SonoPath
Clinical Sonography & Telecytology
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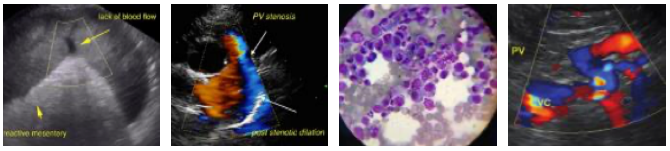

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Annie Englehardt

SPECIES
Canine

BREED
Mixed breed

SEX
Female, spayed

AGE
10 Yrs.

WEIGHT
65.2 lbs.

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

IMAGING PERFORMED BY
Diane McFadden, RVT

HOSPITAL NAME
Ringwood AH

REFERRING VET
Dr. Wilkes

INVOICE
11911

DATE
8/19/21

PRESENTING CLINICAL SIGNS

History: weight loss, hypoglycemia on BW, history of PLN. On benazepril and Benadryl.
Abnormal PE/Chem/CBC/UA Results: glu 49, TP 8.3, alb 2.6, glob 5.7, AL T 13, chol 354, CK 252; UA: protein 3+, blood 1+, rbcs 10-15, epithelial cells 2+, UPC 2.1, USPG 1.030

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 left kidney is normal size (7.29 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is mildly thickened and there is moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (8.03 cm in length) with a normal shape and smooth peripheral contours. The cortex is variably thickened and there is moderate loss of corticomedullary distinction. Hyperechoic shadowing diverticular foci are visualized. Trace pyelectasia is present. There is no evidence of infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.54 cm at cranial pole) (0.91 cm at caudal pole) (3.27 cm in length) with a prominent caudal pole. The glandular echogenicity and detail at the cranial aspect are unremarkable. There is mild heterogeneity in the parenchyma of the caudal aspect with some loss of glandular detail. A pinpoint hyperechoic to mineralized focus is observed in the mid to caudal aspect. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (1.35 cm at cranial pole) (0.74 cm at caudal pole) (3.24 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. A pinpoint hyperechoic focus is observed in the caudal aspect. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

A > 6 cm heterogeneous slightly cavitated mass is arising from the splenic parenchyma. The mass causes capsular expansion. Surrounding mesentery is hyperechoic. The remainder of the spleen has normal curvilinear peripheral contours and slightly mottled parenchyma. Splenic vasculature is normal with no evidence of thrombosis.

Liver

The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen with minor changes consistent with age-related remodeling. No focal lesions are observed. Hepatic vasculature and biliary tracts are of normal volume with no evidence of congestion. The portal vein: caudal vena cava ratio is approximately 1:1. The gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are mostly anechoic. The cystic and common bile ducts are normal/not seen.

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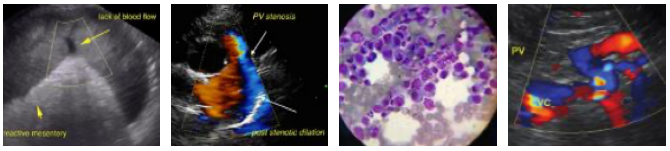

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Gastrointestinal

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 right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely hyperechoic 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

There is no evidence of free fluid. 1-2 prominent medial iliac lymph nodes are visualized, the largest measuring 1.84 cm in length. In addition, a prominent (1.90 cm) mesenteric lymph node is observed.

Other

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

ULTRASONOGRAPHIC FINDINGS

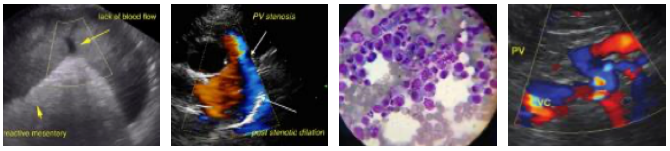
Primary Findings:

- Splenic mass. Neoplasia (i.e., round cell tumor, hemangiosarcoma, other) is considered likely with a lower possibility of benign pathology. Regional peritonitis is present.

Secondary Findings:

- The prominent abdominal lymph nodes are likely reactive with a low possibility of infiltrative neoplasia.
- Bilateral chronic nephropathy
- Mild left adrenomegaly. The pinpoint hyperechoic foci in both adrenal glands are likely benign incidental findings. However, adrenal mineralization can be associated with neoplasia.
- The hepatic parenchymal changes are most consistent with age-related benign pathology. However, micrometastatic disease cannot be completely excluded.
- 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



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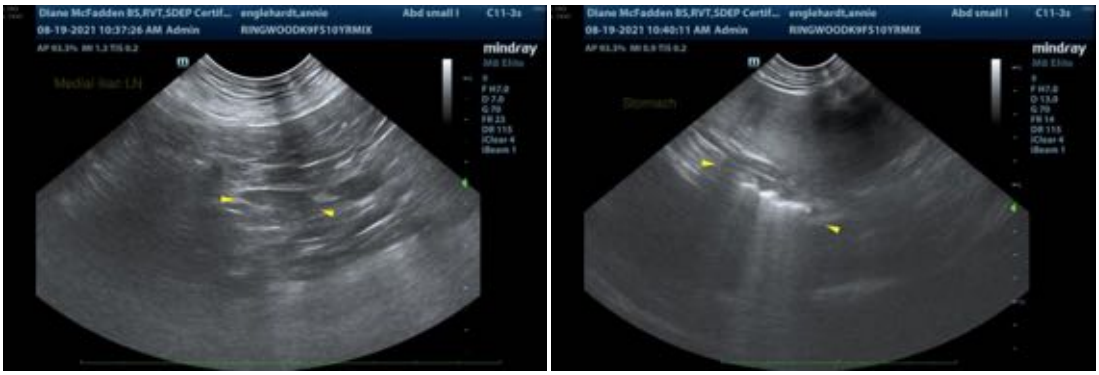
If there is no evidence of pulmonary metastatic disease, a splenectomy with submission of the spleen for histopathology is recommended. A liver biopsy should also be obtained at the time of surgery to assess for microscopic metastases.



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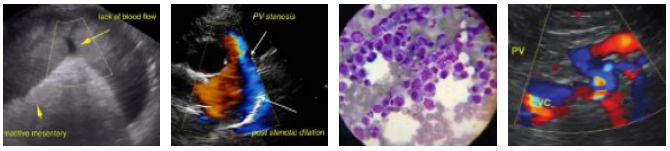

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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