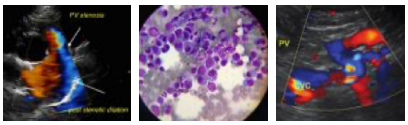
IMAGING PERFORMED BY

IntraPet.com



SonoPath
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DATE

7/20/22

PATIENT

AJ Rigsby

SPECIES

Canine

BREED

Pug

SEX

Male, neutered

AGE

3/24/2008

WEIGHT

30.6 lbs.

INTERPRETED BY

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

HOSPITAL NAME

NOrthwind AH

REFERRING VET

Dr. Repsher

INVOICE

13758

PRESENTING CLINICAL SIGNS

Presented w/ 1 week history of GI upset - diarrhea and inappetence. diarrhea resolve w/bland diet but when o switched back too soon inappetence got worse. o had noted some increased thirst. PE NSF
noted possible splenic mass on x-ray and confirmed /in house fast scan

Current Medications: Cerenia 30mg SID.
Lab Results: mild regenerative anemia, decreased platelet ct – slight, mild thrombocytopenia, USG 1.017, no proteinuria, inactive sediment
mild elevation Globulin, Mild decrease Albumin due to decrease intake/appetite. Mass on Spleen, bladder stones - incidental finding
fast scan of spleen shows lg cavitated mass on Tail of Spleen
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

Imaging Performed By: Andi Parkinson, BS, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is moderately distended. The wall is normal in thickness with a smooth mucosal surface. At least 2 small cystic calculi are visualized within the lumen, the largest measuring 0.40 cm in diameter. The cystourethral junction in the visible portion of the proximal urethra are normal.

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

The left kidney is normal size (4.82 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney is normal in size (4.89 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.

Adrenal Glands

The left adrenal gland is small in size (0.33 cm at cranial pole) (0.41 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 right adrenal gland is small in size (0.28 cm at cranial pole) (0.30 cm at caudal pole) (1.18 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 enlarged with irregular peripheral contours. Several coalescing heterogeneous slightly cavitated masses are observed throughout the organ, the largest measuring between 5-5.4 cm. Surrounding mesentery is hyperechoic.

Liver

The liver is subjectively normal in size with slightly irregular peripheral margin on the right side. The parenchyma is hypoechoic relative to the spleen and mildly heterogeneous in appearance. A 1.87 x 1.44 cm isoechoic swelling/nodule is observed at the tip of the caudate process. 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 amount of aggregated echogenic to mineralized debris/sludge is observed within the lumen, some of which is gravity-dependent and some of which is adhered to the luminal surface. 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 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 right limb is prominent in size with slightly irregular peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat and is mottled in appearance. The pancreatic duct is visible but not overtly dilated (0.23 cm) in diameter. The mesentery effacing the serosal surface is mildly hyperechoic.

Free Abdomen

Trace free fluid is observed. The abdominal lymph nodes are normal/not visible.

Other

A brief echocardiogram reveals no obvious evidence of pericardial effusion.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- Splenic masses. Neoplasia (i.e., hemangiosarcoma, hemangioma, round cell neoplasia) is considered likely with a lower possibility of benign pathology. Adjacent peritonitis is present.
- Cystic calculi.

Secondary Findings:

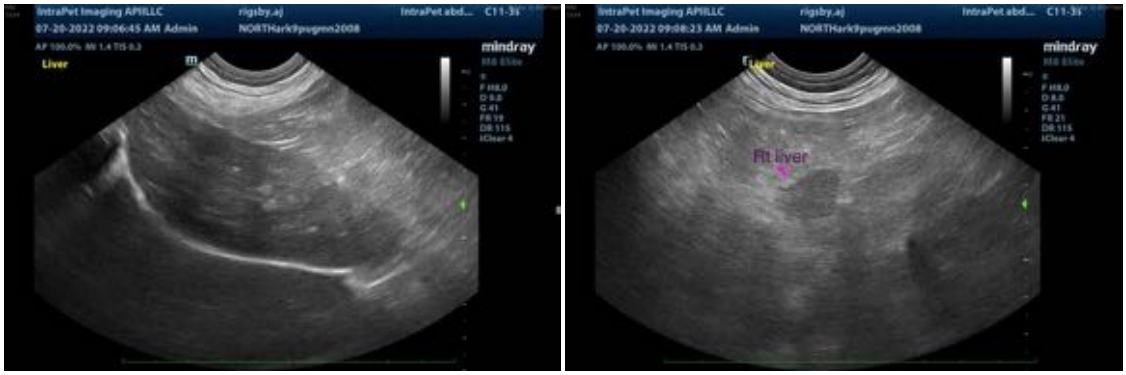
- Mild bilateral age-related renal changes with right dystrophic mineralization.
- The bilaterally small adrenal glands may be a normal variant for this patient or may be secondary to early atrophy (i.e., secondary to hypoadrenocorticism).
- The hepatic parenchymal changes are non-specific and are likely secondary to a benign age-related process (i.e., regenerative nodular hyperplasia, vacuolar hepatopathy). The swelling/nodule at the tip of the caudate process of the liver trends toward the benign with a lower possibility of emerging tumor.
- Gallbladder sludge, non-mucocele.
- The pancreatic changes are consistent with mild, chronic, active pancreatitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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

- If there is no evidence of pulmonary metastatic disease, consider splenectomy with submission of the spleen for histopathology. A liver biopsy should also be obtained at the time of surgery to assess for micrometastatic disease. Given the history of GI signs, also consider obtaining gastrointestinal biopsies at the time of surgery as well as performing a malabsorption panel (i.e., serum cobalamin, folate, TLI and PLI) and fecal evaluation for ova and Giardia.

- If surgery is not pursued, palliative/symptomatic care is recommended.



The information and recommendations provided are based on the images presented by the referring veterinarian. 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 ACVIM (*Small Animal Internal Medicine*)
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