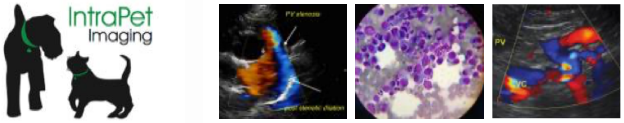
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
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DATE

5.1.23

PATIENT

Dexter McCone

SPECIES

Canine

BREED

Weimaraner

SEX

Neutered Male

AGE

6/17/2019

WEIGHT

103 lbs

INTERPRETED BY

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

HOSPITAL NAME

Timonium AH

REFERRING VET

Dr. Brand

INVOICE

12916

PRESENTING CLINICAL SIGNS

History: 5/1/23 Ate trash 5 days ago. Presented today for not eating, no vomiting, soft stool. Hematochezia, lethargy, tense abdomen.

Current Medications: None yet.
Radiographs: Did not show evidence of obstruction but there is evidence of ascites and a cranial abdominal mass.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Patient sedated with Dexdomitor.
Stat Report: DVM requested.
Imaging Performed By: Andi Parkinson, BS, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is not visualized in its entirety. In the visualized portion, the bladder is mildly to moderate distended. The wall is normal in thickness with a smooth mucosal surface. A scant amount of echogenic debris is suspended within the lumen. No cystic calculi are observed.

The region of the prostate is not visualized due to its pelvic location.

The left kidney is normal in size (7.10 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney is normal in size (7.10 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is normal in size (0.66 cm at cranial pole) (0.97 cm at caudal pole) (2.77 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 are normal.

The right adrenal gland is in normal size (0.66 cm at cranial pole) (0.68 cm at caudal pole) (2.14 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 are normal.

Spleen

The spleen is subjectively prominent in size in size with normal curvilinear peripheral contours. The parenchyma is diffusely mottled with a “moth-eaten” appearance. A 1.95 cm irregular hypoechoic lesion is observed on the capsule adjacent the hilus.

Liver

The liver is subjectively enlarged with irregular peripheral contours. Several hypoechoic-to-heterogenous masses are observed throughout the organ (the largest measuring >8.00 cm in diameter). A few of the masses cause 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 normal in thickness. A few polypoid-like lesions are arising from the luminal surface. A small amount of aggregated hyperechoic debris is also seen 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 is normal in thickness 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 right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely hypoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Free Abdomen

The mesentery throughout the abdomen is hyperechoic. A small amount of free fluid is present. Numerous lymph nodes throughout the abdomen are severely enlarged, rounded and hypoechoic to slightly heterogenous in appearance. The largest node (mesenteric) measures >8.00 cm in diameter.

Other

A small amount of pleural effusion is observed in the visualized portion of the thorax.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Severe diffuse abdominal lymphadenopathy. Neoplasia (i.e., round cell tumor) is the top differential with a lower possibility of severe lymphadenitis (i.e., pyogranulomatous).
- The splenic parenchymal changes are also concerning for infiltrative neoplasia (i.e., round cell tumor). However, a non-neoplastic process (i.e., lymphoid hyperplasia, extramedullary hematopoiesis, or similar) cannot be excluded.
- Hepatic masses. Neoplasia is suspected with a lower possibility of a multi-focal inflammatory process.
- Diffuse peritonitis is present, likely secondary to lymph node, splenic, and hepatic pathology.
- Pleural effusion

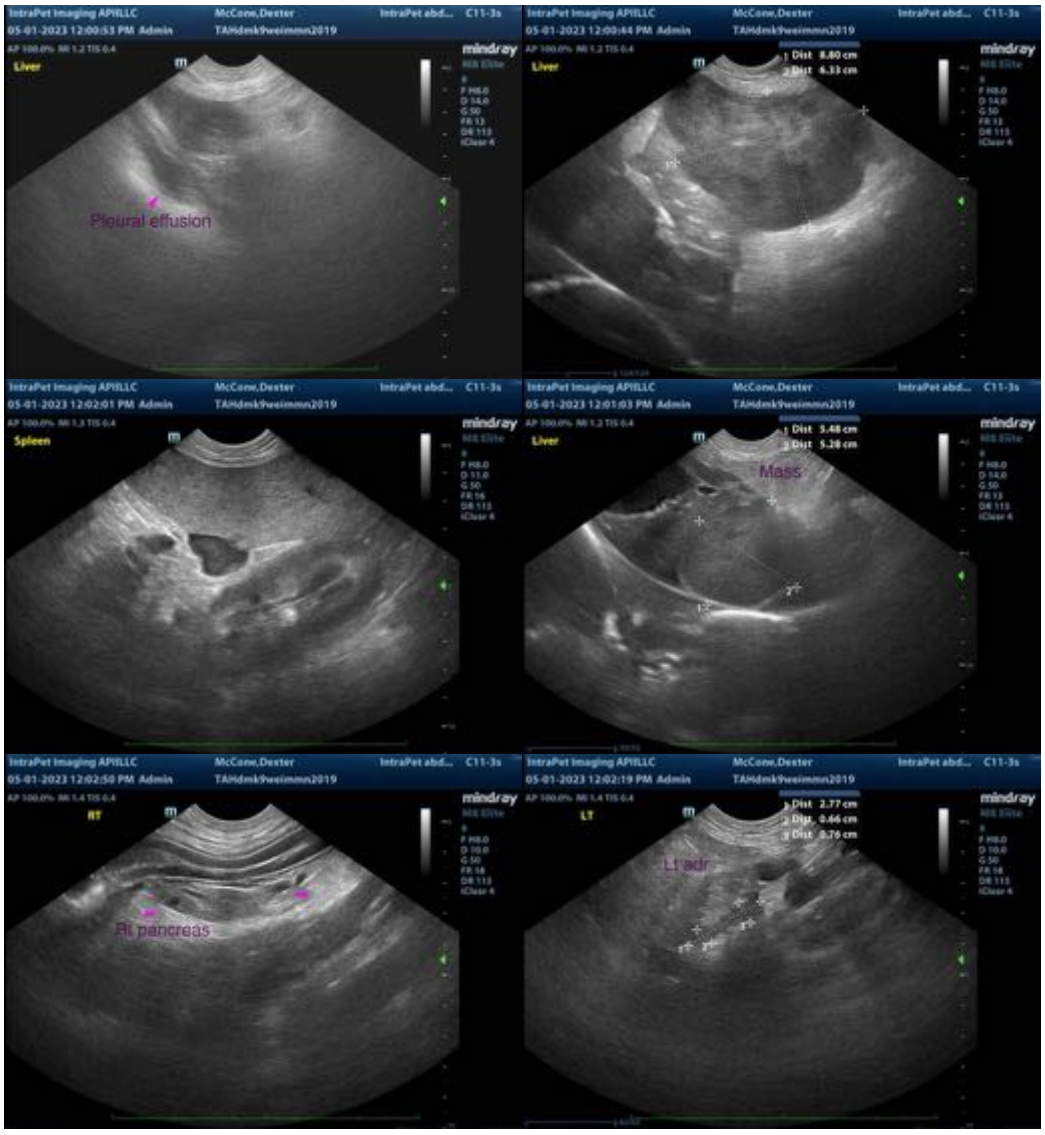
Secondary Findings

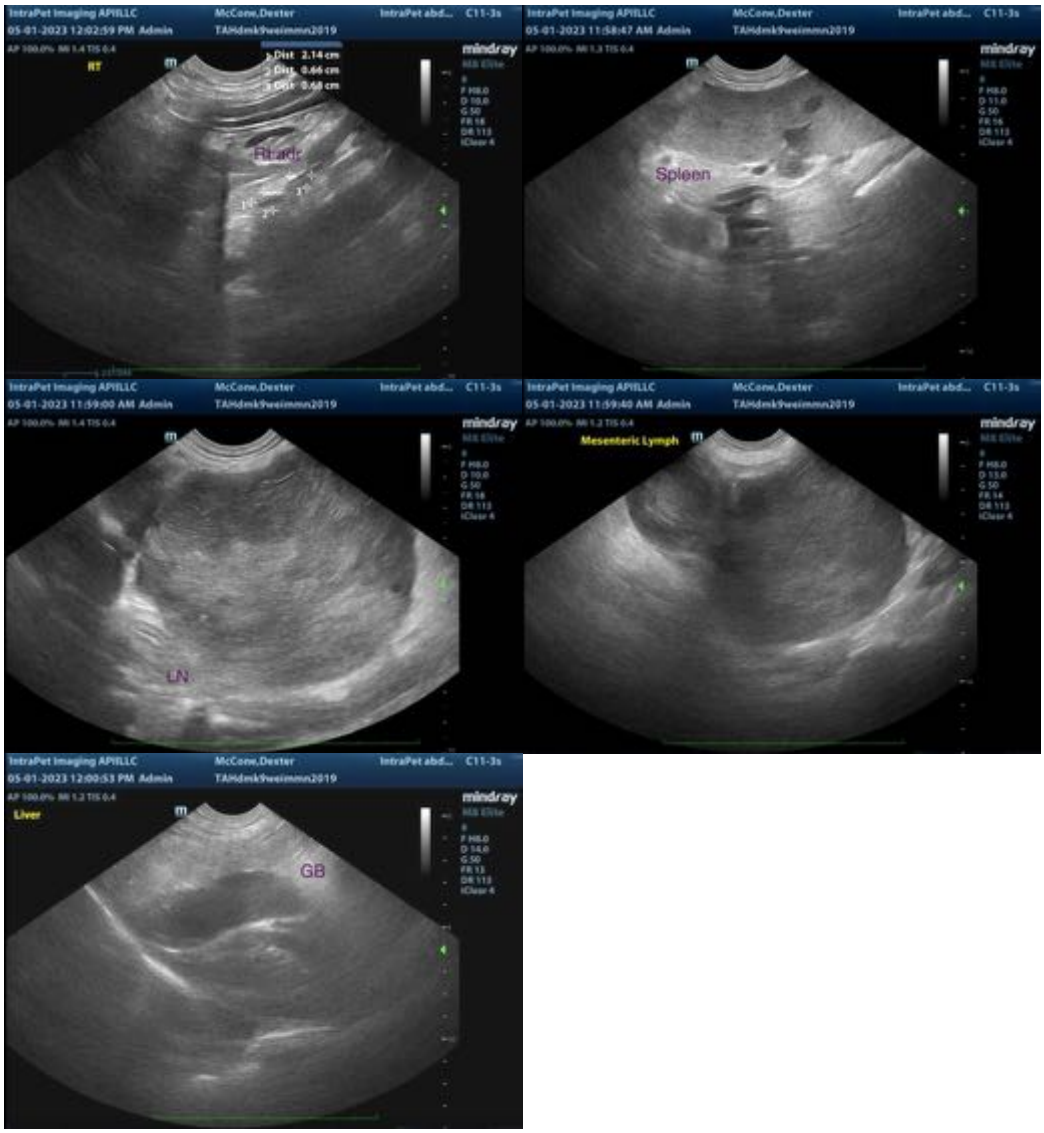
- Minor pancreatic remodeling in the right limb
- The hypoechoic structure adjacent to the splenic hilus may represent an adhered lymph node, splenic capsular mass, thrombus, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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

- Fine-needle aspirates of the enlarged abdominal lymph nodes, hepatic mass, +/- spleen should be considered (if clotting status is appropriate). Twenty-five gauge-needles should be used. If the cytology results are inconclusive, more advanced testing (i.e., PARR, flow cytometry, and/or biopsies) may be necessary to get a definitive diagnosis.





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)
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