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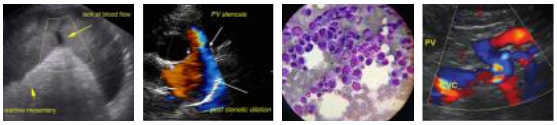

ANIMAL SOUNDS NW
MOBILE VETERINARY ULTRASOUND
IMAGING PERFORMED BY
AnimalSoundsNW.com 541-357-9423

PATIENT

Sheba Ford

SPECIES

Canine

BREED

Siberian Husky

SEX

Female Spayed

AGE

12 years

WEIGHT

52 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Jenna Walsh, CVT

HOSPITAL NAME

Faithful Friends AC

REFERRING VET

Der Stender

INVOICE

14144

DATE

8.16.23

PRESENTING CLINICAL SIGNS

History: varying degrees of hyporexia for 2wk since saw for PU/PD, mild lethargy, frequent urination/UTI and given cephalexin. Stopped cephalexin after 5d. had soft stool, now normal, no vomit Current Medications maropitant and Entyce Primary Question/Differential to Be Answered in This Exam cause of hyporexia, lethargy and PU/PD

Abnormal PE/Chem/CBC/UA Results: 8/1 alp 386, very mild nonregenerative anemia

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness. The mucosal surface in the region of the apex is slightly irregular. The bladder is moderately distended. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal in size (6.85 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. The cortex is isoechoic relative to the spleen. There is mild to moderate loss of corticomedullary distinction. A 0.94 cm cortical cyst is observed at the cranial pole. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal in size (7.48 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. The cortex is isoechoic relative to the spleen. There is mild to moderate 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 in size (0.45 cm at cranial pole) (0.42 cm at caudal pole) (2.47 cm in length) with a normal shape and smooth peripheral contours. A 0.77 x 0.54 cm hyperechoic nodule/area is observed at the cranial pole. In the remainder of the gland, glandular echogenicity and detail are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is prominent at the cranial pole (1.73 cm) and normal in size at the caudal pole (0.43 cm), (3.01 cm in length). A 1.70 x 1.44 cm hyperechoic nodule/area is observed at the cranial aspect. Glandular echogenicity and detail are normal at the caudal aspect. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (1.11 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 prominent in size with irregular peripheral contours. A >7.00 cm hyperechoic-to-heterogenous mass, with ill-defined cavitations is observed deep on the left side. The lesion causes capsular expansion. In the remainder of the liver, the parenchyma is hypoechoic relative to the spleen and homogenous in appearance. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

The gall bladder is displaced caudally due to the large hepatic mass. The wall normal in thickness.

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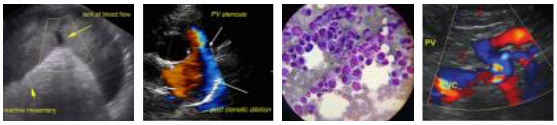

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Several, small polypoid-like lesions are arising from the luminal surface. A moderate amount of aggregated, echogenic to mineralized gravity-dependent debris/sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is 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 is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas

The right 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

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Large deep left hepatic mass. Neoplasia (i.e., adenoma, adenocarcinoma, round cell tumor) is suspected. However, a large focal inflammatory process cannot be completely excluded.
- Trace ascites

Secondary Findings

- Bilateral chronic age-related renal changes.
- Bilateral adrenal nodules. These lesions may represent focal areas of hyperplasia, adenoma, adenocarcinoma, pheochromocytomas, other. A benign process is favored at this time.
- Minor age-related pancreatic remodeling in the right limb.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
- Consider a fine-needle aspirate of the hepatic masses (if accessible and if clotting status is appropriate). A 25-gauge needle should be used. If the cytology results are inconclusive, consider a consultation with a board-certified surgeon to discuss mass removal or debulking. An abdominal CT scan would be useful in presurgical planning.

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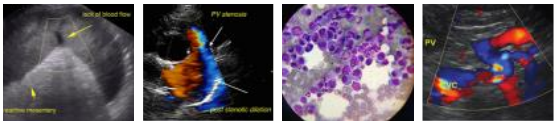

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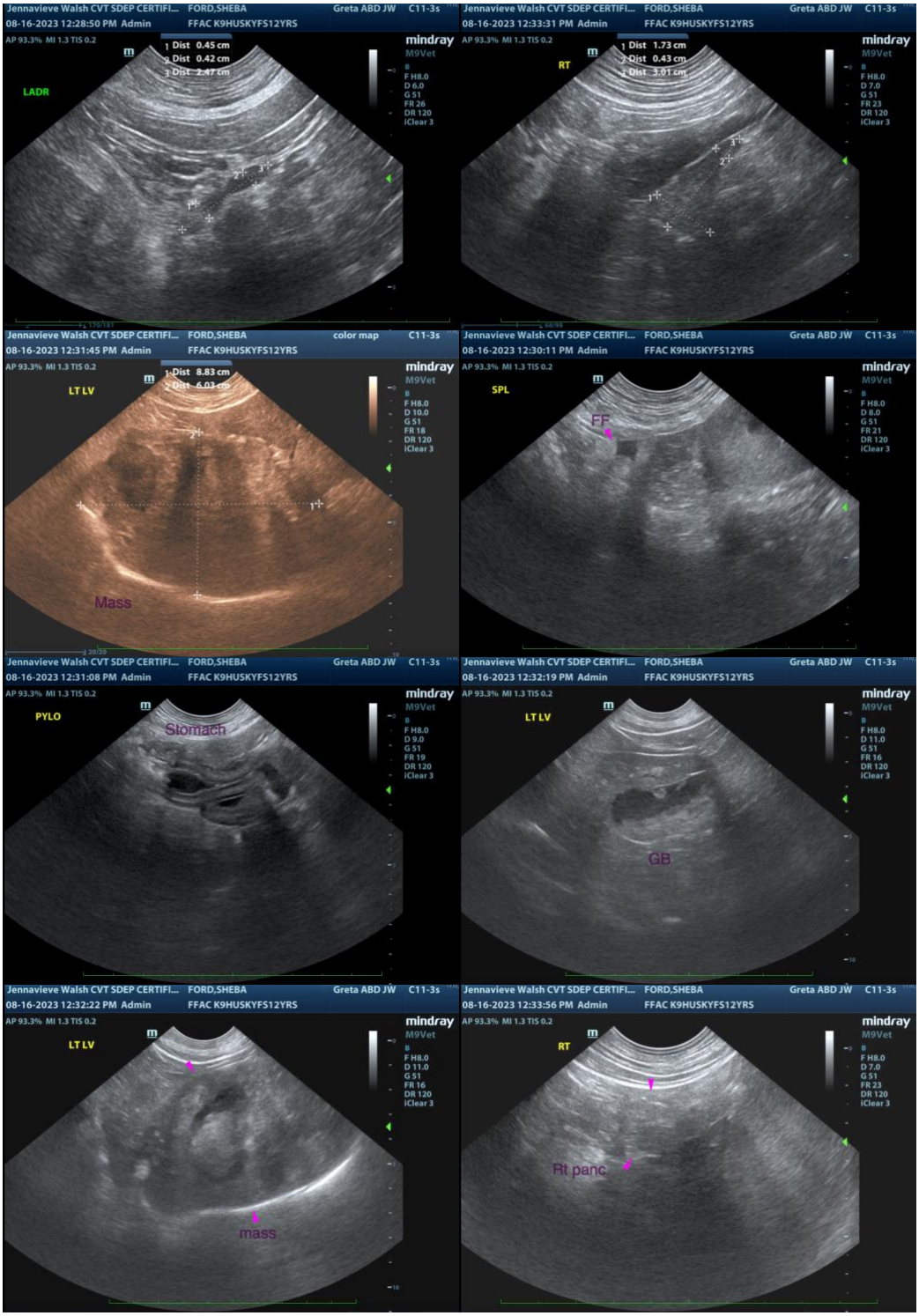
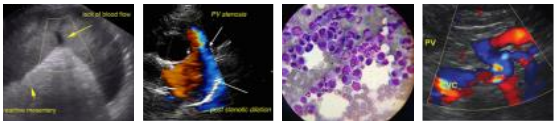


The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not



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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)
info@SonoPath.com