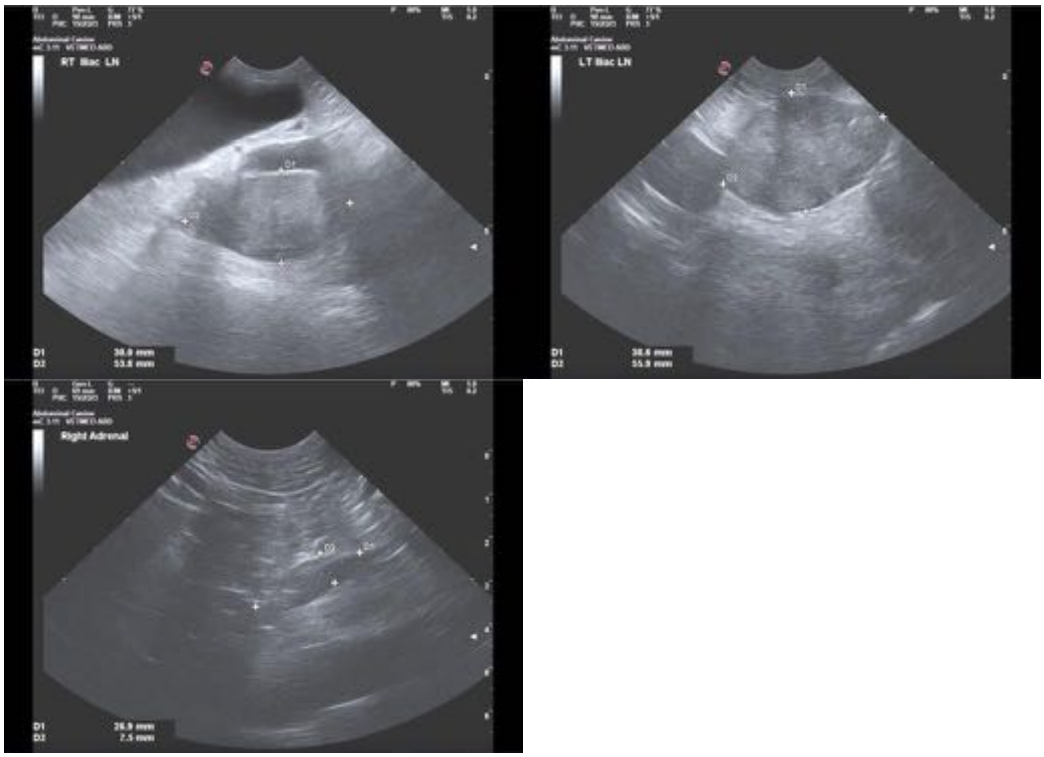
- The hyperechoic hepatic nodules trend toward the benign (i.e., regenerative nodules) with a lower possibility of a more insidious process (i.e., an emerging tumor).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.

- Consider fine-needle aspirate of the splenic and caudal abdominal masses, as well as the enlarged abdominal lymph nodes (if accessible). Twenty-five gauge-needles should be used. If surgery is ultimately pursued for this patient's splenic and caudal abdominal masses, an abdominal/pelvic CT scan would be beneficial in presurgical planning. However, given the possibility of metastatic neoplasia, consider palliative care in lieu of invasive diagnostics.


Descending C
D1 2.2 mm
Urethra
Sagittal
D1 66.5 mm
D2 65.8 mm
Stomach
Liver GB Sag
Gallbladder Wall
Thickn 2.1 mm
SPL BODY TR
D1 61.8 mm
D2 47.7 mm
Left Adrenal
D1 35.8 mm
D2 11.8 mm
Bladder Sag
Urinary Bladder Wall
Thickn 1.2 mm
Urethra
MASS
D1 80.8 mm
D2 58.2 mm



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