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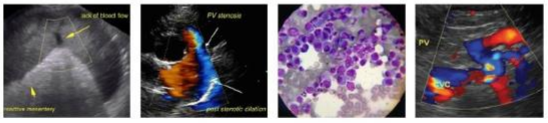


IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Scallywag Kelly

SPECIES

Canine

BREED

Skiperkee

SEX

Neutered Male

AGE

12 years

WEIGHT

16 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT LVT

HOSPITAL NAME

Brighton Greens AH

REFERRING VET

Dr. Robin Janeway

INVOICE

10847

DATE

5/4/22

PRESENTING CLINICAL SIGNS

History: Mast cell tumor removed from right thorax 4/6/22 (I - III): II. Two-tier (low/high): high. Mitotic index (in 10 hpf): 13. Surgical margins: The mass appeared completely excised. The mass is discrete, nodular and appeared completely excised. nearest lateral surgical margin was 5.0 millimeters and the nearest deep margin was 2.2 millimeters. Angiolymphatic invasion: None. Radiographic Findings There is mild cardiomegaly with mild left atrial enlargement suspected. Pulmonary vascular and parenchymal character is normal. In the visible cranial abdomen, the liver is mildly diffusely enlarged with smooth margins. Conclusion Mild cardiomegaly with mild left atrial enlargement. There is no evidence of cardiac decompensation. Mild hepatomegaly. SEe previous ultrasound report. Current medications: Benazepril 5mg PO SIDBID Ursodiol 1⁄4 x 300mg tab PO SID Denamarin 225 mg PO SID Vetmedin 1⁄3 x 7.5mg tab PO 3/8/22 UPC 2.3 O gives CBD for possible focal seizures 4/6/22 chem 6 ALP 879, otherwise WNL Pt is fed a homecooked diet formulated by UCD nutrition dept. Staging for neoplasia metastasis. Email (s) where report is to be sent: brightongreensvet@gmail.com Contact Information For Questions: Dr. J

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 region of the trigone and the visible portion of the proximal urethra are normal.

The prostate is normal in size (0.73 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

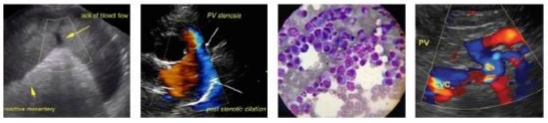
The left kidney is normal in size (5.11 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild to moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. A few, small cortical cysts are visualized. Pinpoint hyperechoic foci are observed in within the cortex. Trace pyelectasia is present. At least one small, nonobstructive nephrolith is visualized. There is no evidence of infarcts or hydroureter.

The right kidney is normal in size (4.97 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild to moderate loss of corticomedullary distinction. Pinpoint hyperechoic foci are observed within the cortex. Several hyperechoic shadowing diverticular foci are observed. A few small, nonobstructive nephroliths are present. There is no evidence of pyelectasia, infarcts or hydronephrosis.

Adrenal Glands

The left adrenal gland is borderline enlarged (0.67 cm at cranial pole) (0.60 cm at caudal pole) (1.68 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 mildly enlarged (0.85 cm at cranial pole) (0.73 cm at caudal pole) (2.26 cm in length); with a slightly irregular shape. A 1.34 x 0.86 cm hyperechoic nodule is observed at the caudal



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pole. In the remainder of the gland, the parenchyma is slightly heterogenous with some loss of glandular detail. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (1.57 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A 2.13 x 1.05 cm irregular, heterogenous, cavitated nodule/mass is observed at the caudolateral aspect. Splenic vasculature is normal.

Liver

The liver is prominent in size with slightly swollen 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 distended. The wall is normal in thickness. A moderate to large amount of aggregated, echogenic, partially dependent to suspended sludge is observed 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 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 right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely hyperechoic relative to surrounding omental fat and slightly mottled in appearance, with a few irregular, hypoechoic nodules, the largest measuring 0.68 cm in diameter. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Free Abdomen

There is no evidence of free fluid. A 0.99 cm medial iliac lymph node is visualized. The node is normal in shape and echogenicity.

Other

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The splenic nodule/mass is slightly larger compared to the previous sonogram. Differentials include neoplasia versus a benign process (i.e., focus of inflammation, extramedullary hematopoiesis or lymphoid hyperplasia.).
- Gall bladder sludge. Differentials include emerging mucocele, cholestasis, or less likely, fasting.

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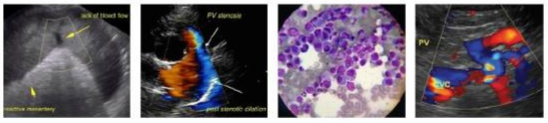

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Secondary Findings

- Suspected benign diffuse hepatopathy. Top differentials include regenerative nodular hyperplasia, age-related remodeling and/or vacuolar hepatopathy. Inflammatory disease is considered less likely, given the normal ALT. Infiltrative neoplasia is possible, but considered less likely, given the static appearance of the parenchyma.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Mild bilateral adrenomegaly. The right adrenal nodule is slightly larger compared to the previous sonogram. Differentials include nodular hyperplasia or emerging neoplasia (i.e., adenoma, adenocarcinoma, pheochromocytoma).
- Bilateral, chronic age-related renal changes with nonobstructive nephrocalcinosis. Changes are similar to the previous sonogram.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
- Fine-needle aspirates the liver and spleen can be considered to evaluate for microscopic mast cell disease (if clotting status is appropriate). If pursued, the patient should be pre-treated with diphenhydramine at 2.2 mg/kg subcutaneously, a few minutes prior to aspiration to help reduce the risk of mast cell degranulation. However, a cytologic evaluation may be of low yield. With regard to aspiration of the splenic nodule, given its cavitated nature, there is some risk of iatrogenic hemorrhage with the procedure. Therefore, if an aggressive approach is desired, consider a splenectomy with submission of the spleen for histopathology, along with a liver biopsy.
- Consider testing for hyperadrenocorticism with a low-dose dexamethasone suppression test or ACTH stimulation test if clinical signs (i.e., PU/PD) develop in the futured.
- Given the presence of proteinuria and bilateral adrenomegaly, consider a baseline blood pressure measurement to evaluate for systemic hypertension.
- Regarding the gall bladder sludge, continuation of Ursodiol therapy is recommended with serial sonographic monitoring, (i.e., every 6-8 weeks) to assess for progression to a mucocele.

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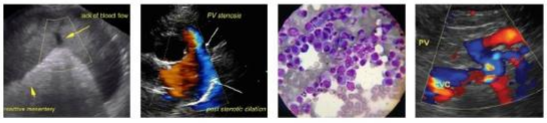

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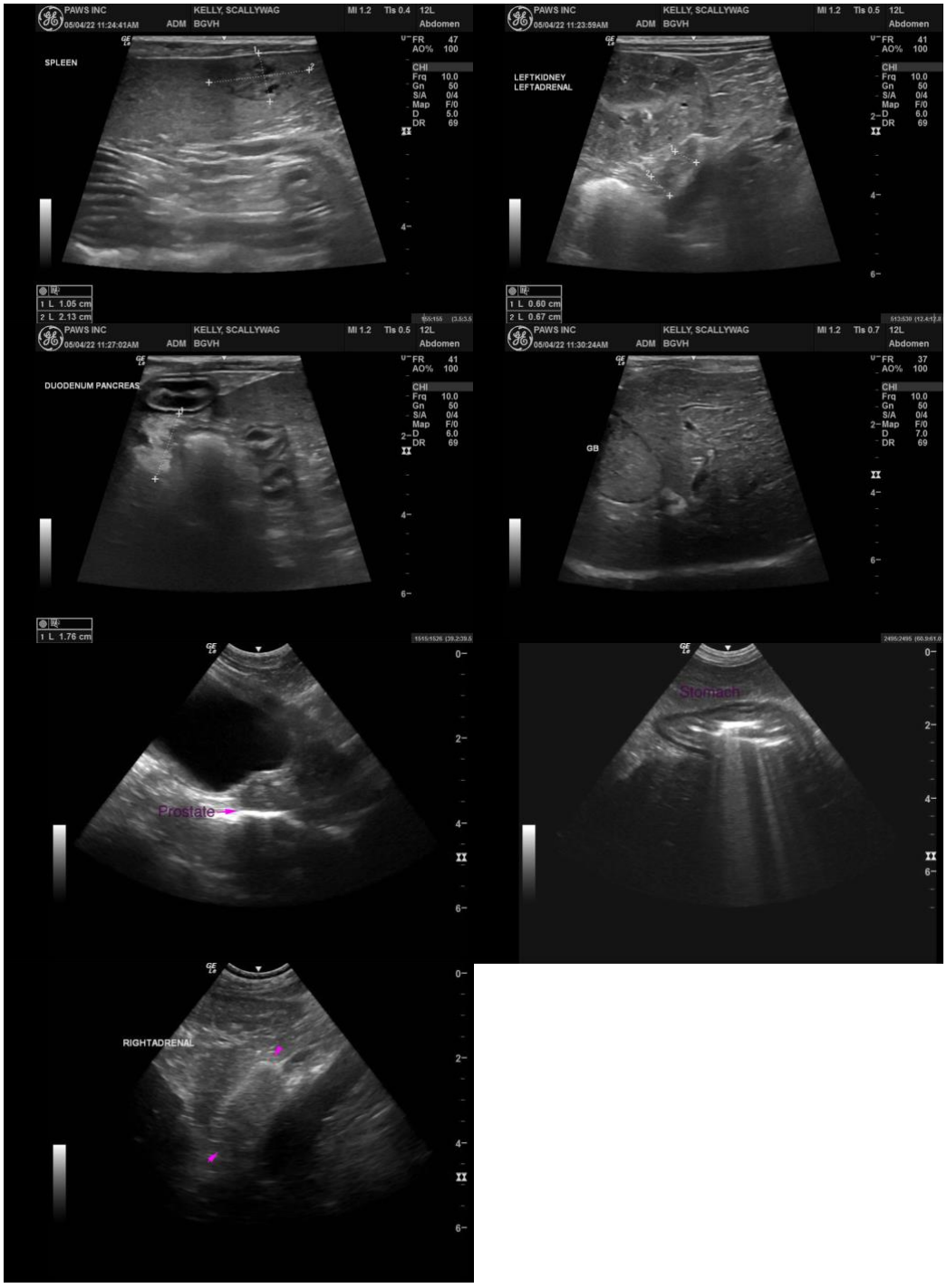

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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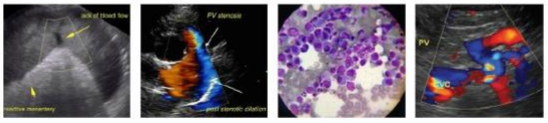

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Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance, please contact me.

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