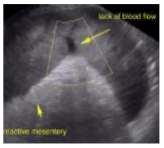
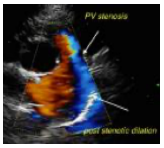
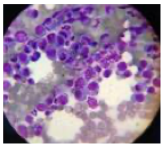
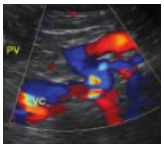
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

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PATIENT
Lucy Harter

SPECIES
Canine

BREED
Mixed

SEX
Spayed Female

AGE
13 years

WEIGHT
17 lbs

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

IMAGING PERFORMED BY
Dr Saum Hadi

HOSPITAL NAME
Bethany Family PC

REFERRING VET
Dr Saum Hadi

INVOICE
11632

DATE
9.12.22

PRESENTING CLINICAL SIGNS

History: P presented for acute hyporexia, panting, and lethargy yesterday. On exam, P was tense and exhibited a moderate pain response on palpation of the cranial abdomen. P was bradycardic with a HR of 50. CBC/Chem 17 revealed a mild ALT/ALKP increase and an abnormal snap cPL. Fasted radiographs revealed a possible cranioventral abdominal mass. DCM and JPGs of the rads are attached.

Abnormal PE/Chem/CBC/UA Results: Mild ALT/ALKP increase, abnormal snap cPL.

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. A small amount of suspended, echogenic debris is observed within the lumen. No masses, inflammatory or changes are observed. There is a questionable small, cystic calculus observed in one video clip. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 1-2 cm, are normal.

The **left kidney** is subjectively normal in size with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild to moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. Several nonobstructive nephroliths are visualized. A few, small cortical cysts are seen. There is no evidence of pyelectasia, infarcts or hydronephrosis.

The **right kidney** is normal in size (4.20 cm in length) with a slightly irregular shape. There is mild to moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. A cortical infarct is suspected at the lateral aspect. There is no evidence of pyelectasia or hydronephrosis.

Adrenal Glands

The **adrenal** glands are not definitively visualized. See Other category.

The **right adrenal gland** is normal size (xxx cm at cranial pole) (xxx cm at caudal pole) (xxx 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

The **spleen** is subjectively normal in size (1.02 cm in width at the level of the hilus). A 1.07 cm irregular, heterogenous nodule is observed at the cranial medial aspect. The lesion causes minimal capsular expansion. The remaining peripheral margins are curvilinear. Splenic vasculature is normal with no evidence of thrombosis.

Liver

The **liver** is normal in size with normal curvilinear 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 **gall bladder** lumen is moderately distended. The wall is thin and smooth. A moderate amount of gravity dependent, echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The **gastric lumen** is distended with fluid and also contains shadowing material within the lumen. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract appears patent at the time of this study. 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.

Pancreas
The region of the pancreas is partially obscured by the gastric distention. In the visualized portions, no obvious abnormalities are seen.

Free Abdomen
Trace **free fluid** is observed.

Lymph nodes
(See "Other "category)

Other
A 3.40 cm irregular hypoechoic to heterogenous mass is observed in the left mid-abdomen, in the region of the left adrenal gland. Surrounding mesentery is hyperechoic.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Mass effect in the left mid-abdomen, the origin of which is unclear. It may be arising from the left adrenal gland, lymph node, mesentery, pancreas, other. The lesion is concerning for a neoplasia, with a lower possibility of a focal inflammatory process. Adjacent peritonitis is present.

- The shadowing material within the gastric lumen is cconsistent for foreign material. The gastric distention may be secondary to ileus or an intermittent outflow obstruction, resulting from the foreign material.

- The splenic nodule is concerning for a neoplastic process (i.e., metastatic disease, primary tumor). However, a focal benign process (i.e., extramedullary hematopoiesis, lymphoid hyperplasia or similar) is also possible.

Secondary Findings

- Bilateral degenerative renal changes with nonobstructive nephrolithiasis and a suspected right cortical infarct

- Suspected small cystic calculus

- Diffuse hepatopathy. Top differentials include inflammatory disease, infiltrative neoplasia (less likely), hepatotoxicosis (i.e., copper) and/or benign age-related change (i.e., vacuolar hepatopathy).

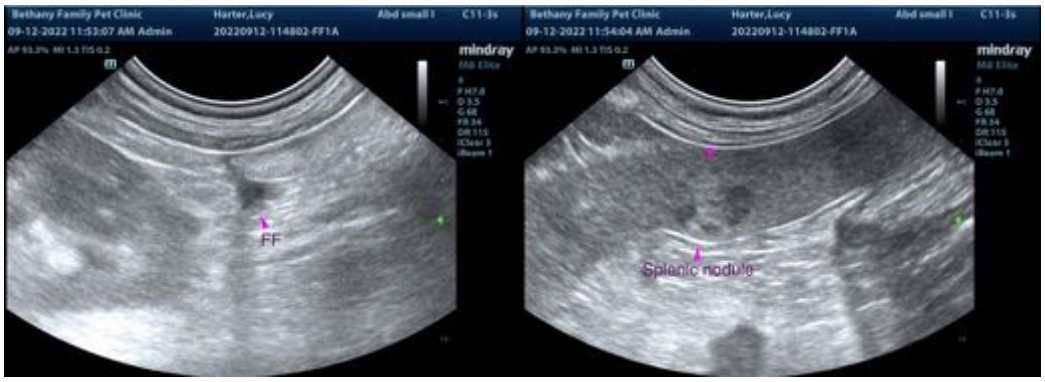
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

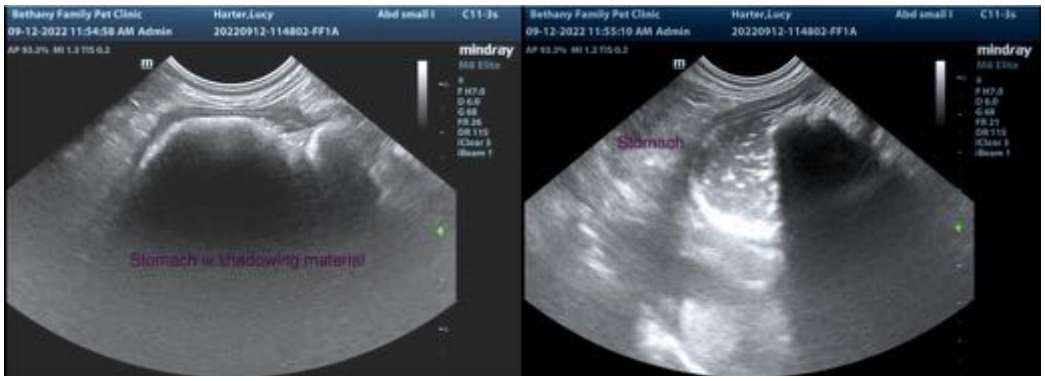
Three-view thoracic radiographs are recommended to assess for pulmonary metastatic disease.

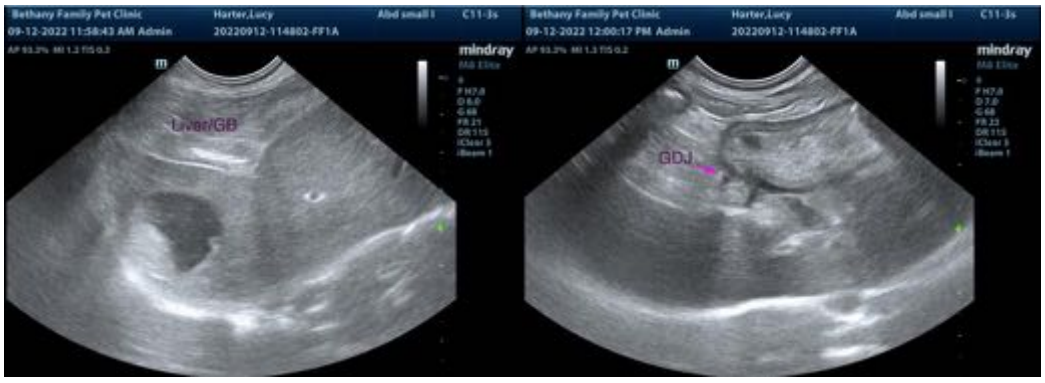
Consider a fine-needle aspirate of the splenic nodule if clotting status is appropriate. A 25-gauge needle should be used.

To further evaluate the origin of the mass effect in the left mid-abdomen, consider an abdominal CT scan. Aspiration of the mass is not recommended due to the concern of possible adrenal origin.

If surgical removal of the mass is ultimately pursued, a gastrotomy with removal of the foreign material is recommended, if still present. Endoscopic removal may or may not be feasible.







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