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Clinical Sonography & Telecytology
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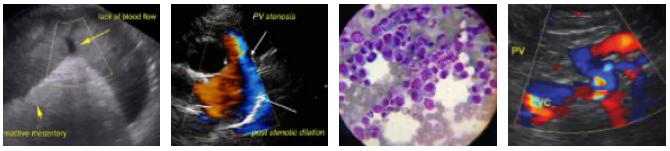


SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Wilbur Jenkins

SPECIES
Canine

BREED
Miniature Schnauzer

SEX
Male, neutered

AGE
14 Yrs.

WEIGHT
23 lbs.

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

IMAGING PERFORMED BY
Dr. Jennifer Todd

HOSPITAL NAME
Lambs Gap AH

REFERRING VET
Dr. Jennifer Todd

INVOICE
12073

DATE
9/14/21

PRESENTING CLINICAL SIGNS

Wilbur is a fourteen year old, MN, Miniature Schnauzer with a recent history of lethargy, decreased appetite, diarrhea and nausea/vomiting. Approximately 2 weeks ago, Wilbur fell down a few stairs. Exam and bloodwork on 9/4/21 showed stiff gait and mild anemia (HCT=36%) Recheck exam on 9/11/21 showed tense abdomen on palpation, normal snap cPL. Cerenia, famotidine and bland diet were advised. Recheck exam yesterday showed tense abdomen, depressed, excessive salivation and lip smacking. CBC showed worsening anemia (HCT=22%, non-regenerative), abdominal rads showed space occupying mass effect mid-abdomen.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are 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 (1.27 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 (5.18 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (5.20 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. Hyperechoic shadowing diverticular foci are visualized. 1-2 cortical infarcts are observed at the lateral aspect. Mild pyelectasia is present (0.29 cm in the longitudinal plane). There is no evidence of hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is not definitively visualized due to the large mid-abdominal mass.

The right adrenal gland is normal size (1.22 cm at cranial pole) (0.57 cm at caudal pole) (2.51 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.

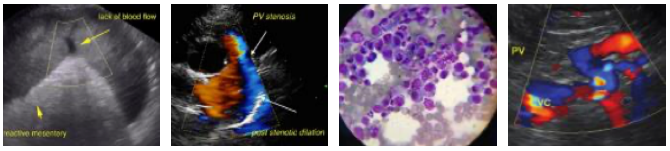
Spleen

The spleen is subjectively normal in size (1.70 cm in width at the level of the hilus) with slightly undulating peripheral contours. The parenchyma is subtly mottled in appearance. A few small hyperechoic nodules are observed throughout the parenchyma. Splenic vasculature is normal. See also *Other*.

Liver

The liver is subjectively prominent in size with swollen curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and exhibits mild heterogeneity. No distinct focal lesions are observed. Hepatic vasculature and biliary tracts are of normal volume with no evidence of congestion. The gall bladder lumen is mildly distended. The wall is thin and smooth. A moderate amount of mostly gravity dependent echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal



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The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is mildly distended with ingesta. 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 left and right limbs 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. See also *Other*.

Free Abdomen

The mesentery in the cranial to mid-abdomen is hyperechoic. Trace free fluid is observed.

Lymph nodes

See Other.

Other

A >11 cm irregular, heterogeneous, cavitated mass is observed in the cranial to mid-abdominal region.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

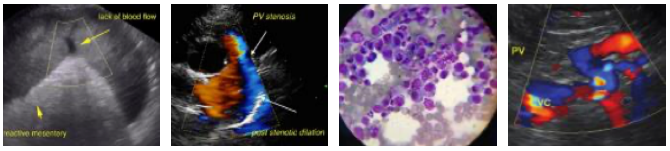
- Large cranial to mid-abdominal mass, the origin of which is unclear. It may be arising from a stalk off of the spleen, pancreas, left adrenal gland, mesentery, lymph node, other. Neoplasia (i.e., sarcoma) is considered likely with a low possibility of benign pathology (i.e., abscessation).

Secondary Findings:

- Bilateral age-related renal changes with right dystrophic mineralization and cortical infarcts.
- The splenic parenchyma changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis or splenitis with a low possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).
- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory and infiltrative disease are considered less likely.
- 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

- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
- A fine needle aspirate of the abdominal mass can be considered. However, given the cavitated areas, there is risk for iatrogenic hemoabdomen following aspiration. Therefore, if an aggressive approach is desired and there is no evidence of pulmonary metastatic disease, consider an abdominal exploratory with mass removal or debulking and submission for histopathology. Referral to a board-certified



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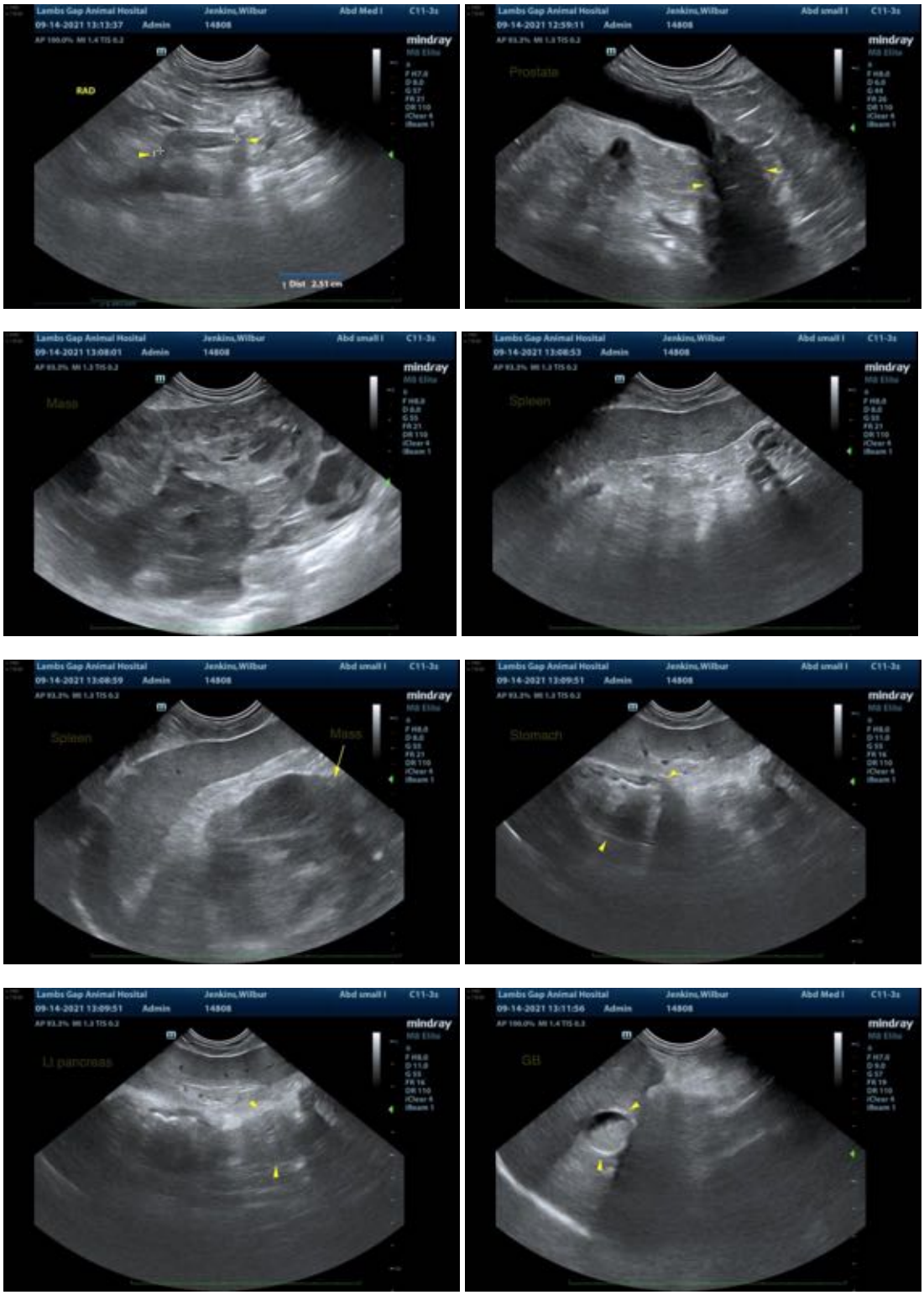
veterinary surgeon is recommended due to the potential for perioperative complications. An abdominal CT scan would be useful in pre-surgical planning. Give the size of the mass, the prognosis for this patient is considered guarded.



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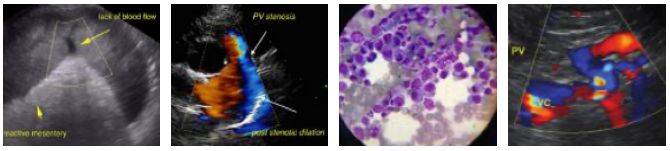

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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