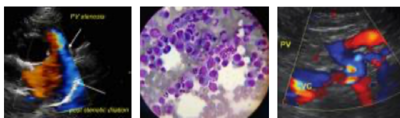
IMAGING PERFORMED BY

IntraPet.com



SonoPath
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DATE
5.7.23

PATIENT
Fergie Kozlowski

SPECIES
Canine

BREED
Great Pyrenees

SEX
Spayed Female

AGE
2010

WEIGHT
82 lbs

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

HOSPITAL NAME
Animal EH

REFERRING VET
Dr. Ruby

INVOICE
12960

PRESENTING CLINICAL SIGNS

Presenting Complaint: Not Eating. Lethargic. Vomiting.
History: Date: 05-06-2023 Notes: Tuesday not eating breakfast or dinner, only treats. Wed ate only one meal. Chicken only on Thursday Friday and Saturday very small amount. Vomited twice this week, vomiting only water. Decreased urine.
Assessment: Anorexia. Icterus.
Current Medications: Vitamin B Complex Injection, Ampicillin 125mg/vial Injection, Pantoprazole (Protonix) 40mg/vial Injection, Ondansetron 2mg/mL Injection.

Lab Results: GGT 77. tBili 9.4. ALT and ALP are off the scale. 4dx negative. liver enzymes with dilution. ALT 3783. ALP 4546.
Radiographs: Abdomen 2 View: No obvious FB or obstructive pattern. Hepatomegaly.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

Imaging Performed By: Rachel Brilhart, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone and visible portion of the proximal urethra are normal.

The left kidney is normal in size (6.52 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. Renal vasculature is normal.

The right kidney is normal in size (6.91 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild 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 in size (0.66 cm at cranial pole) (0.72 cm at caudal pole) (2.44 cm in length) with a normal shape and smooth peripheral contours. The parenchyma is slightly hypoechoic with some loss of glandular detail. No focal lesions are observed. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal in size (1.09 cm at cranial pole) (0.76 cm at caudal pole) (2.90 cm in length) with a normal shape and smooth peripheral contours. The parenchyma is slightly hypoechoic with some loss of glandular detail. No focal lesions are observed. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (xxx 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 enlarged. An approximately 8.00 cm round, isoechoic mass is observed on the left side. The lesion causes capsular expansion. In the remainder of the liver, the margins are curvilinear. The parenchyma is hypoechoic relative to the spleen with subtle mottling. 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 to large amount of aggregated echogenic, stranding, suspended sludge, in a partially stellate pattern, is observed within the lumen. 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 ileocecocolic junction and colonic wall are 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 isoechoic 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 in the right cranial quadrant, adjacent to the gallbladder, is mildly hyperechoic. There is no obvious evidence of free fluid. A 1.65 cm lymph node is observed in the right cranial quadrant.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The gallbladder changes are consistent with a developing mucocele.
- Left hepatic mass. Neoplasia (i.e., adenocarcinoma, adenocarcinoma, round cell tumor) is suspected with a lower potential for a benign process (inflammatory disease, regenerative nodule).
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Focal peritonitis in the right cranial quadrant, the cause of which is unclear. It may be secondary to hepatobiliary disease, mild pancreatitis, other.

Secondary Findings

- Minor bilateral chronic renal changes
- The bilateral adrenal changes may be a normal variant for this patient or may represent early hyperplastic change.

- The prominent cranial abdominal lymph node is likely reactive, with a lower possibility of emerging neoplasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

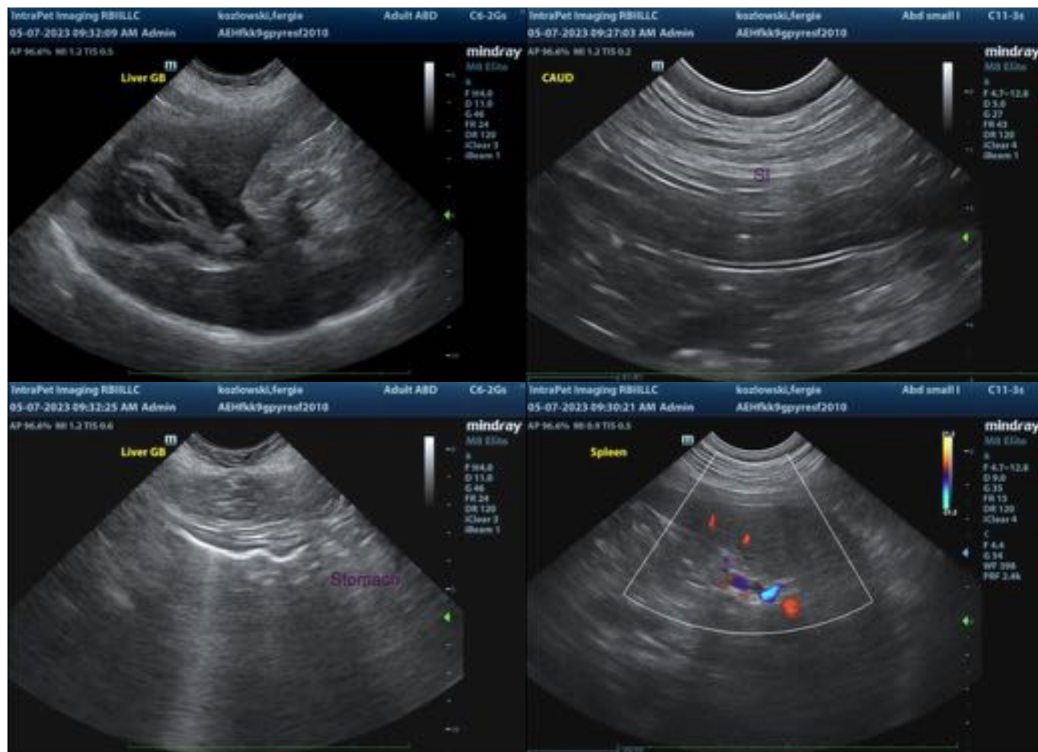
- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.

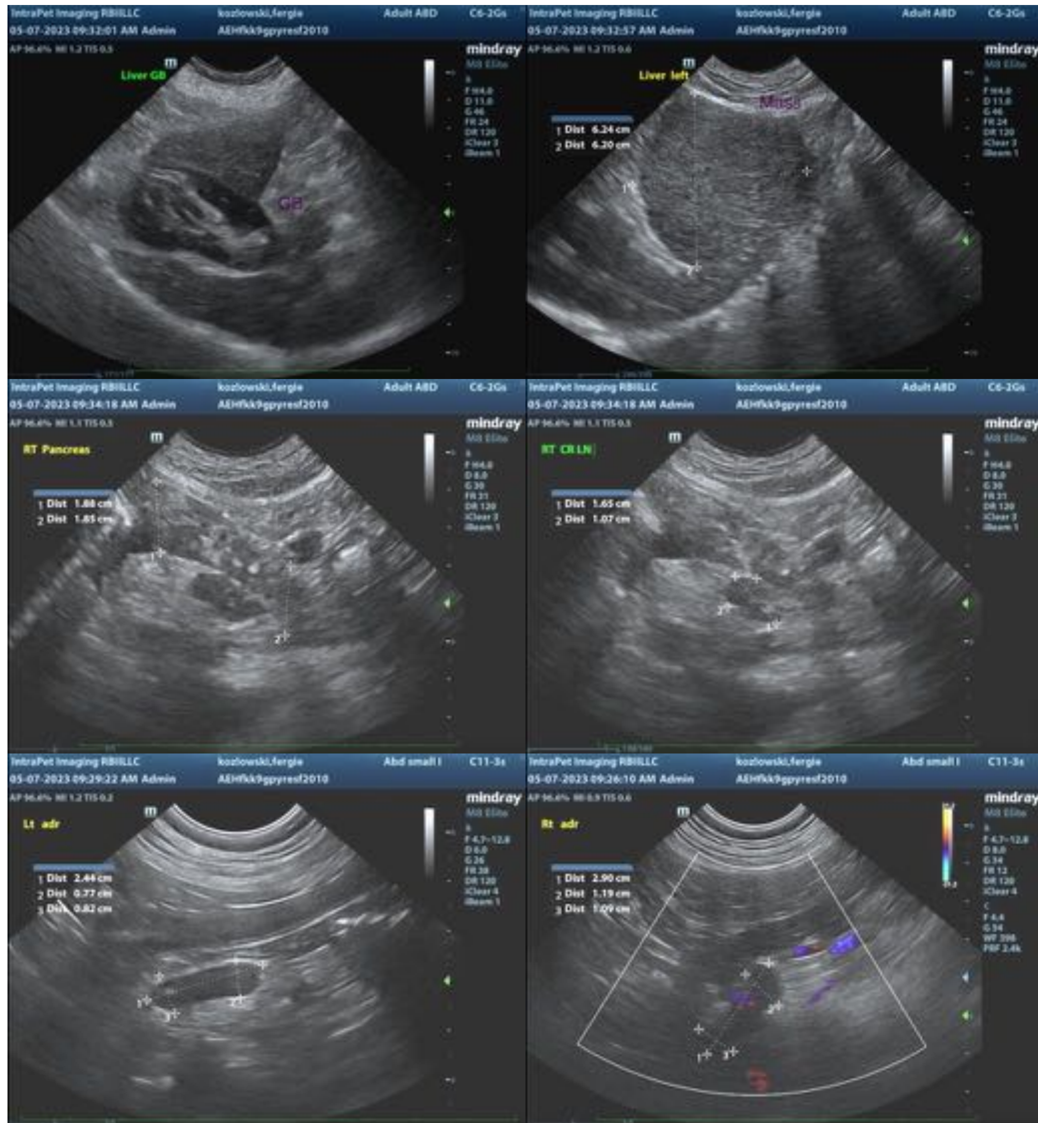
- Consider a fine-needle aspirate of the hepatic mass (if clotting status is appropriate). A 25-gauge needle should be used. Alternatively, consider an abdominal exploratory with excisional biopsy of the hepatic mass and submission for histopathology, along with a cholecystectomy. If surgery is pursued, biopsies of the other liver lobes is also recommended.

- Consider Leptospirosis testing, particularly if clinical suspicion for disease is high.

- Also consider a cPLI to further assess for pancreatitis.

- While awaiting test results, empirical treatment for cholecystits/bacterial cholangiohepatitis is recommended, including broad-spectrum antibiotics, fluid therapy, gastric protectants, Ursodiol and other hepatic antioxidants, as needed.





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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