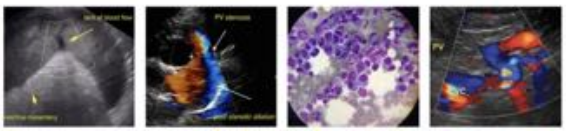

PATIENT

Dallas Skelton

SPECIES

Canine

BREED

Bloodhound

SEX

Neutered Male

AGE

9/29/2011

WEIGHT

88.2 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

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INVOICE

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DATE

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PRESENTING CLINICAL SIGNS

Clinical Exam Findings/history: Spring of 2023 one liver mass removed and benign, the other not removed but also benign. Has been doing well up until last week. Acute onset hyporexia and evidence of pneumonia on thoracic radiographs. Since treatment, has started drooling excessively. Still not eating well. Primary versus Extra GI Voice/bark change - laryngeal paralysis, neoplasia, foreign body, laryngitis/infectious, other/ Decreased appetite- secondary to delayed gastric emptying and ileus

Abnormal lab-work values: history of elevated ALT and ALKP
Current Medications: Simparica Trio Q 30, days Welactin, Movoflex, Enrofloxacin 204mg SID, Cerenia 80mg SID, Amox/Clav 562.5mg BID, Omeprazole 40mg BID, Metoclopramide 15mg BID, Ondansetron 24mg BID]

Thoracic radiographs from today reveal stable pneumonia.

Radiographic Findings - chest & abdomen 8/2/23:
1. Infiltrates within the right middle lung lobe are most consistent with bronchopneumonia, however metastatic disease is not completely ruled out. Aggressive antibiotic therapy followed by repeat radiographs in 7-10 days to evaluate response should be considered.
2. Right-sided hepatic mass, consistent with reported history of infiltrative hepatic disease.
3. The gastric contents may represent residual food, foreign material, or a combination of both. I do not see evidence of a small intestinal mechanical obstruction. Repeat radiographs after 8-12 hours of fasting, along with fluid therapy and supportive medical management could be considered to evaluate gastric emptying. If clinical signs persist or worsen, abdominal ultrasound would be suggested.

Addendum: When the provided study is compared to the previous study from February 15, 2023, the pulmonary infiltrates were not evident. The previous suspicion for sternal lymph node enlargement is no longer seen. In light of this, recommendations are unchanged

Abdomen 8/5/23: Unchanged hepatomegaly.

The soft tissue within the stomach may be consistent with the reported ingested food. Some decreased or delayed gastric emptying cannot be ruled out. There is no evidence of radiopaque foreign material or an obstructive pattern within the small intestine. The mild decreased serosal detail could be associated with with a scant volume of peritoneal effusion, peritoneal inflammation or pancreatitis. Additional testing for pancreatitis could be considered. Fasting radiographs could be considered if there is concern for ingested foreign material or to possibly evaluate gastric emptying times. A fasting abdominal ultrasound may be considered if available.

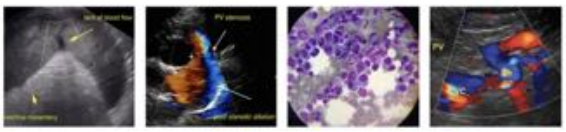
ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. Luminal contents are mostly anechoic. No cystic calculi are observed. The region of the trigone and visible portion of the proximal urethra are normal.

The prostate is normal in size (0.85 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 (7.49 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is mildly thickened and there is mild loss of corticomedullary distinction. A hyperechoic medullary band is observed at the corticomedullary junction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.



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The right kidney is normal in size (7.62 cm in length) normal shape and architecture with smooth peripheral margins. The cortex is mildly thickened and there is mild loss of corticomedullary distinction. A hyperechoic medullary band is observed at the corticomedullary junction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.54 cm at cranial pole) (0.55 cm at caudal pole) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature appear normal.

The right adrenal gland is in normal size (1.41 cm at cranial pole) (0.69 cm at caudal pole) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature appear normal.

Spleen

The spleen is normal in size (1.56 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 appears normal.

Liver

The liver is enlarged with swollen/irregular peripheral contours. A >14.00 cm slightly heterogenous mass is observed on the right side. The mass causes cranial displacement of the gallbladder. In the remainder of the liver, the parenchyma is hypoechoic relative to the spleen and slightly mottled in appearance. Hepatic vasculature and intrahepatic 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 amount of mostly gravity-dependent echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is moderately distended with ingesta despite fasting. The gastric wall in the region of the fundus is normal in thickness with a normal layering pattern. In the region of the pyloric outflow tract, the wall is concentrically thickened (up to 0.75 cm) with retention of the normal layering pattern. The pyloric outflow tract appears patent. The small intestinal lumen is segmentally dilated with chyme. The small intestinal wall is normal in thickness 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 granular-appearing fecal material.

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.

Other

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

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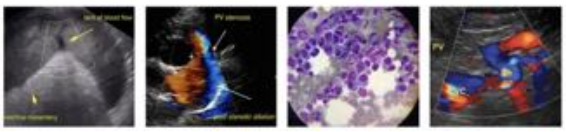

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ULTRASONOGRAPHIC FINDINGS

Primary Findings

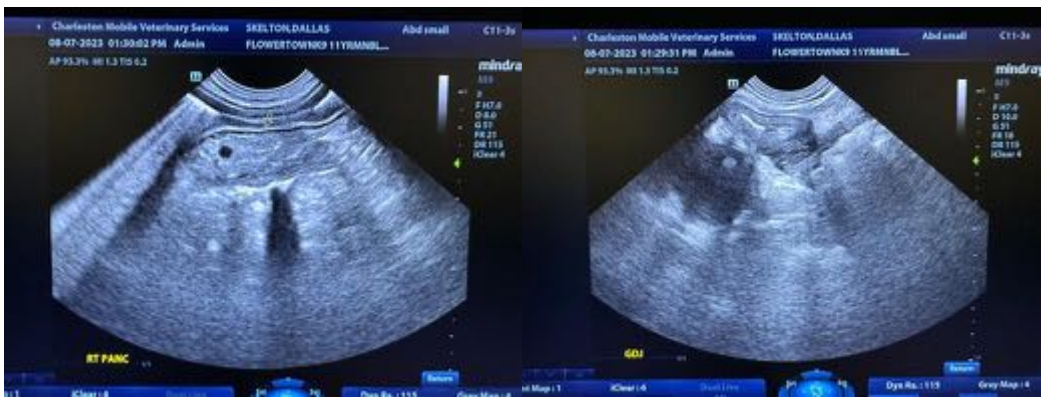
- Large right hepatic mass. The mass has increased in size by approximately 6.00 cm since the previous sonogram.
- The presence of ingesta within the gastric lumen despite fasting suggests delayed gastric emptying. Possibilities include mild compression of the gastric outflow tract by the hepatic mass, pyloric outflow tract, ileus of other some other ideology.
- The thickening of the pyloric wall may be secondary to inflammatory, hypertropthy or less likely, emerging neoplasia.

Secondary Findings

- Bilateral chronic age-related renal changes. Changes are similar to the previous sonogram.
- 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

- Consider empirical treatment for reflux esophagitis (i.e., sucralfate, small, frequent bland meals).
- Also consider increasing metoclopramide to every 8 hours. Give 30 minutes prior to meals.
- An upper GI endoscopy can be considered to further evaluate for esophagitis and pyloric outflow tract obstruction and to obtain biopsies. However, the patient would be at increased risk for aspiration pneumonia under anesthesia.
- Consider a repeat consultation with a board-certified surgeon to determine if debulking of the hepatic mass is an option. A repeat abdominal CT scan may be warranted.



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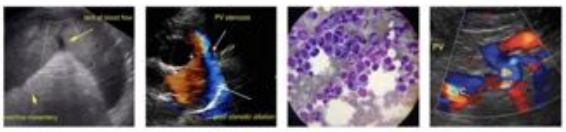

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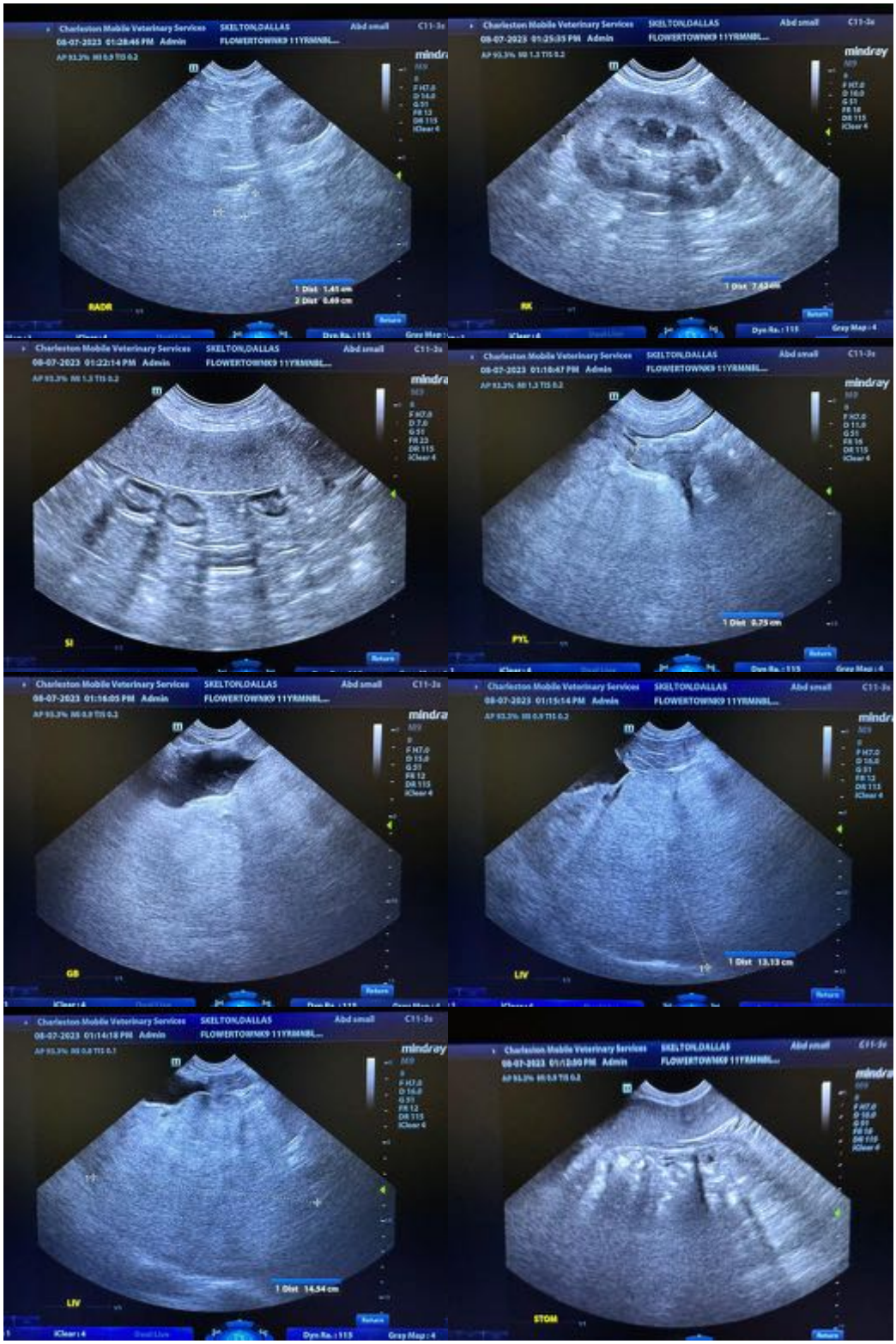

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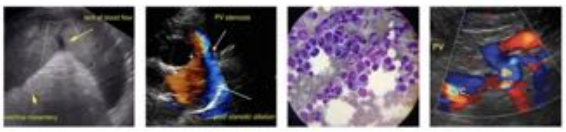

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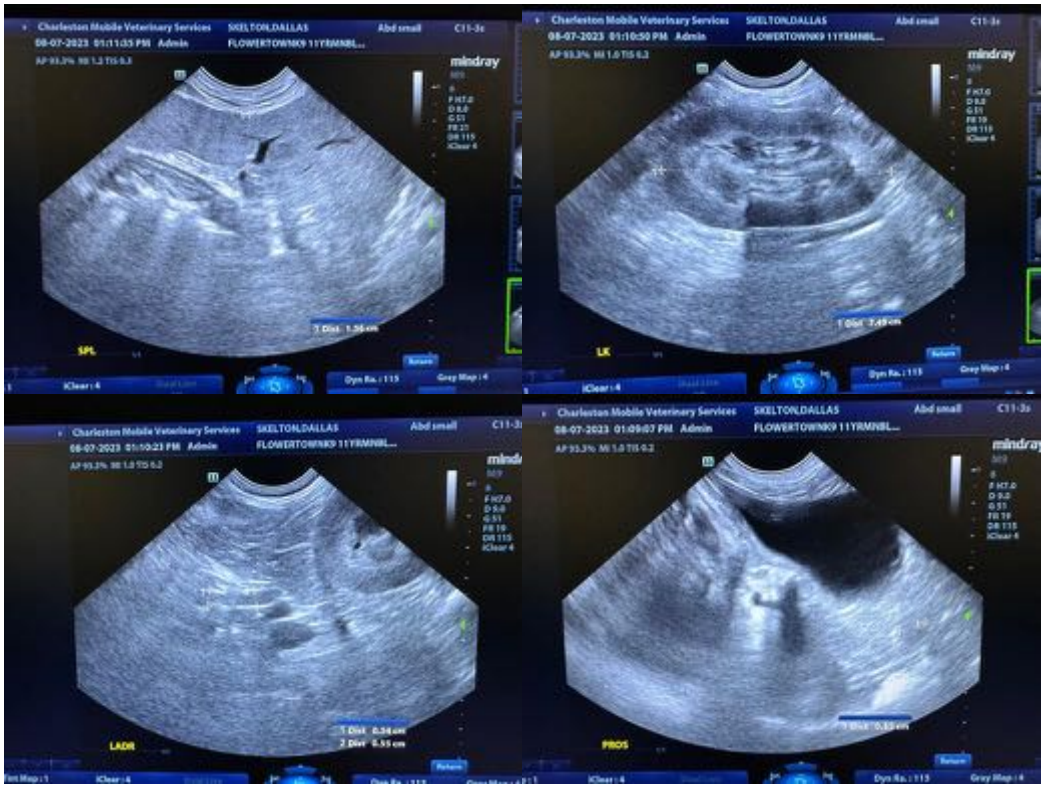

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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