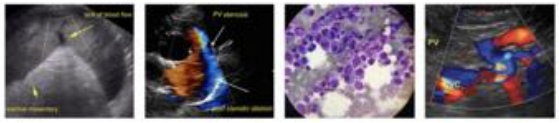

PATIENT

Albert Ball

SPECIES

Canine

BREED

Poodle Mix

SEX

Neutered Male

AGE

5.8.2013

WEIGHT

10 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

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HOSPITAL NAME

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INVOICE

11332

DATE

8.4.2022

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: ASACA that was removed by Dr. Hill on 1/8/2021. metastatic to regional LN. Completed Mito protocol 6/9/2021.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** is moderately distended. The wall is normal in thickness. In the region of the apex, the mucosal surface is irregular. A few, small cystic calculi are visualized within the lumen, the largest measuring 0.65 cm in diameter. The remaining luminal contents are mostly anechoic. The region of the trigone and the visible portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The **prostate** is normal in size with a normal shape and smooth peripheral contours. Parenchyma is mildly heterogenous. No distinct focal lesions are observed. The prostatic urethra is not overtly dilated.

The **left kidney** is normal size (5.41 cm in length); with a relatively normal shape. The cortex is diffusely thickened and hyperechoic to slightly heterogenous in appearance, with numerous small, cortical cysts. Pinpoint hyperechoic foc are observed throughout the cortex. Moderate pyelectasia is present (0.53 cm in the transverse plane). There is no evidence of infarcts or hydroureter. Renal vasculature is normal.

The **right kidney** is normal size (6.31 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is mildly thickened and there is mild to moderate loss of corticomedullary distinction. The cortex is hyperechoic. Hyperechoic shadowing diverticular foci are visualized. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The **left adrenal gland** is mildly enlarged (0.62 cm at cranial pole) (0.72 cm at caudal pole) (2.18 cm in length); normal shape and smooth peripheral contours. 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 mildly enlarged (1.26 cm at cranial pole) (0.86 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.

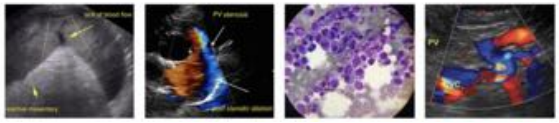
Spleen

The **spleen** is normal in size (1.30 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A 0.52 cm hyperechoic nodule is observed at the medial aspect. Splenic vasculature is normal.

Liver

The **liver** is subjectively enlarged with slightly swollen peripheral contours. The parenchyma is isoechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1: 1.

The **gall bladder** lumen is moderately distended. The wall is thin and smooth. A small to moderate amount of gravity dependent, echogenic debris 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 irregular. A 1.12 cm irregular shadowing structure is also observed within the lumen. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract appears patent. The small intestinal lumen is segmentally dilated with chyme. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. The colonic lumen contains shadowing fecal material. There is no evidence of an obstructive pattern.

Pancreas

The base limbs of the **pancreas** are visible with normal curvilinear peripheral contours. The parenchyma is slightly hypoechoic 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 right medial iliac **lymph node** is visible and is normal in size (0.81 cm in length) with a normal shape and echogenicity.

ULTRASONOGRAPHIC FINDINGS

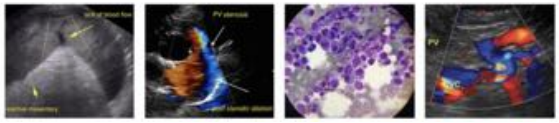
Primary Findings

- There is no obvious evidence of metastatic disease in the abdomen. The medial iliac lymph nodes appear normal.

Secondary Findings

- Cystic calculi (one cystic calculus was observed on the last ultrasound).
- The bilateral renal changes are consistent with chronic interstitial nephrosis/nephritis with dystrophic mineralization, left cortical cysts and pyelectasia.
- The bilateral adrenomegaly may be secondary to hyperplastic change or may be a normal variant for this patient.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The hyperechoic splenic nodule is likely benign (i.e., myelolipoma or similar) with a lower possibility of emerging neoplasia.
- Gall bladder debris – incidental.
- Suspected benign diffuse hepatopathy. Top differentials include vacuolar hepatopathy, regenerative nodular hyperplasia and/or age-related remodeling.
- Gastric foreign body, likely a rock, based on the abdominal radiographs. It appears non-obstructive at this time.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS



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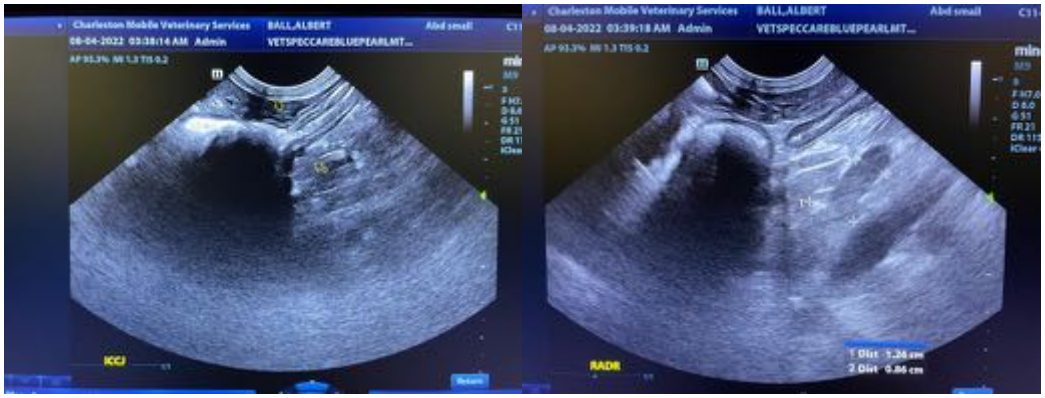
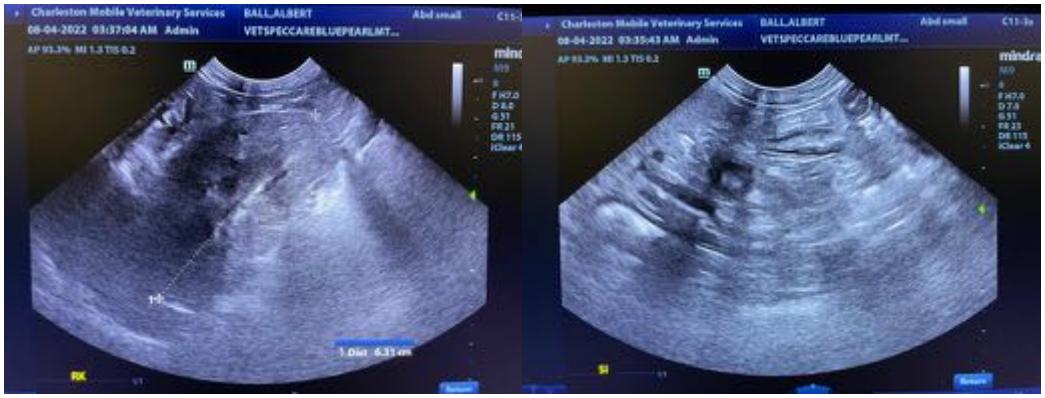
Baseline lab work, including a CBC, chemistry panel, T4 and urinalysis +/- urine culture and sensitivity, is recommended.

A cystotomy with stone removal, analysis and culture is recommended. Alternatively, medical dissolution of the stones can be considered with a prescription renal diet and broad-spectrum antibiotic therapy. If there is no improvement in stone size after 4 weeks of therapy, a cystotomy should be reconsidered. If the stone size is reduced, continue therapy until complete dissolution has been achieved.

Consider testing for hyperadrenocorticism with a low-dose dexamethasone suppression test or ACTH stimulation test if clinical signs (i.e., PU/PD) develop.

Further diagnostics and treatments are to be implemented by the overseeing oncologist.





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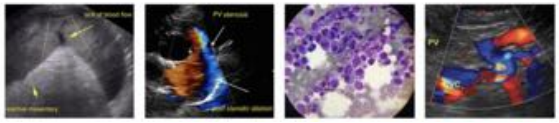

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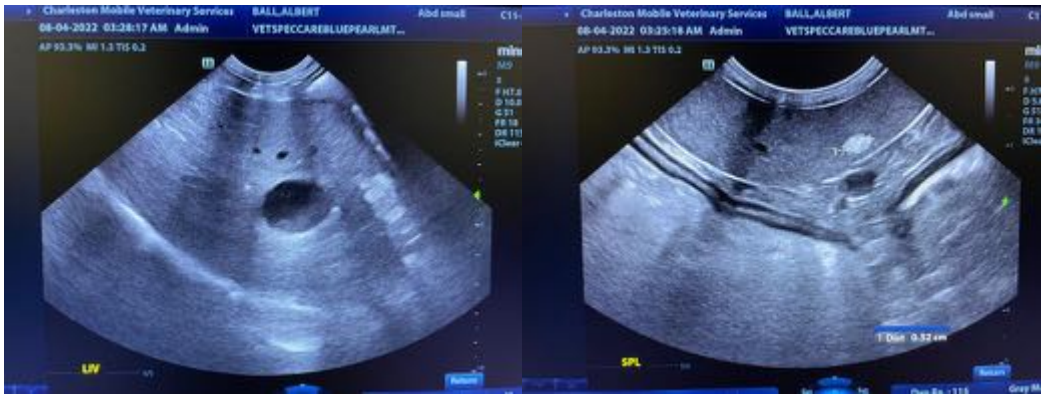

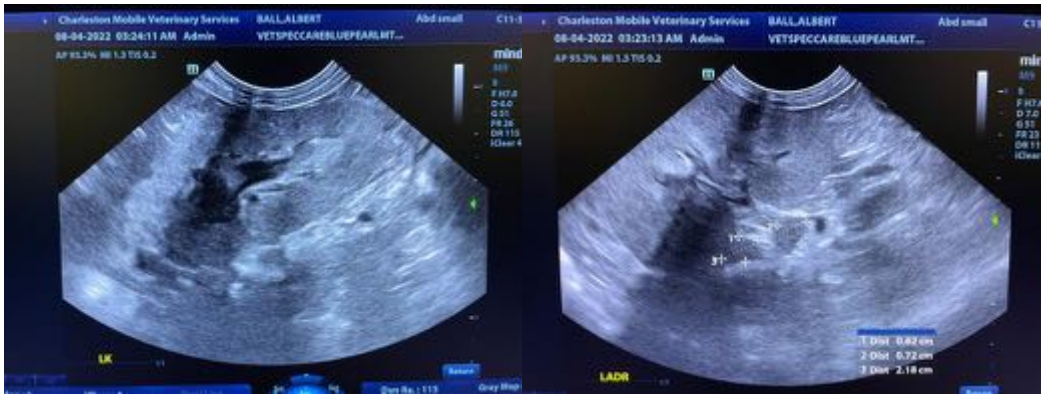

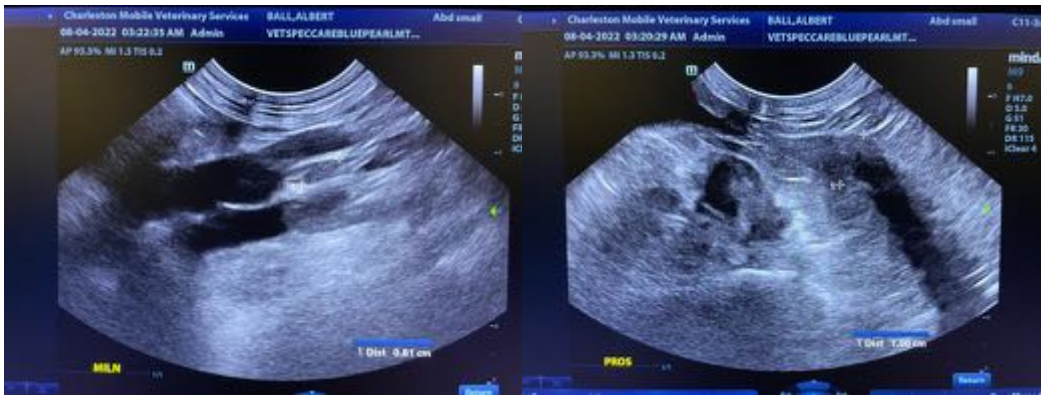

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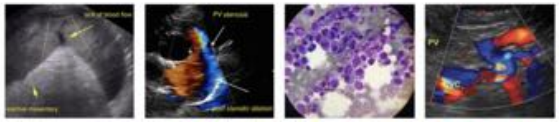

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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