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Clinical Sonography & Telecytology
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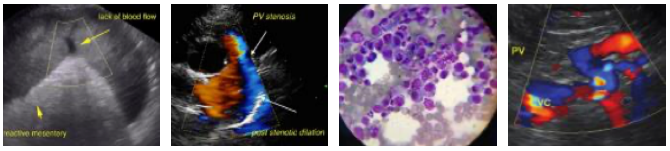

SonoPath.com
1-800-838-4268 info@sonopath.com

**PATIENT**
Rudy Osborne

**SPECIES**
Canine

**BREED**
Rottweiler mix

**SEX**
Male, neutered

**AGE**
12 Yrs.

**WEIGHT**
67.2 lbs.

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

**IMAGING PERFORMED BY**
Diane McFadden, RVT

**HOSPITAL NAME**
Westwood Regional VH

**REFERRING VET**
Dr. Goldman

**INVOICE**
11872

**DATE**
8/12/21

## PRESENTING CLINICAL SIGNS

History: Diarrhea for the past week, vomiting and anorexia started yesterday . On Denamarin, gabapentin, phenobarbital , Previcox,
Abnormal PE/Chem/CBC/UA Results: pending CBC/chem, fecal/giardia, PLI

## 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 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 (1.00 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 (6.30 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. Renal vasculature is normal.

The right kidney is normal size (5.47 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

### *Adrenal Glands*

The left adrenal gland is normal size (0.82 cm at cranial pole) (0.67 cm at caudal pole) (3.22 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 (1.56 cm at cranial pole) (0.57 cm at caudal pole) (3.05 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 normal in size (2.45 cm in width at the level of the hilus) with a normal capsular contour. The parenchyma is subtly mottled in appearance. No focal lesions are observed. Splenic vasculature is normal.

### *Liver*

The liver is subjectively normal in size with slightly irregular peripheral contours. The parenchyma is hypoechoic relative to the spleen. An 8.34 x 6.82 cm heterogeneous mass is observed deep left liver. The lesion causes mild capsular expansion. The remaining parenchyma is subtly mottled in appearance. Vascular and biliary tracts are of normal volume with no evidence of congestion. The gallbladder is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. The cystic and common bile ducts are normal.

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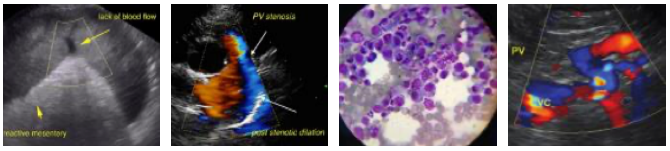

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### *Gastrointestinal*

The gastric lumen is mildly distended with chyme. The gastric wall in the region of the fundus is normal in thickness with a normal layering pattern. The wall of the pyloric antrum is moderately thickened (0.76-1.21 cm) with apparent retention of the normal layering pattern. The pyloric outflow tract is patent. The proximal duodenal lumen is mildly to moderately distended with chyme and hyperperistaltic. The remaining small intestinal segments are 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. No obstructive disease is noted.

### *Pancreas*

The left 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 peritoneal cavity is normal. There is no evidence of inflammation or effusion. A 1.55 cm lymph node is observed at the aortic trifurcation.

## ULTRASONOGRAPHIC FINDINGS

**Primary Findings:**

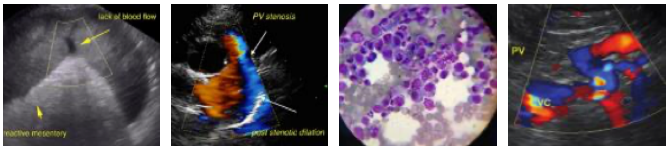
- Left hepatic mass. Neoplasia (i.e., adenocarcinoma, round cell tumor) is considered likely with a lower possibility of benign pathology.
- The gastrointestinal changes are most consistent with gastroenteritis. However, an emerging neoplastic process cannot be completely excluded.

**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 caudal abdominal lymph node is likely reactive.
- The splenic parenchyma changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis or splenitis with a low possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).
- Minor age-related renal pathology.

## 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 and an aggressive approach is desired, consider referral to a board certified surgeon to discuss hepatic mass removal. An abdominal CT scan would be useful in pre-surgical planning. If surgery is pursued, gastrointestinal biopsies should also be obtained.



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- A malabsorption panel should also be considered as well as a fecal evaluation for ova and giardia.
- If a more conservative approach is desired, a fine needle aspirate of the hepatic mass can be considered (if clotting status is appropriate). A 25-gauge needle should be used. It should be noted however that primary hepatic masses are often difficult to diagnose cytologically.

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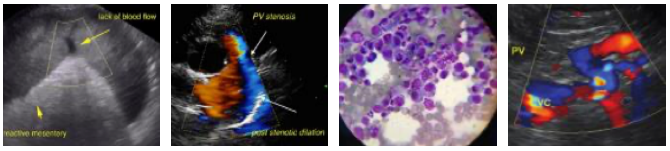

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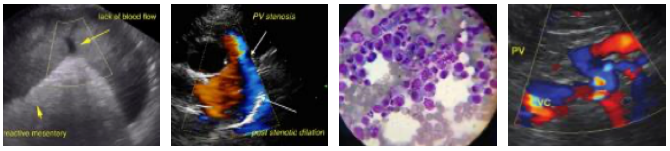

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**The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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*)

andrea_nicastro2@hotmail.com