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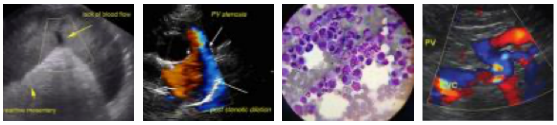


ANIMAL SOUNDS NW
MOBILE VETERINARY ULTRASOUND
IMAGING PERFORMED BY
AnimalSoundsNW.com 541-357-9423

PATIENT

Dash Culp

SPECIES

Canine

BREED

Havanese

SEX

Neutered Male

AGE

11 years

WEIGHT

15 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Sara Hansen

HOSPITAL NAME

So. Willamette VC

REFERRING VET

Dr Shelton

DATE

8.31.22

INVOICE

11544

PRESENTING CLINICAL SIGNS

History: ADR at home, intermittent vomiting, weight loss despite a good appetite

Abnormal PE/Chem/CBC/UA Results: WBC mildly elevated, neutrophils mildly elevated -SDMA markedly elevated -Calcium oxalate stones, bilirubin in urine Albumin and TP low normal, BUN high normal Current Medications Maropitant Radiographic Findings Soft tissue opacity on tail of the spleen on right lateral abdominal view

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** is mildly distended with anechoic urine. The wall in the region of the apex is mildly thickened (up to 0.36 cm) with a relatively smooth mucosal surface. The wall tapers to a normal thickness as it extends toward the cystourethral junction. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2-3 cm, are normal.

The **prostate** is normal in size (0.79 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 (4.27 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The **right kidney** is normal in size (3.92 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of 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 (0.79 cm at cranial pole) (0.52 cm at caudal pole) (1.61 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.

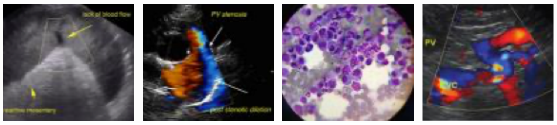
The **right adrenal gland** is normal size (1.16 cm at cranial pole) (0.47 cm at caudal pole) (1.87 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

A 2.28 x 1.71 cm hypoechoic, vascular mass is observed approximately **mid-spleen.** The mass causes capsular expansion. In the remainder of the spleen, the margins are curvilinear. The parenchyma is homogenous. Splenic vasculature appears normal with no evidence of thrombosis.

Other

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



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Liver

The **liver** is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative, or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed.

The **gall bladder** is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No cholelithsare observed. 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. There is no evidence of an obstructive pattern.

Pancreas

The region of the **pancreas** is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional inflammation or effusion.

Free Abdomen

There is no evidence of free fluid. The abdominal **lymph nodes** are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Splenic mass. Neoplasia (i.e., hemangiosarcoma, hemangioma, round cell tumor) is considered likely with a lower possibility of a benign process. It is unclear whether the splenic mass is causing the patient's current clinical signs or if a concurrent underlying issue (gastrointestinal, other) may be present.

Secondary Findings

- Mild degenerative renal changes.
- The urinary bladder wall thickening in the region of the apex may be secondary to cystitis or lack of luminal distention. Correlation with the patient's urinalysis and clinical history is recommended.

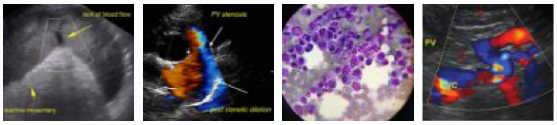
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Three-view thoracic radiographs are recommended to assess for pulmonary metastases.

A fine-needle aspirate of the splenic mass is an option. However, given its vascular nature, there is a risk of iatrogenic hemorrhage with the procedure. Therefore, a splenectomy with submission of the spleen for histopathology should be considered in lieu of aspiration.

Given the history of vomiting, other diagnostic considerations could include the following:

1. Malabsorption panel including serum cobalamin and folate, TLI and PLI



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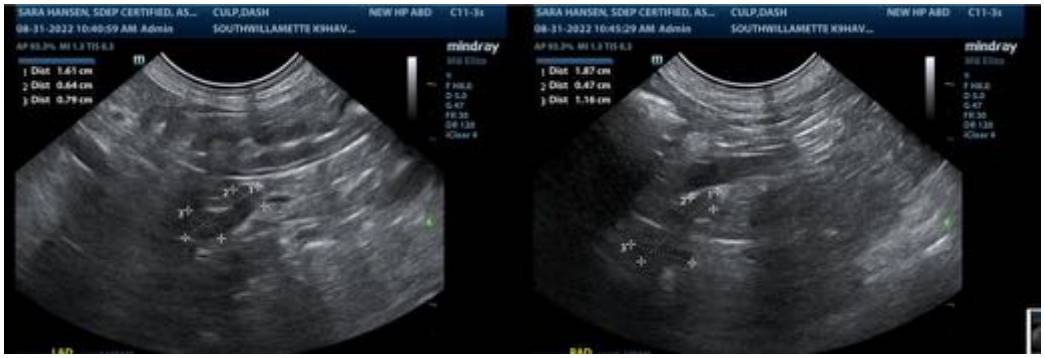
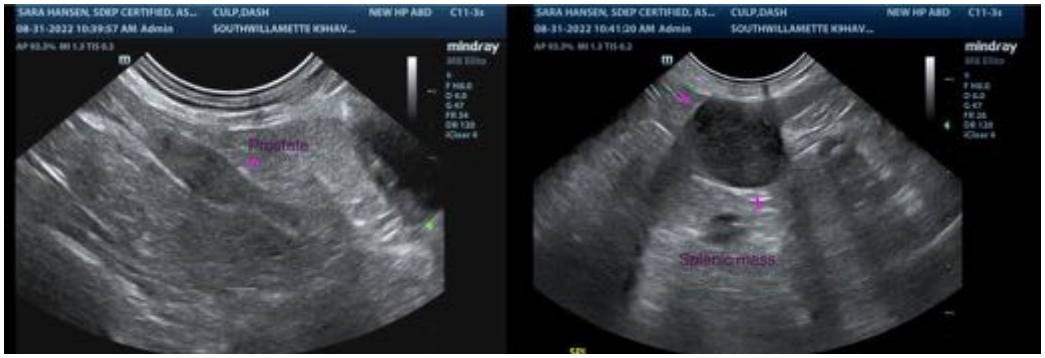
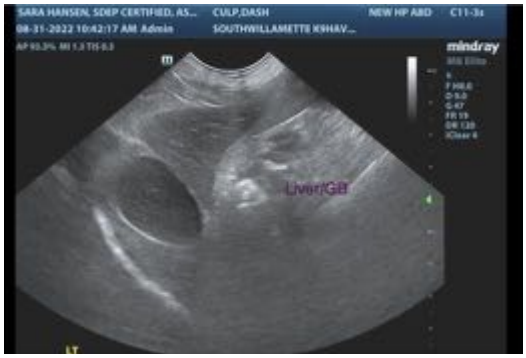
2. A fecal evaluation for ova and Giardia
3. Resting cortisol level to screen for hypoadrenocorticism
4. +/- GI biopsies (Biopsies could be obtained at the time of splenectomy).



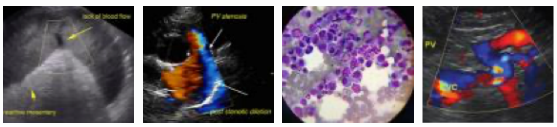




The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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



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