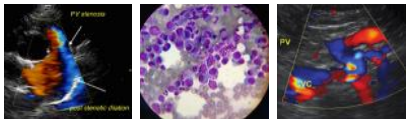
IMAGING PERFORMED BY

IntraPet.com



SonoPath
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DATE

4/14/2022

PATIENT

Sasha Sheridan

SPECIES

Canine

BREED

Pit Bull Mix

SEX

Spayed Female

AGE

5/1/2013

WEIGHT

70 lbs

INTERPRETED BY

Andrea Nicastro, DMV, Diplomate DACVIM (Small Animal Internal Medicine)

HOSPITAL NAME

Stay Pet Veterinary

REFERRING VET

Dr. Klimovitz

INVOICE

10745

PRESENTING CLINICAL SIGNS

Proteinuria. Upcoming stifle surgery. Elevating ALP value (mild).

Current Medications: Carprofen now is Galliprant.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Stephanie Pearce RDCS, RVT.

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 is moderately distended. A small amount of suspended echogenic debris is observed within the lumen. 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 left kidney presented normal size (6.60 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. Renal vasculature is normal.

The right kidney presented normal size (6.45 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. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.69 cm at cranial pole) (0.69 cm at caudal pole) (2.50 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 (0.70 cm at cranial pole) (0.55 cm at caudal pole) (2.84 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 (1.54 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively prominent in size with swollen peripheral contours and an irregular margin at the tip of the left lateral lobe. The parenchyma is isoechoic relative to the spleen and subtly heterogenous in appearance. A 3.75 x 3.43 cm hyperechoic nodule/mass is observed deep on the right side adjacent to the diaphragm. Just adjacent to this lesion, a 2.75 x 1.38 cm septated cystic lesion is visualized. On the left side a 2.73 x 1.55 cm hypoechoic to slightly heterogenous, vascular nodule/mass is observed at the tip of the

left lateral lobe. This lesion causes capsular expansion. 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 aggregated, echogenic, mostly gravity-dependent debris is observed within the lumen. The cystic and common bile ducts are normal.

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 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
The peritoneal cavity is normal. There is no evidence of inflammation or effusion. The abdominal lymph nodes are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The nodule/mass at the tip of the left lateral lobe could be consistent with an early neoplastic process (i.e., adenoma, adenocarcinoma), particularly given the capsular expansion. Alternatively, a regenerative nodule or other benign process is possible. The hyperechoic hepatic nodule trends toward the benign (i.e., myelolipoma, area of lymphoid or nodular hyperplasia) with a lower possibility of a neoplastic process. The cystic hepatic lesion also trends toward the benign with a lower possibility of an emerging vascular tumor. The diffuse hepatic parenchymal changes are most consistent with a benign age-related process (i.e., idiopathic vacuolar hepatopathy or regenerative nodular hyperplasia). It is these changes that are likely causing the elevated ALP.
- Gall bladder debris, non-mucocele

Secondary Findings

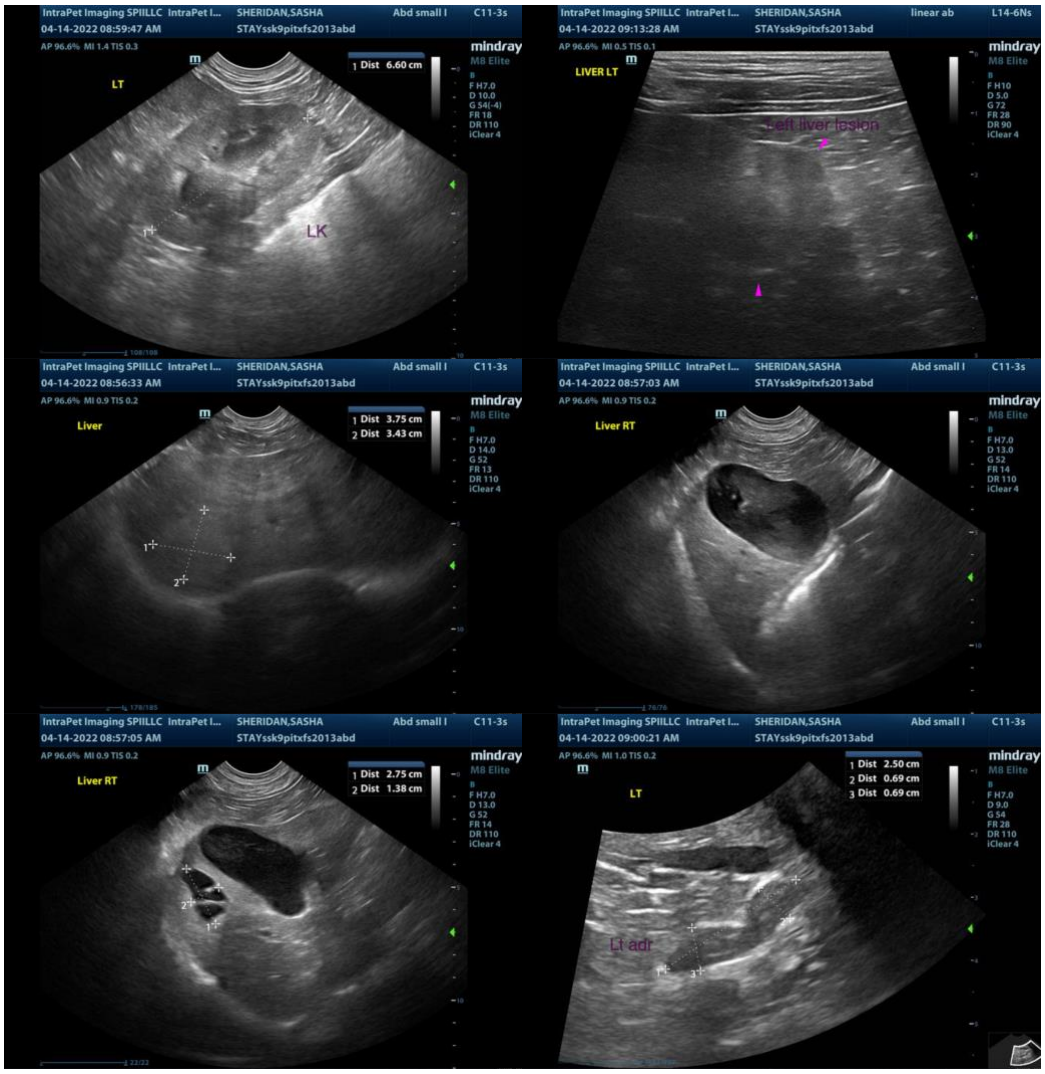
- Minor nonspecific age-related renal changes

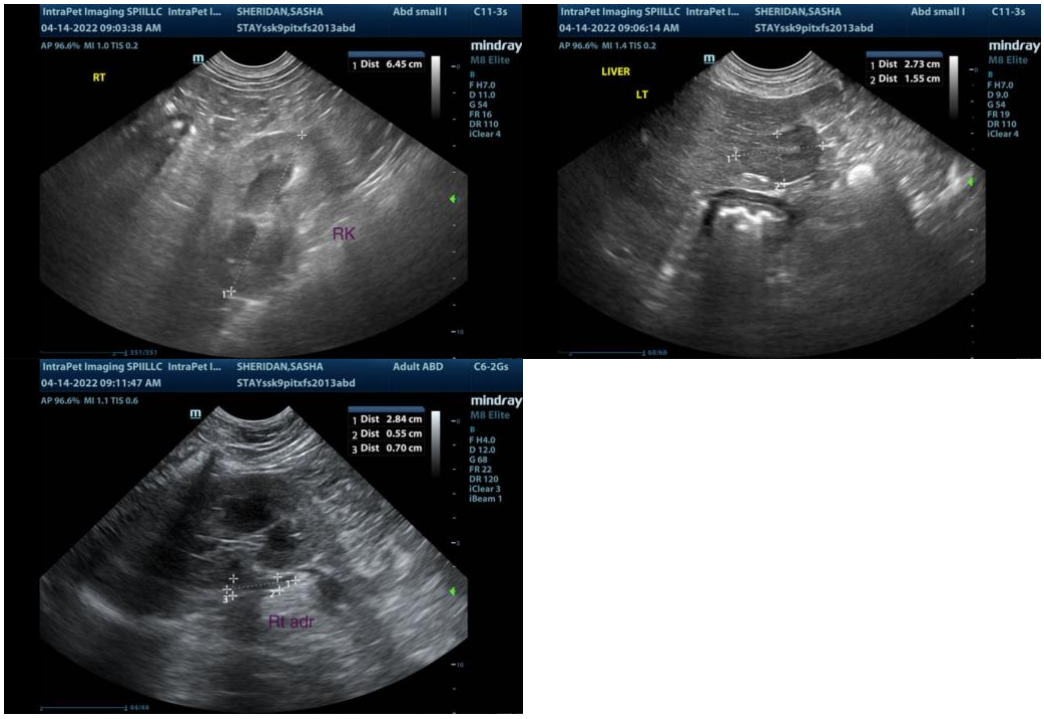
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
- A fine-needle aspirate of the hepatic nodule/mass at the tip of the left lateral lobe is recommended (if clotting status is appropriate). However, it should be noted that primary hepatic tumors can be difficult to diagnose cytologically. Therefore, surgical removal of the lesion with submission for

histopathology may be necessary to get a definitive diagnosis. If hepatic tissue sampling is not to be pursued at this time, serial sonographic monitoring (i.e., every 1-2 months) is recommended to assess for progression of all hepatic lesions. Liver values should also be monitored at least every 3-4 months to assess for further increases.

- Given the patient's proteinuria, a UPC and urine culture and sensitivity should be considered.





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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