IMAGING PERFORMED BY

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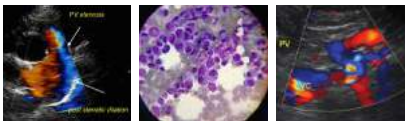

SonoPath
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DATE

9/22/21

PATIENT

Beau Glen-Campbell

SPECIES

Canine

BREED

Staffordshire Mix

SEX

Male Neutered

AGE

8/21/10

WEIGHT

67.3 lbs.

INTERPRETED BY

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

HOSPITAL NAME

Timonium Animal Hospital

REFERRING VET

Dr. Kauder

INVOICE

11873kk

PRESENTING CLINICAL SIGNS

History: Biannual screen for mets- secondary to apocrine anal gland adenocarcinoma excised 10/5/2020 and a new heart murmur detected 7/13/21- when in for ear infection. The patient is also having an echocardiogram today.

Current Medications: Deramaxx 75mg- 1/2-3/4 tab once daily, Gabapentin 600mg- 1/2 tab twice daily, Denamarin 425mg- 1 daily.

Lab Results: chem/cbc/T4/FT4 sending out day of sonogram; last run 4/2021. Liver aspirate 10/2020- no cancer, but some lymphocytes noted on liver aspirate, uncertain significance.

Radiographs: Not provided by the veterinarian.

Date of Previous IntraPet Ultrasound: April 2021

Sedation: Sedation not required for scan.

Stat Report: STAT report not requested by the veterinarian.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly distended with mostly anechoic urine. The wall is of appropriate thickness for the level of repletion with a slightly irregular mucosal surface. No cystic calculi are observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The prostate is not definitively visualized due to its pelvic location.

The left kidney is normal size (7.13 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. A 1.18 x 1.12 cm irregular cortical cyst is observed at the medial aspect. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney is normal size (6.60 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is upper limits of normal size (1.30 cm at cranial pole) (0.82 cm at caudal pole) (3.05 cm in length) with a slightly irregular shape. A 1.60 x 0.98 cm hyperechoic nodule is observed at the cranial pole. Glandular echogenicity and detail at the caudal pole are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is upper limits of normal size (0.80 cm at cranial pole) (0.81 cm at caudal pole) (2.72 cm in length) with a slightly irregular shape. 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 (1.05 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 is normal.

Liver
The liver is subjectively prominent in size with normal curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and mildly heterogeneous with a few, ill-defined, hyperechoic areas. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion. The gall bladder is distended. The wall is normal in thickness. A large amount of echogenic sludge is observed within the lumen, some of which is adhered to the wall and some of which is suspended in a partially stellate pattern. The cystic and common bile ducts are normal/not seen.

Gastrointestinal
The gastric lumen is not distended. The gastric wall in the region of the fundus is normal to mildly thickened (up to 0.68 cm). with a prominent muscularis layer in one region. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall is normal to mildly thickened (up to 0.57 cm) with a normal layering pattern. There is disruption in the normal 1:3 muscularis to mucosal ratio in some segments. In these segments, the mesentery effacing the serosal surface is hyperechoic. 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.

Lymph Nodes
A 6.29 x 3.36 cm irregular, severely enlarged, cystic, sublumbar lymph node is visualized. The node appears vascular. The cystic areas are septated.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The sublumbar lymphadenopathy is concerning for metastatic disease from the previously excised apocrine gland adenocarcinoma. Reactive lymphadenitis or lymphoid hyperplasia are possible but considered less likely.
- The gall bladder changes are consistent with an emerging mucocele.

Secondary Findings:

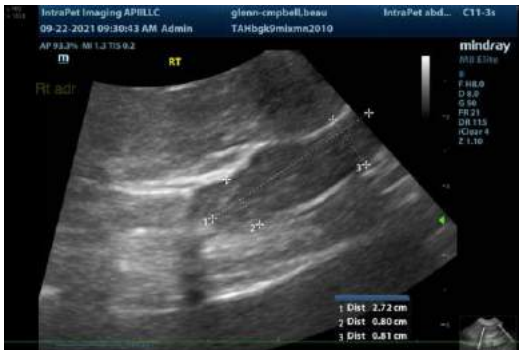
- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory and infiltrative disease are considered less likely.
- The bilateral adrenal changes are most consistent with hyperplasia.
- Bilateral, age-related renal changes.
- The bowel changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease with potential for emerging neoplasia). Regional peritonitis is present.

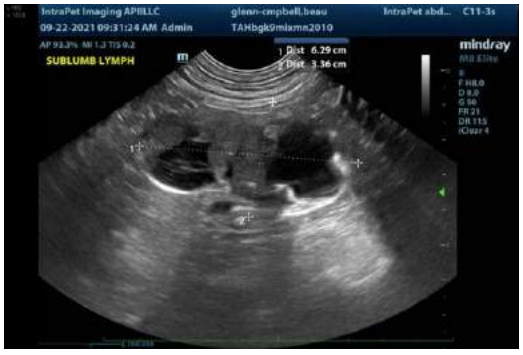
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

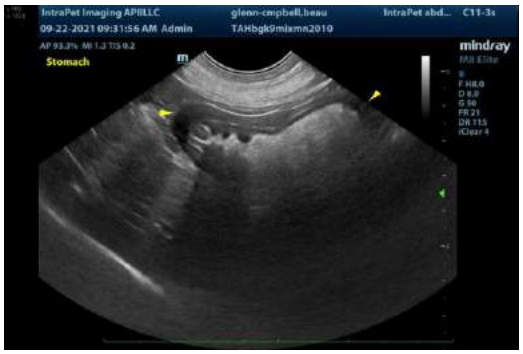
1. Three-view thoracic radiographs are recommended to assess for pulmonary metastases.

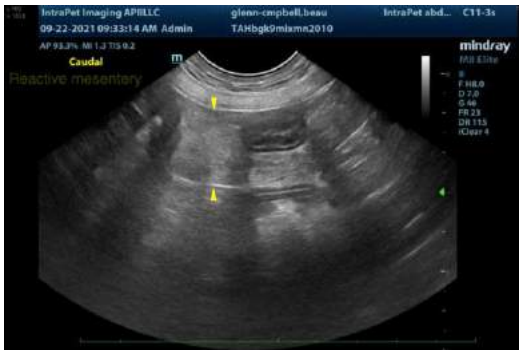
2. Regarding the sublumbar lymph node, consultation with a board-certified veterinary oncologist is recommended for follow up treatment recommendations.

3. Given the gall bladder changes, Ursodeoxycholic acid (Ursodiol) is recommended. Serial sonographic monitoring (e.g., every 6-8 weeks) of the gall bladder is recommended to assess for progression to a fully-formed mucocele. *If surgical removal of the sublumbar lymph node is pursued, consider a cholecystectomy at the time of surgery.









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*)
Andrea.nicastro@sonopath.com