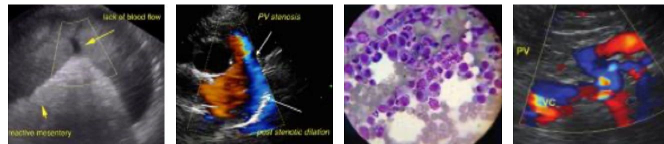
SonoPath

Clinical Sonography & Telecytology

EDUCATIONAL TELECONSULTATION SERVICES™



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1-800-838-4268 info@sonopath.com

PATIENT

Buddy Ledsworth

SPECIES

Canine

BREED

Spaniel mix

SEX

Male,

AGE

14 Yrs.

WEIGHT

37.2 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Sammy Burmeister

HOSPITAL NAME

Faith Animal Care

REFERRING VET

Dr. Faith

INVOICE

14910

DATE

5/9/23

PRESENTING CLINICAL SIGNS

History: Patient presented for unsteadiness, weakness in hind legs, and anorexia. Bloodwork was done and results showed elevated kidney enzymes, elevated phosphorus and calcium, and significantly elevated lipase. White blood cell count was high with neutrophilia. Patient was hospitalized and started in IV fluids. He was started on Cerenia, Baytril, Famotidine, and Mirtazapine. After 3 days of treatment, he did seem a little improved. He was more steady on his feet and had a small appetite. He is still very quiet and slow to start moving around in the mornings. BUN 47, creat 3.9, SDMA 64, calcium 14.8, albumin 2.3, USG 1.016, 1+ proteinuria, active sediment, bacteriuria, low T4, 4DX negative

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface in the region of the apex is mildly irregular. The bladder is moderately distended. A scant amount of suspended echogenic debris is observed within the lumen. No cystic calculi are observed. The region of the trigone is normal.

The prostate is not definitively visualized due to its pelvic location.

The left kidney is subjectively normal size with normal curvilinear peripheral contours. The cortex is diffusely thickened and isoechoic relative to the spleen with small cortical cysts observed. There is a moderate loss of corticomedullary distinction. Mild to moderate pyelectasia is present (0.55 cm in the longitudinal plane). There is no evidence of nephroliths, infarcts or hydroureter.

The right kidney is normal size (6.40 cm in length); normal shape and architecture with 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 mildly enlarged (0.56 cm at cranial pole) (0.87 cm at caudal pole); 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.

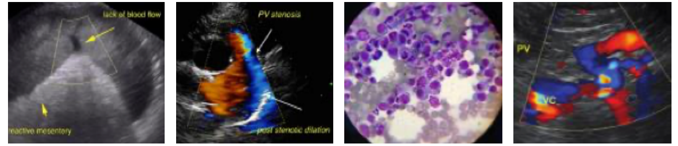
The region of the right adrenal gland is evaluated. The gland is not definitively visualized. However, no obvious pathology is observed in this region.

Spleen

The spleen is normal in size (1.40 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 with irregular peripheral contours. A >11 cm slightly heterogeneous mass is arising from the right side. The mass causes capsular expansion. In the remainder of the liver, there is diffuse mineralization throughout the biliary tree, obscuring some of the hepatic parenchyma. Vascular and biliary tracts are of normal volume with no evidence of congestion. The gall bladder is mildly distended. The wall is thickened (up to 0.42 cm) with a “double-walled” effect. The inner portion of the wall appears mineralized. Luminal contents are mostly anechoic. The cystic and common bile ducts are normal/not seen.



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Gastrointestinal

The gastric 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 colonic wall is normal. There is no evidence of an obstructive pattern.

Pancreas

The left limb of the pancreas is visible/prominent with slightly irregular peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat and mottled in appearance. No distinct focal lesions are observed. The pancreatic duct is not overtly dilated.

Free Abdomen

The mesentery in the right cranial quadrant is mildly hyperechoic. Trace free fluid is observed. A 1.59 x 1.03 cm cystic lymph node is observed in the left mid-abdomen, just caudal to the left renal artery. In addition, 2-3 prominent lymph nodes are suspected in the right cranial quadrant, the largest measuring 1.42 cm in length.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

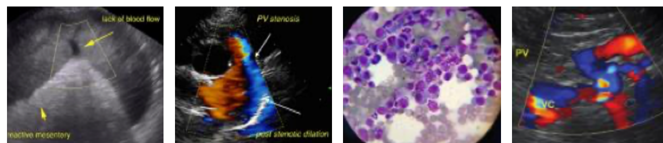
- Large right hepatic mass. Neoplasia (i.e., adenoma, adenocarcinoma, round cell tumor) is suspected with a lower possibility of a non-neoplastic process (i.e., inflammatory, excessive regenerative nodular hyperplasia, other). Diffuse biliary tract mineralization. This may be an incidental finding but could be associated with cholangitis.
- The gallbladder wall changes are most consistent with cholecystitis. However, other differentials (i.e., low oncotic pressure, anaphylaxis, increased hydrostatic pressure, other) cannot be excluded. In rare instances, gallbladder wall mineralization can be associated with carcinoma.
- Bilateral, chronic nephropathy. The right pyelectasia may be secondary to pyelonephritis, age-related remodeling, fluid therapy (if applicable) or some combination thereof.
- Trace ascites, likely secondary to hepatobiliary pathology.

Secondary Findings:

- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The prominent lymph nodes in the right cranial quadrant could be consistent with reactive change or emerging neoplasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Consider a fine needle aspirate of the hepatic mass if clotting status is appropriate. A 25-gauge needle should be used.



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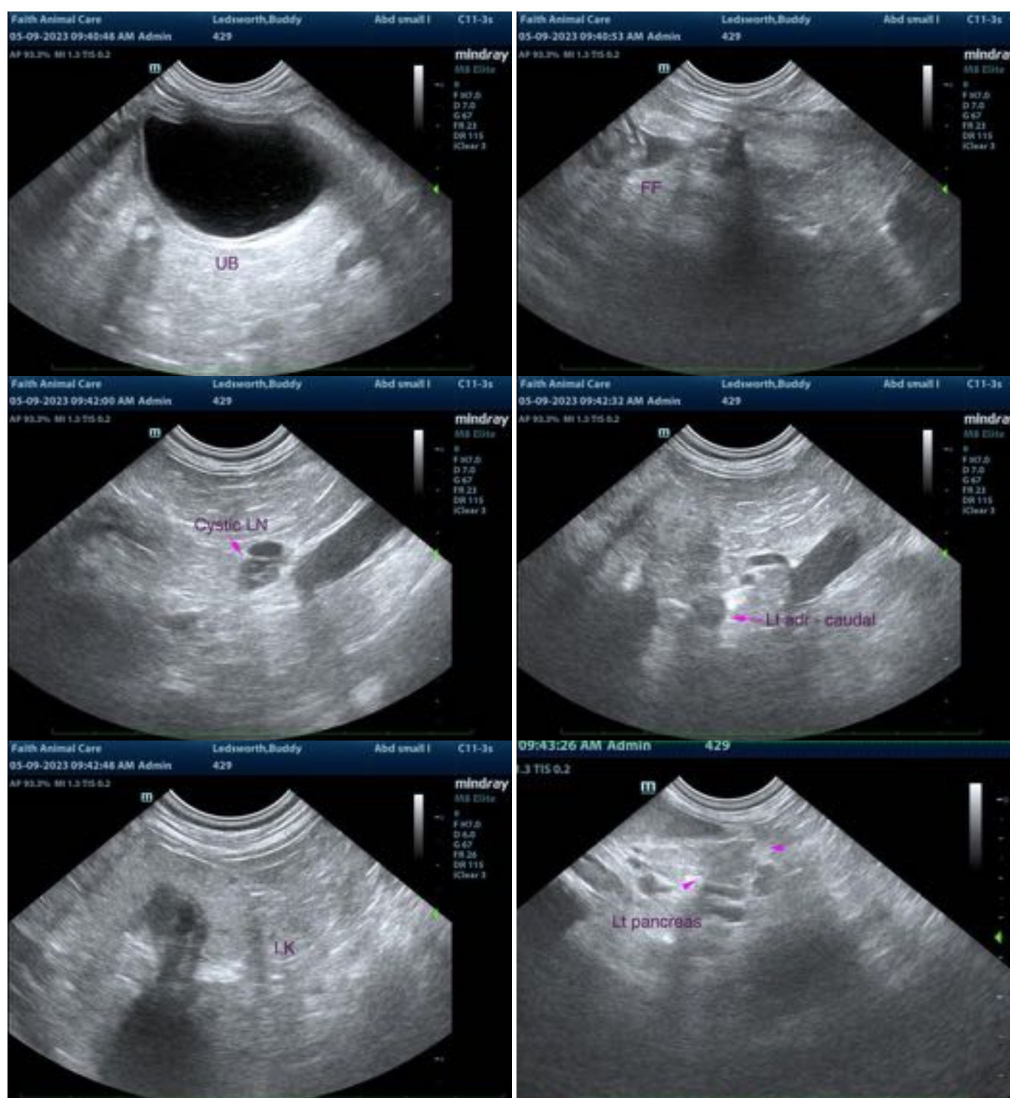
- Regarding the renal disease, consider the following:
  1. Urine culture and sensitivity
  2. UPC if proteinuria persists in the absence of infection
  3. Baseline blood pressure measurement
  4. IV fluid diuresis, broad spectrum antibiotics (while awaiting urine culture and sensitivity results) and other symptomatic measures, as needed
- Regarding the hypercalcemia, consider the following:
  1. Three-view thoracic radiographs to assess for occult neoplasia in the chest
  2. Rectal examination to assess for anal gland neoplasia
  3. PTH/PTHrP/ionized calcium



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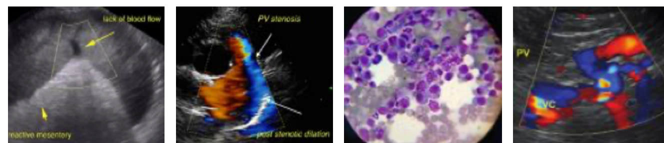

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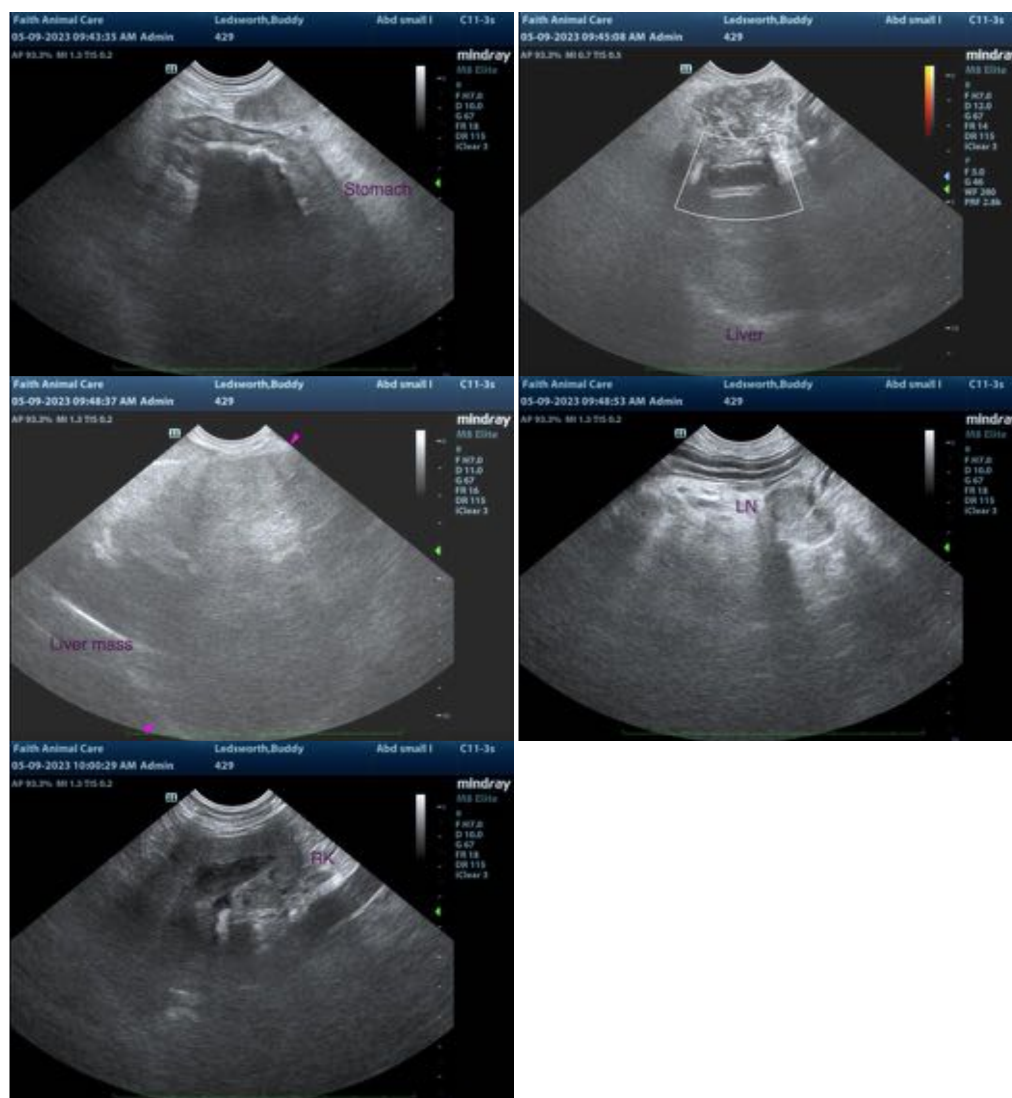

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
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