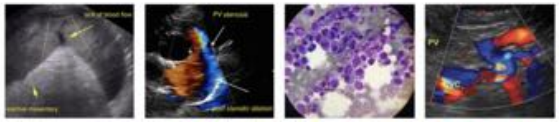

PATIENT

Mr.Darcy Evans

SPECIES

Canine

BREED

Schnauzer

SEX

Neutered Male

AGE

10.8.2008

WEIGHT

37.5 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

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HOSPITAL NAME

Flowertown AH

REFERRING VET

Dr. Randinelli

INVOICE

11163

DATE

6.28.22

PRESENTING CLINICAL SIGNS

Clinical Exam Findings:
- Nuclear sclerosis OU
- Large round firm SQ mass R ventral abdomen/inguinal area
- Heart murmur 5/6
- Cranial organomegaly
- Cachexic with generalized muscle loss

Abnormal lab-work values: ALKP 1141, ALT 219, AMYL 2166
Current Medications: Gabapentin, Denamarin and Clavamox

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** is mildly to moderately distended. The wall is normal to mildly thickened (up to 0.45 cm) with a slightly irregular mucosal surface. A few cystic calculi are observed, the largest measuring 0.44 cm in diameter. The region of the trigone and the visible portion of the proximal urethra are normal.

The prostate is normal in size (1.05 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 (6.62 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. A few nonobstructive nephroliths are visualized. Trace pyelectasia is present (0.41 cm in the transverse plane). There is no evidence of infarcts or hydroureter. Renal vasculature is normal.

The **right kidney** is normal in size (7.20 cm in length) 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.

Adrenal Glands

The **left adrenal gland** is normal size (0.68 cm at cranial pole) (0.68 cm at caudal pole) (2.62 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.

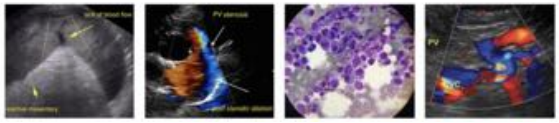
The **right adrenal gland** is normal size (1.18 cm at cranial pole) (0.59 cm at caudal pole) (1.72 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The **spleen** is subjectively normal in size (1.34 cm in width at the level of the hilus) with slight rounding of the peripheral margins at the cranial pole. The parenchyma is subtly mottled in appearance. A 0.77 x 0.67 cm target-like lesion is observed at the craniomedial aspect. At least one, smaller hyperechoic nodule is also observed. Splenic vasculature is normal with no evidence of thrombosis.

Liver

The **liver** is subjectively enlarged with swollen to slightly irregular peripheral contours. A >10 cm cavitated heterogenous mass is extending from the mid- to left liver. The mesentery effacing the



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serosal surface of the mass is mildly hyperechoic. The remaining parenchyma in the right liver is mostly homogenous in appearance. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1: 1.

The **gall bladder** lumen is moderately distended. The wall is thin and smooth. A moderate amount of aggregated, echogenic, mostly gravity dependent debris/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 mildly distended with 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 segmentally dilated with chyme. 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. The colonic lumen contains shadowing fecal material. There is no evidence of an obstructive pattern.

Pancreas

The base and limbs of the pancreas are 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

Trace free fluid is observed.
A 1.40 x 0.93 cm cystic lymph node is observed in the right, cranial quadrant.

Other

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

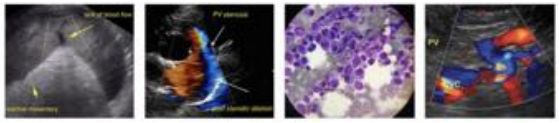
ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Large mid- to left hepatic mass. Neoplasia (i.e., hemangiosarcoma, adenocarcinoma, round cell tumor) is considered likely with a lower possibility of benign pathology. Adjacent peritonitis is present.
- Cystic calculi. The bladder wall changes are suggestive of cystitis, likely secondary to the presence of cystic calculi.
- The cystic lymph node in the right cranial quadrant may represent a reactive change or metastatic neoplasia.
- The target-like splenic lesion could be consistent with metastasis from the hepatic mass. Alternatively, it may represent a benign process (i.e., myelolipoma).

Secondary Findings

- Bilateral, age-related renal changes with nonobstructive nephrolithiasis and trace pyelectasia.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.



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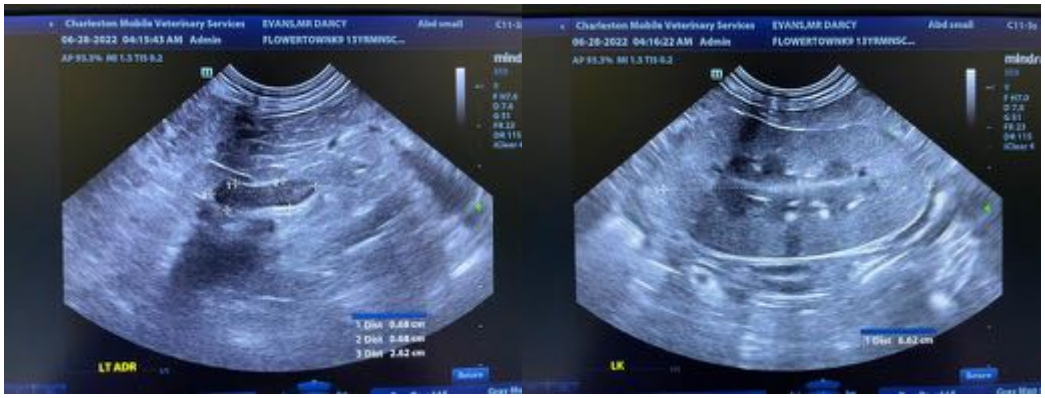
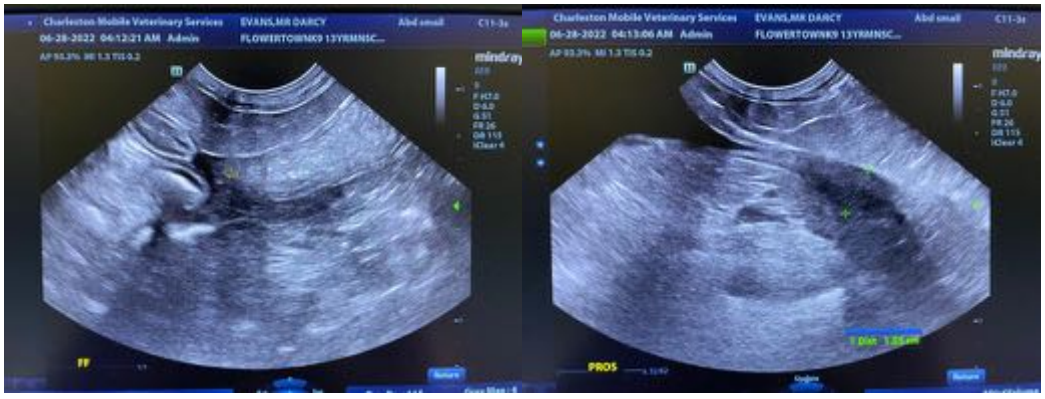
- Gall bladder/sludge – non-mucocele

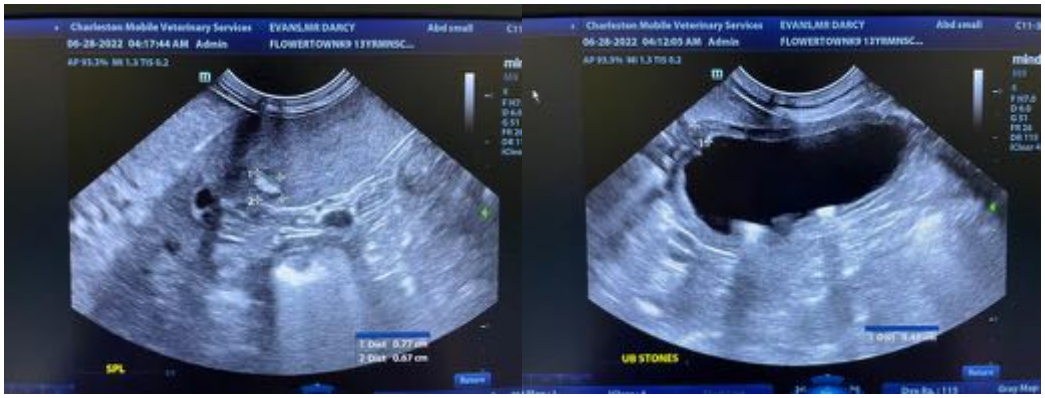
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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

If an aggressive approach is desired, consider referral to a board-certified surgeon to discuss liver mass removal or debulking. An abdominal CT scan would be useful in presurgical planning. The target-like splenic lesion should also be biopsied at the time of surgery. However, a splenectomy may be warranted, depending on the appearance of the lesion. If surgery is pursued, a cystotomy with stone removal analysis and culture is also recommended, as well as biopsy/removal of the cystic lymph node in the right cranial quadrant.







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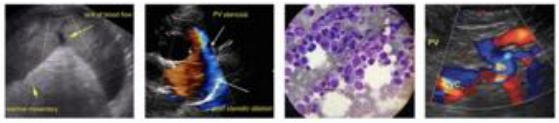

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CharlestonMobile.Net 800.403.5408

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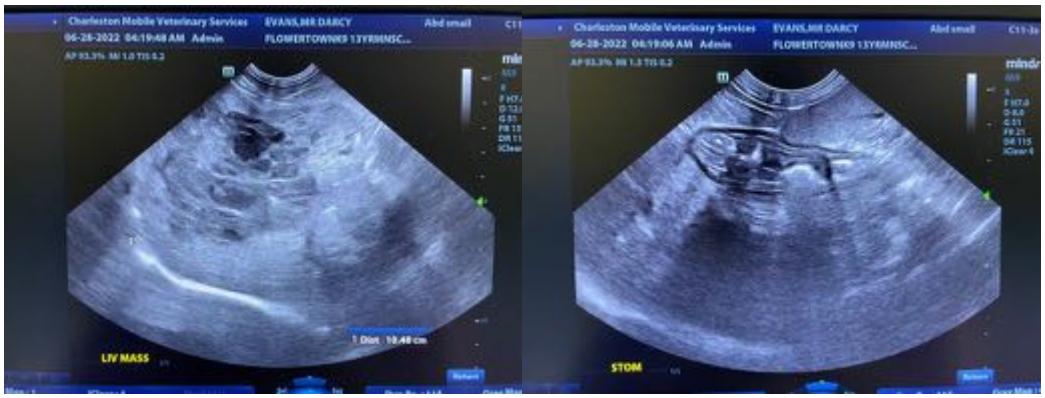

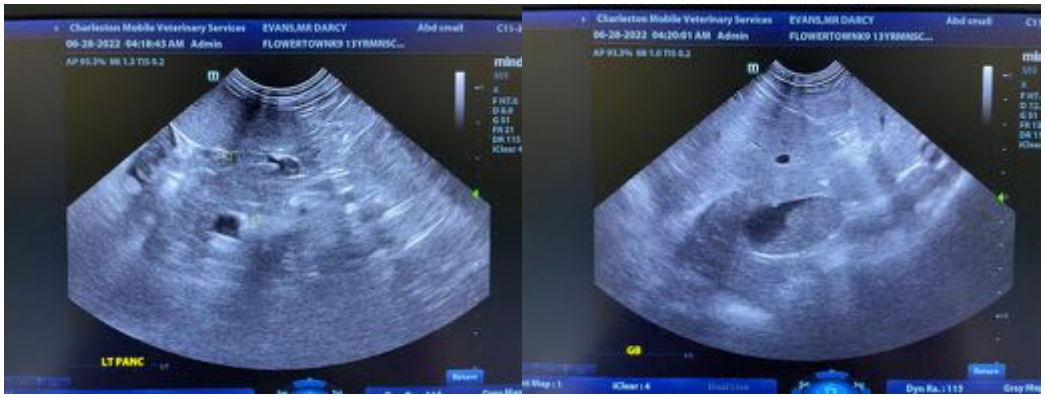

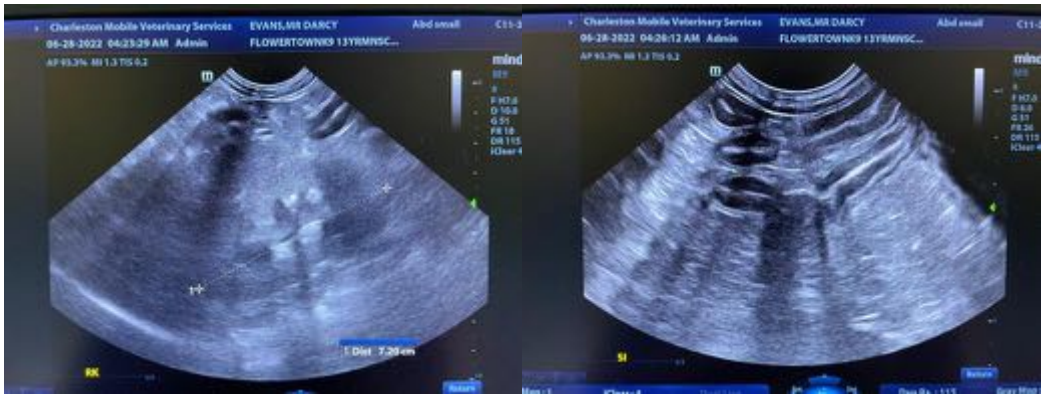

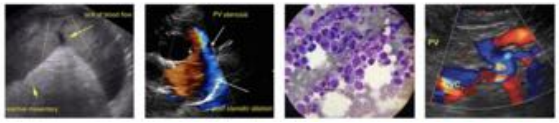

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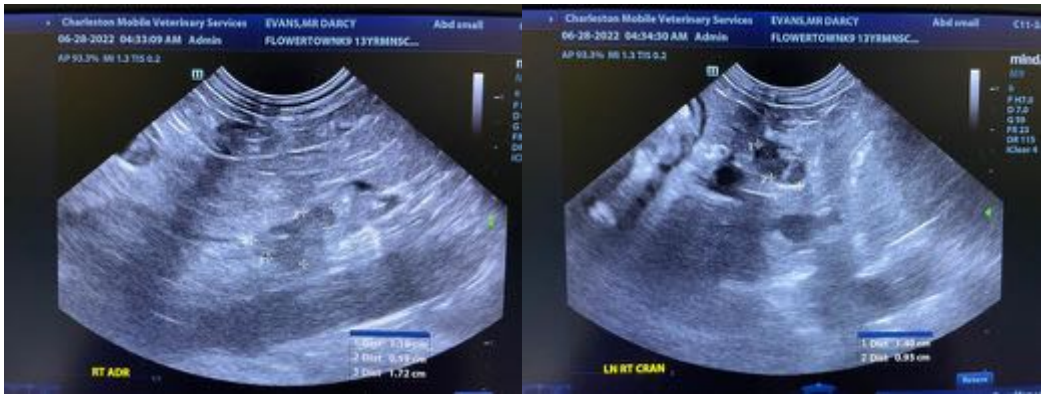

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@SonoPath.com