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Clinical Sonography & Telecytology
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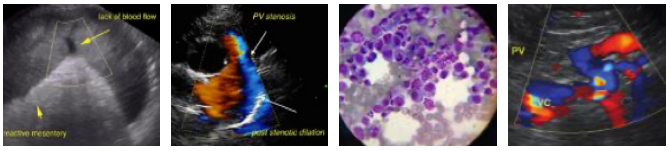


PATIENT
Chloe Coril

SPECIES
Canine

BREED
Maltese

SEX
Female, spayed

AGE
12 Yrs.

WEIGHT
10.6 lbs.

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

IMAGING PERFORMED BY
Dr. Sheldon

HOSPITAL NAME
Advanced PetCare of Oakland

REFERRING VET
Dr. Sheldono

INVOICE
13863

DATE
8/23/22

PRESENTING CLINICAL SIGNS

History: One month history of sporadic vomiting and diarrhea. On Pepcid, Cerenia and Proviable. Normal appetite and energy level. Has lost 3 lbs. BCS 4/9 Elevated ALT 158, ALP 1268, GGT 564, amylase 2068, lipase 5815, UA WNL.
Abnormal PE/Chem/CBC/UA Results: BCS 4/9 Elevated ALT 158, ALP 1268, GGT 564, amylase 2068, lipase 5815, UA WNL.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder and visible portion of the pelvic urethra are normal for the degree of luminal distension. The urine is anechoic with no evidence of debris. Cystic calculi and discrete masses are not observed. The region of the trigone is normal.

The left kidney is normal in size (4.06 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is mild loss of corticomedullary distinction. Pinpoint hyperechoic foci are observed within the cortex. 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 size (3.61 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is mild loss of corticomedullary distinction. Pinpoint hyperechoic foci are observed within the cortex. 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 (0.49 cm at cranial pole) (0.56 cm at caudal pole) (1.90 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.

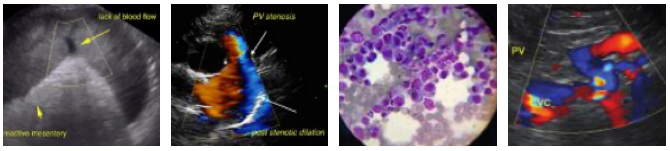
The right adrenal gland is normal size (0.65 cm at cranial pole) (0.50 cm at caudal pole); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (1.00 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 enlarged with irregular peripheral contours. A >5.5 cm irregular hyperechoic to slightly heterogeneous mass is arising from the left side. The mass causes capsular expansion and displacement of the gallbladder. In the remainder of the liver the parenchyma is isoechoic relative to the spleen and heterogeneous in appearance with ill-defined hyperechoic areas. Vascular and 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 small to 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.



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Gastrointestinal

The gastric lumen is moderately distended with ingesta and a 2.36 cm shadowing structure. The gastric wall is mildly thickened (up to 0.35 cm) with retention of the normal layering pattern and a prominent muscularis layer. The pyloric outflow tract is patent. The small intestinal lumen is segmentally fluid distended (mild). 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. No obstructive disease is noted.

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

The peritoneal cavity is normal. There is no evidence of inflammation or effusion. The abdominal lymph nodes are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- Large left hepatic mass. Neoplasia (i.e., adenoma, adenocarcinoma) is suspected. However, a benign process (i.e., excessive regenerative nodular hyperplasia) cannot be completely excluded. The diffuse hepatic parenchymal changes trend toward the benign (i.e., nodular hyperplasia and/or vacuolar hepatopathy) with a lower possibility of infiltrative neoplasia.
- Suspected gastric foreign material.

Secondary Findings:

- Gallbladder debris/sludge- incidental.
- Mild degenerative renal changes with subtle dystrophic mineralization.
- 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

- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
- If there is no evidence of pulmonary metastatic disease, consider hepatic mass removal with submission for histopathology. If surgery is pursued, referral to a board-certified surgeon is recommended due to the potential for perioperative complications. An abdominal CT scan would be useful in pre-surgical planning. If a gastric foreign body is present, it can also be removed at the time of the surgery if the patient is stable. Also consider obtaining gastrointestinal biopsies given the recent history of vomiting and diarrhea.

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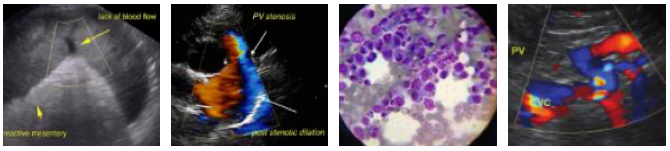

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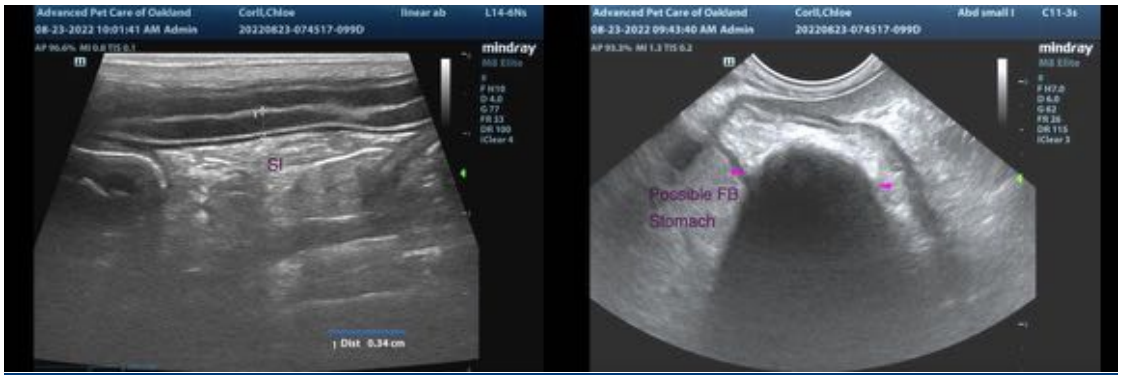

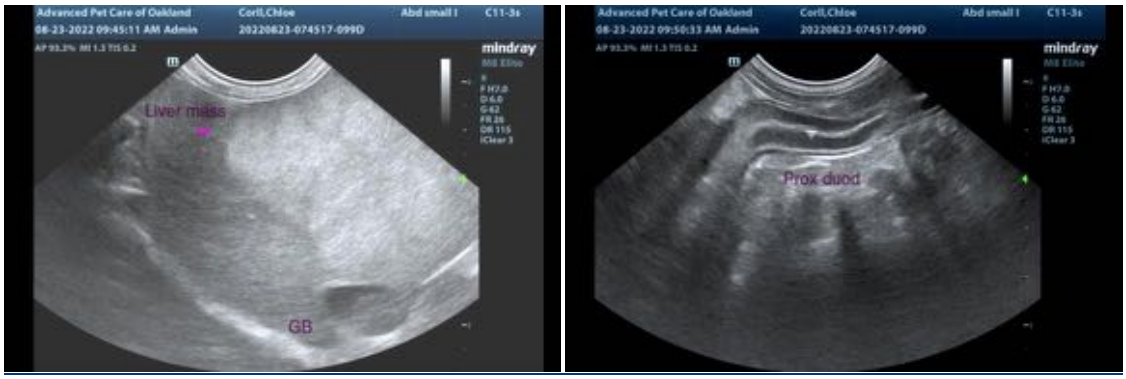

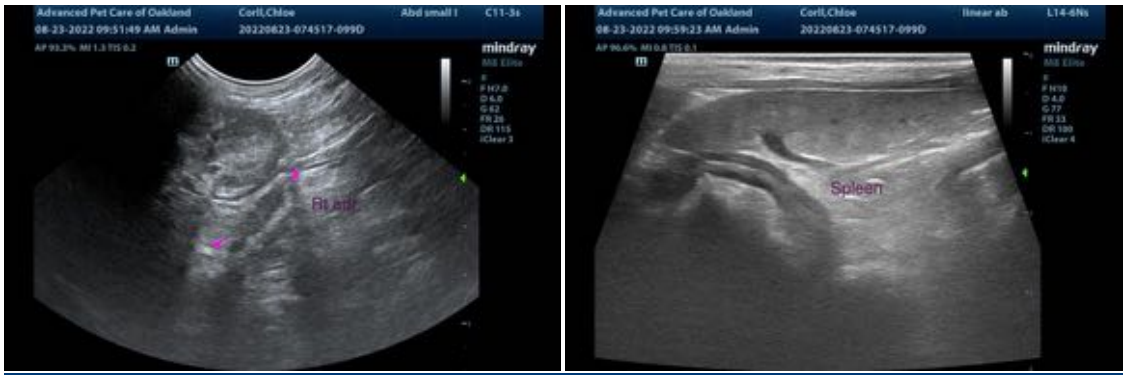

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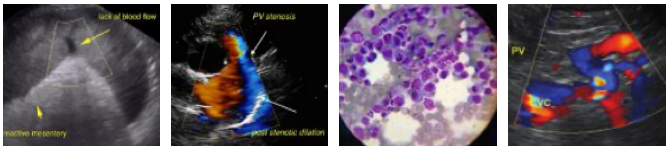

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com