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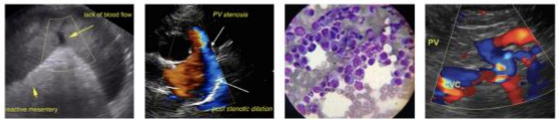


Charleston Mobile Veterinary Services
IMAGING PERFORMED BY
CharlestonMobile.Net 800.403.5408

PATIENT

Iggy Pride

SPECIES

Canine

BREED

Mixed

SEX

Neutered Male

AGE

1/24/2016

WEIGHT

72 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

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

HOSPITAL NAME

Charleston Animal

REFERRING VET

Dr. Elizabeth Fuller

INVOICE

10842

DATE

5/2/22

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: Presented 5/1/22 with 12-hour history of inappetence with some recent vomiting. No known history of toxin ingestion--dog is quiet, stays by owner's side.
Exam shows significant dehydration--at least 5%. Dog is weak, has difficulty standing. Abdomen is soft but possibly somewhat uncomfortable on deep palpation.
Owner reported dog was not urinating for the last 8 hours.
Somewhat poor distal perfusion.
Patient improved with fluid therapy and began urinating, distal perfusion and hydration status improved greatly. Vomiting resolved.

Abnormal lab-work values: Initial bloodwork (on presentation) showed ALT > 2000, BUN 49, Phos 8.7, Creat. 3.2, K 6.5, remainder within reference range. HCT 35%, TS 8.0

Follow up the next morning: ALT > 2000, ALP 177, AMY 1674--remainder within reference range
Current Medications: IV crystalloids, plan to begin Denamarin

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 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 enlarged (3.26 cm in width) with a normal shape and smooth peripheral contours. The parenchyma is mottled in appearance with 1.03 cm irregular cystic area. The prostatic urethra is not overtly dilated.

The left kidney is normal in size 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. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal size (9.59 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. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

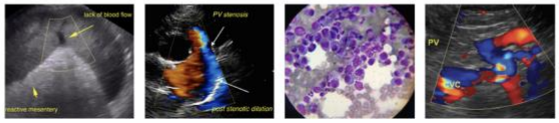
Adrenal Glands

The caudal pole of the left adrenal gland is visualized and is normal in size (0.57 cm in width) with a normal shape, glandular echogenicity and detail. Surrounding vasculature is normal.

The right adrenal gland is normal size (0.55 cm at cranial pole) (1.14 cm at caudal pole) (1.80 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 enlarged with irregular peripheral contours. A >10 cm irregular, isoechoic to slightly



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heterogenous, minimally cavitated mass is arising from the caudal aspect. In the remainder of the spleen, the peripheral contours are slightly irregular, and the parenchyma is mottled in appearance. Splenic vasculature is normal with no evidence of thrombosis.

Liver

The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is slightly mottled in appearance. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion

The gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is distended with fluid and ingesta. 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 wall of the descending colon is thickened (up to 0.83 cm) with possible loss of the normal layering pattern. There is no evidence of an obstructive pattern.

Pancreas

A portion of the pancreas is obscured by the gastric distention. In the visualized portions, no obvious pathology is observed.

Free Abdomen

Trace free fluid is observed. The abdominal lymph nodes are normal/not visible.

Other

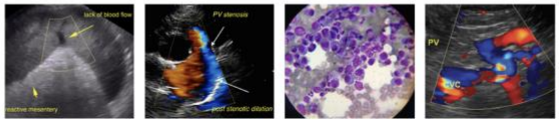
In the caudal abdomen, a >6.00 cm area of ill-defined hypoechoic to slightly heterogenous tissue is visualized. Surrounding mesentery is mildly hyperechoic.

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Splenic mass. Neoplasia (i.e., hemangiosarcoma, hemangioma, round cell tumor) is considered likely with a lower possibility of benign pathology.
- The origin of the irregular tissue in the caudal abdomen is unclear, but may be arising from the mesentery, lymph node, other. The tissue is concerning for infiltrative neoplasia (i.e., metastatic disease). However, an organized blood clot cannot be excluded. Regional peritonitis is present.



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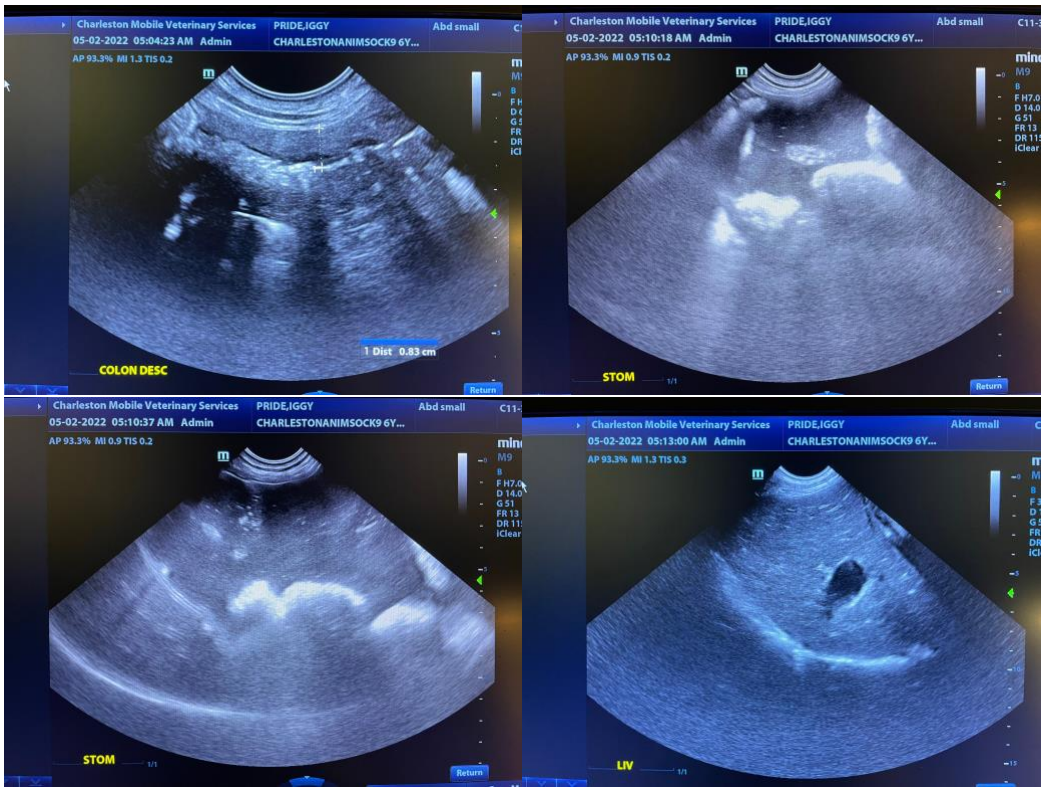
- The prostate changes could be consistent with late-in-life neutering/age-related remodeling. However, emerging neoplasia (i.e., adenocarcinoma, round cell tumor) cannot be excluded.
- The descending colonic wall thickening could be consistent with emerging neoplasia or an inflammatory process. The loss of layering is more concerning for a malignancy.
- An obvious cause for the elevated liver enzymes is not identified in the study. However, a microscopic hepatopathy (i.e., bacterial cholangiohepatitis, Leptospirosis, chronic active hepatitis, copper-associated hepatotoxicity, infiltrative neoplasia (less likely)) are possible.

Primary Findings

- The gastric distention could be consistent with ileus or recent ingestion of food/water.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Repeat thoracic radiographs are recommended to assess for evidence of pulmonary metastatic disease. If pulmonary metastases are not seen, and an aggressive approach is desired, consider an abdominal exploratory with splenectomy, liver biopsy, aerobic and anaerobic bile cultures, biopsy/removal of the irregular tissue in the caudal abdomen, and biopsy of the thickened colonic wall. However, the client should be warned that metastatic disease may be present within the abdomen.



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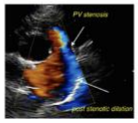
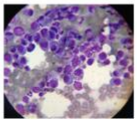
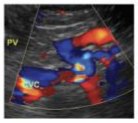

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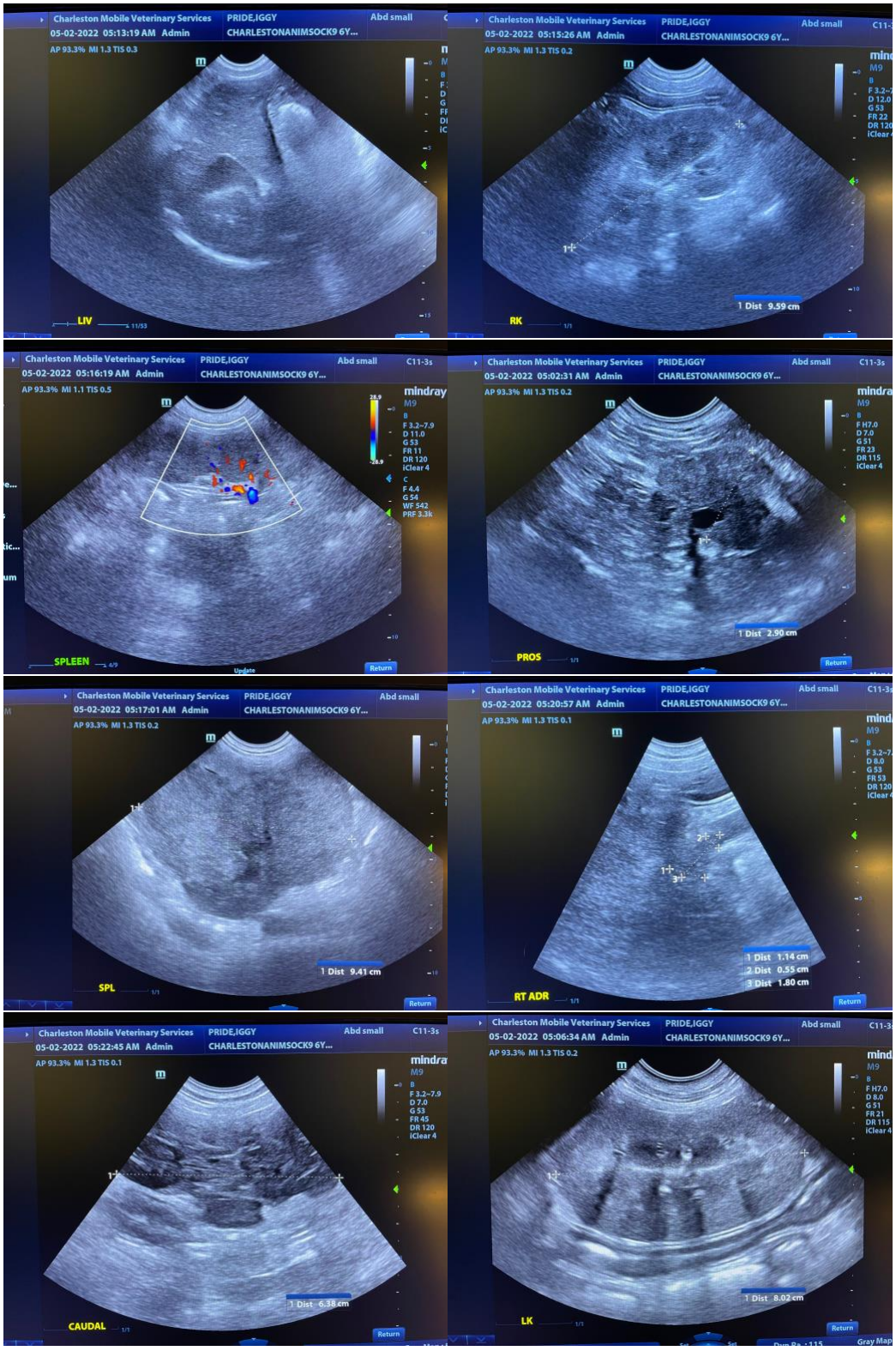

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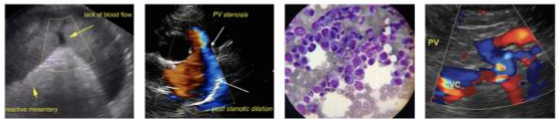

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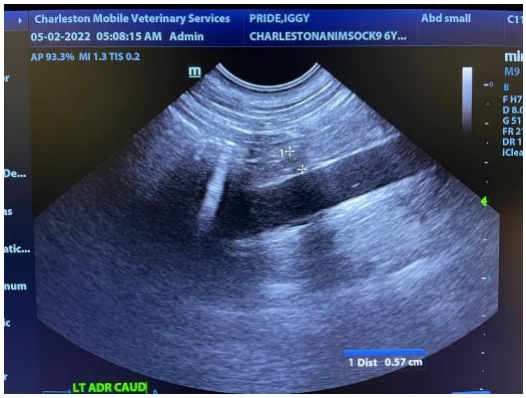

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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