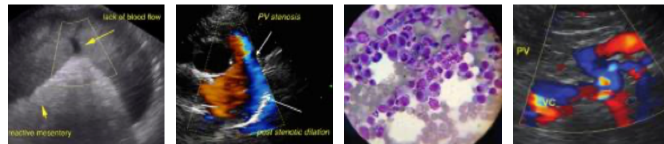

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1-800-838-4268 info@sonopath.com

PATIENT
Sunny Gowan

SPECIES
Canine

BREED
French Bulldog mix

SEX
Male, neutered

AGE
8 Yrs.

WEIGHT
9.4 kg.

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

IMAGING PERFORMED BY
Tom McNeill

HOSPITAL NAME
SVS Imaging CT

REFERRING VET
Tom McNeill

INVOICE
13870

DATE
8/23/22

PRESENTING CLINICAL SIGNS

History: Sunny presented on ER as a transfer from Stoughton Vet. Barb explained that Sunny has been slowing down over the past month and a half. Last week, Sunny's appetite was decreased and he generally seemed a bit more lethargic. He also started coughing and dry heaving. This progressed to him refusing all food that is offered to him, including his favorite human foods, on Friday. Sunny has lost weight and is super weak/unable to jump up on surfaces he typically could jump up on before. Barb explained that Sunny has also been breathing hard over the past couple months. Sunny hasn't had anything but some peanut butter since Friday. Barb used peanut butter to give him his Trazodone, which he did not take readily. Sunny has otherwise been healthy.
Abnormal PE/Chem/CBC/UA Results: Bicavitary effusion found on FAST scan. Abdominocentesis and thoracocentesis performed prior to ultrasound. Thoracocentesis Performed @ 2:00pm Blood Tinged Fluid 275ml removed Abdominocentesis Performed @ 2:15pm Blood Tinged Fluid and Congealed Blood ~375ml removed

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is 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 (0.93 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 (5.13 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 size (4.75 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.

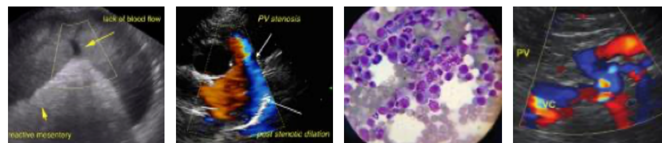
Adrenal Glands

The left adrenal gland is normal size (0.52 cm at cranial pole) (0.51 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 normal size (0.72 cm at cranial pole) (0.42 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 subjectively enlarged with irregular peripheral contours. Numerous coalescing heterogeneous nodules/masses are observed throughout the organ, the largest measuring >4 cm. Many of the lesions cause capsular expansion. Splenic vasculature appears normal with no evidence of thrombosis. Surrounding mesentery is hyperechoic.



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Liver

The liver is normal to slightly prominent in size with mild rounding of the peripheral contours. The parenchyma is isoechoic relative to the spleen and homogeneous in appearance. No distinct focal lesions are observed. Intrahepatic biliary tracts are of normal. Hepatic vasculature appears dilated. The gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. 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 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 base and right limb of the pancreas are 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

A small amount of free fluid is present. The medial iliac lymph nodes are visualized/prominent with the left measuring 1.64 x 0.42 cm and the right measuring 1.90 x 0.80 cm. In addition, a 3.30 x 1.15 cm hepatic lymph node is seen.

Other

The caudal vena cava is subjectively dilated (1.40 cm in diameter).

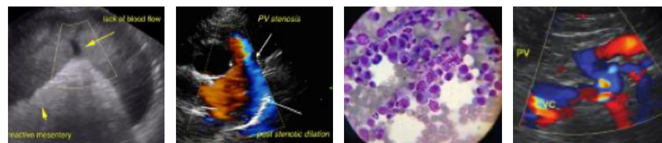
ULTRASONOGRAPHIC EXAMINATION FO THE THORACIC CAVITY

A 6.63 X 5.66 cm heterogeneous heart-based mass is visualized. In addition, a 2.24 x 1.90 cm cranial mediastinal lymph node is seen. A small amount of pleural effusion is present. There is minimal to no pericardial effusion seen.

ULTRASONOGRAPHIC FINDINGS (ABDOMEN)

Primary Findings:

- Splenic masses/nodules. Neoplasia (i.e., sarcoma, round cell tumor, neuroendocrine) is suspected with a low possibility of a benign process.
- The dilated hepatic vessels and caudal vena cava are likely secondary to increased hydrostatic pressure as a result of the heart-based mass.
- The ascites may be secondary to splenic pathology and/or a result of increased hydrostatic pressure resulting from the heart-based mass.



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- The hepatic and medial lymphadenopathy could be consistent with reactive lymphadenitis, lymphoid hyperplasia or infiltrative neoplasia (i.e., metastatic disease).

Secondary Findings:

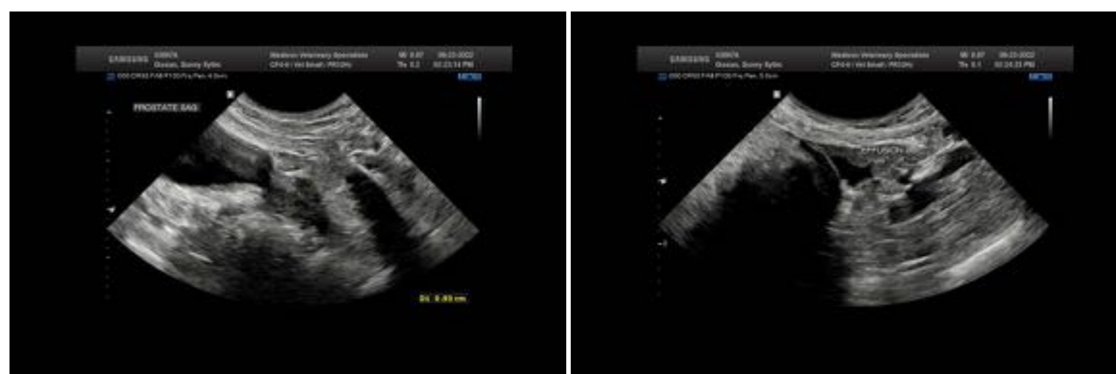
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Suspected benign diffuse hepatopathy (i.e., vacuolar hepatopathy and/or regenerative nodular hyperplasia). However, micrometastatic disease cannot be completely excluded.

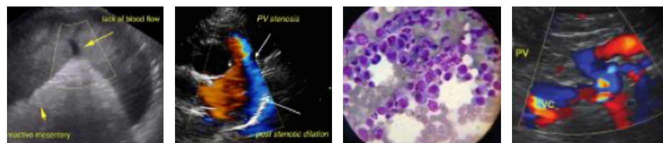
ULTRASONOGRAPHIC FINDINGS (THORAX)

- Heart-based mass. Top differentials include aortic body tumor, hemangiosarcoma, lymphoma, ectopic thyroid tumor, other.
- The cranial mediastinal lymphadenopathy may be secondary to metastatic disease or reactive change.
- Pleural effusion is likely secondary to the heart-based mass.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Submission of the previously obtained pleural and abdominal fluid for analysis and cytology can be considered. Fine needle aspiration of the splenic masses is also a consideration (if clotting status is appropriate). However, given the high likelihood of bi-cavity neoplasia, the prognosis for this patient is considered guarded and palliative/symptomatic care is recommended.





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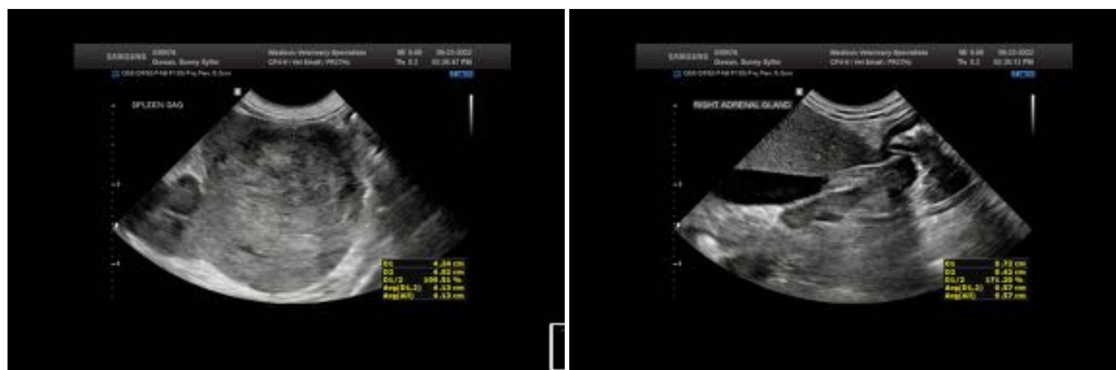

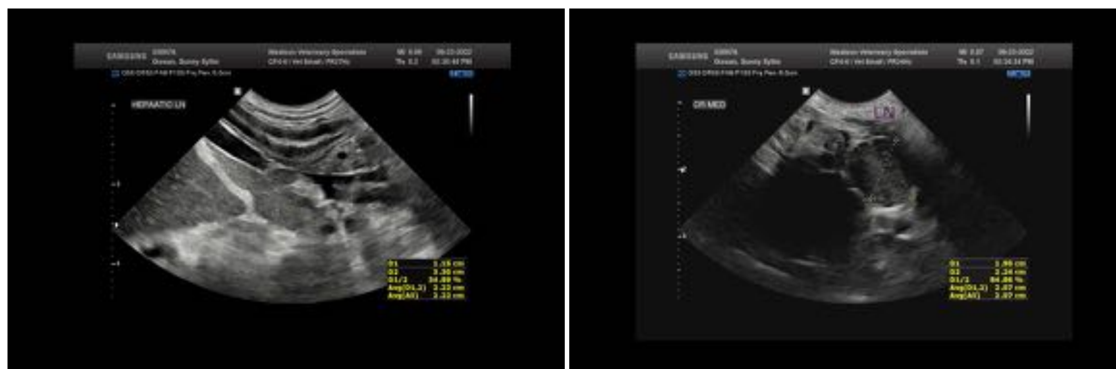

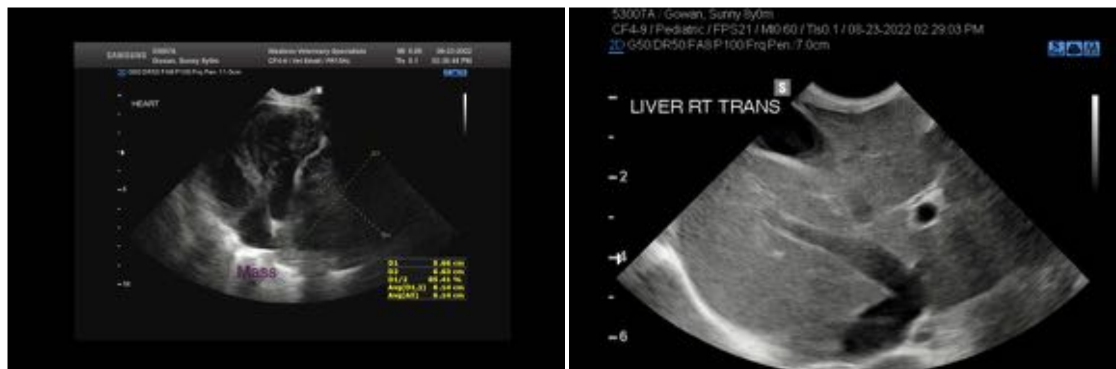

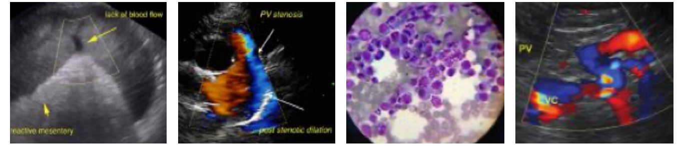

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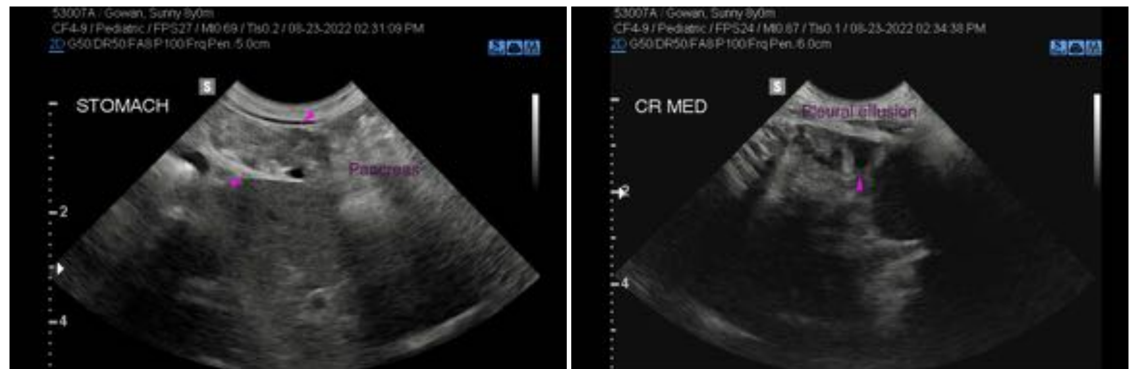

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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