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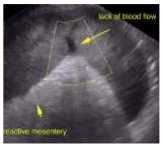
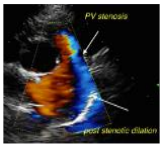
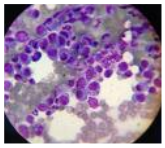
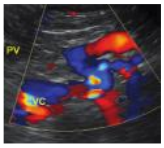
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

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

PATIENT
Beau Krajcik

SPECIES
Canine

BREED
Shetland Sheepdog

SEX
Neutered Male

AGE
11 years

WEIGHT
43.2 lbs

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

IMAGING PERFORMED BY
Shari Reffi, CVT

HOSPITAL NAME
Summit Dog & Cat Hosp

REFERRING VET
Dr. Vogler

INVOICE
11000

DATE
6/1/22

PRESENTING CLINICAL SIGNS

History: Decreased appetite.
Abnormal PE/Chem/CBC/UA Results:

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 mostly 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 normal in size (1.09 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal size (5.32 cm in length); normal shape and smooth peripheral contours. The cortex is variably thickened and hyperechoic to heterogenous in appearance with numerous, small cortical cysts. Focus of mineralization are visualized. Mild pyelectasia is present (0.21 cm in the longitudinal plane). There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. There is no evidence of hydroureter. Renal vasculature is normal.

The right kidney is normal in size (5.38 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is moderate loss of corticomedullary distinction. One to two, small cortical cysts are seen. Several hyperechoic shadowing diverticular foci are observed. Trace pyelectasia is present. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is borderline enlarged (0.72 cm at cranial pole) (0.72 cm at caudal pole) (2.72 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 normal size (1.00 cm at cranial pole) (0.68 cm at caudal pole) (2.92 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 overall normal in size (1.61 cm in width at the level of the hilus). The parenchyma is subtly mottled in appearance. A 1.21 x 1.18 cm isoechoic to slightly heterogenous nodule is arising from the caudal pole. The lesion causes capsular expansion. The remaining peripheral margins are curvilinear. A few, small, myelolipomas are observed in the region of the hilus. Splenic vasculature is normal with no evidence of thrombosis.

Liver

The liver is subjectively prominent in size with slightly swollen peripheral contours. The parenchyma is isoechoic relative to the spleen. Several, irregular, hyperechoic to slightly heterogenous nodules/masses are visualized, the largest measuring 3.48 cm in diameter. 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 small amount of gravity dependent to mineralized debris 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 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 colonic wall is normal. No obstructive disease is noted.

Pancreas

The left limb of the pancreas is visible/prominent with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Free Abdomen

The peritoneal cavity is normal. There is no evidence of inflammation or effusion. The abdominal lymph nodes are normal/not visible.

Other

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Splenic nodule (caudal pole). Neoplasia (i.e., sarcoma, round cell tumor) is suspected. However, a benign process (i.e., a focus of lymphoid hyperplasia, extramedullary hematopoiesis, or similar) cannot be excluded. The diffuse splenic parenchymal changes are nonspecific and could be consistent with lymphoid hyperplasia, extramedullary hematopoiesis, antigenic stimulation, splenitis, or less likely, infiltrative neoplasia.
- The hepatic nodules trends toward the benign (i.e., regenerative nodules). Multifocal neoplasia is also possible but considered less likely.i

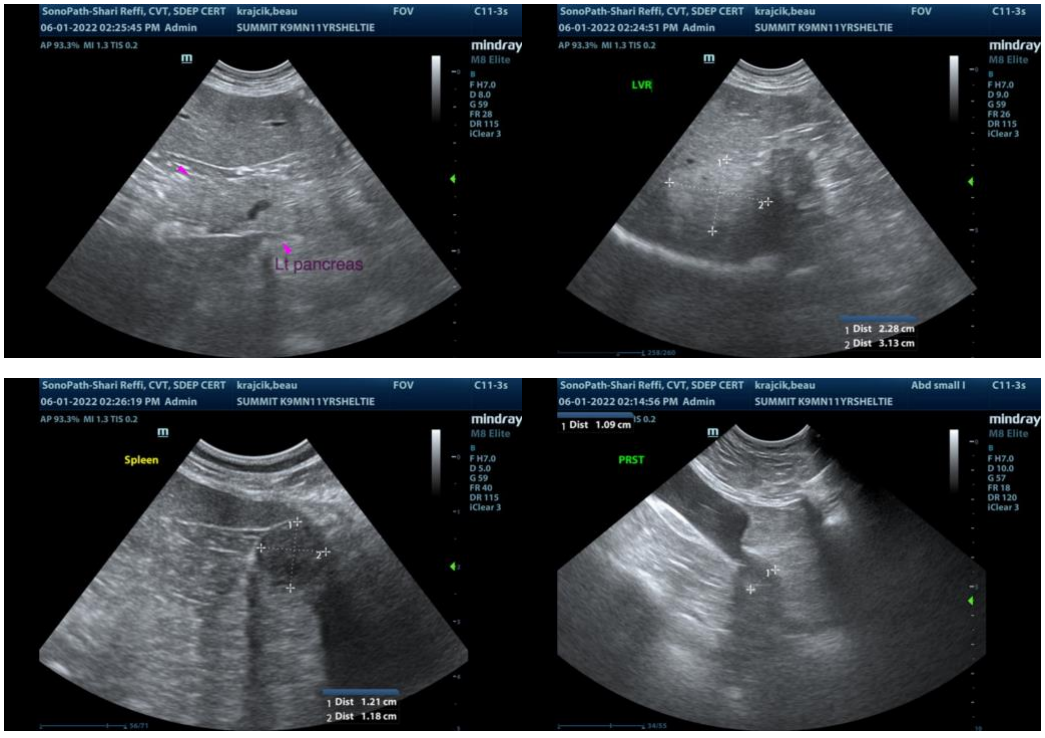
Secondary Findings

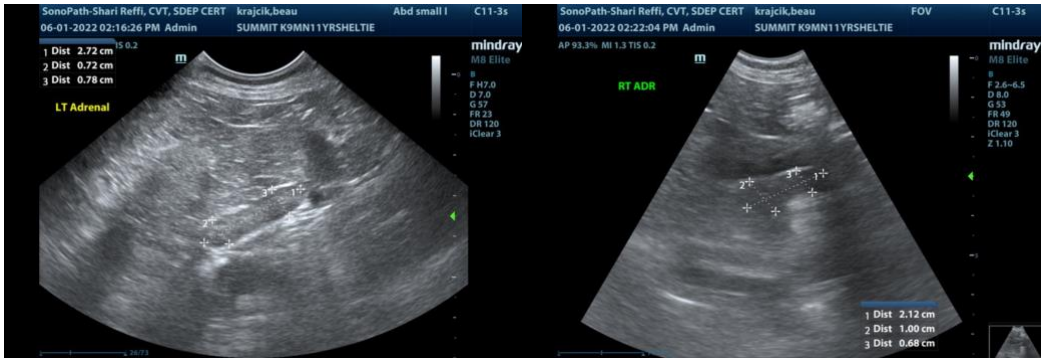
- Bilateral, chronic, age-related renal changes with cortical cysts

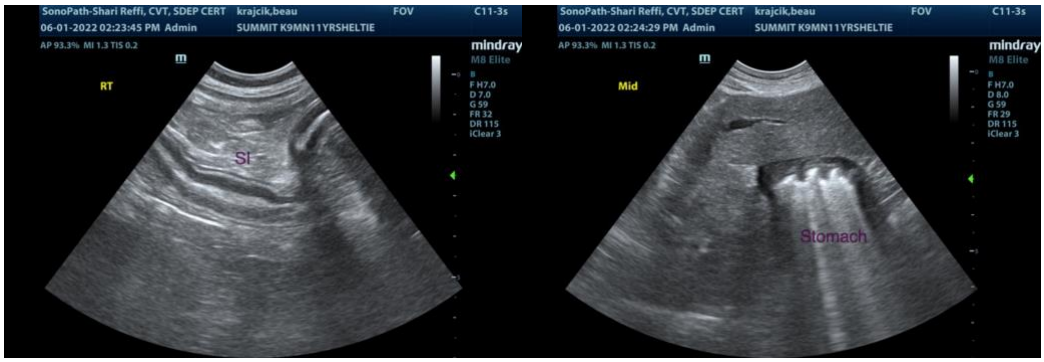
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
- Baseline lab work, including a CBC Chemistry panel, urinalysis and T4 is recommended, to assess overall metabolic function.
- Consider a fine-needle aspirate of the hepatic and splenic nodules if clotting status is appropriate.
- Also consider a malabsorption panel (Send to TX A&M) to further assess for microscopic gastrointestinal and pancreatic disease.







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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