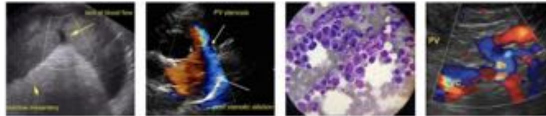

PATIENT
Rebel Williams

SPECIES
Canine

BREED
Cavalier King Charles

SEX
Male, neutered

AGE
1/11/2014

WEIGHT
30 lbs.

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

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

HOSPITAL NAME
Sun Dog Cat Moon

REFERRING VET
Dr. Pruitt

INVOICE
14922

DATE
5/10/22

PRESENTING CLINICAL SIGNS

Ravenous appetite; o has had concerns with losing weight in the past, but now doing well; mass noted on base of tail appears endocrine, o noted about 1 year ago;

Increasing ALP 729 despite being on Denamarin Advanced, hyperphosphatemia (erroneous?), hypercholesterolemia (non-fasted), precision PSL mildly elevated
urine cortisol screening test wnl 11/2022

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface in the region of the apex is slightly irregular. The bladder is moderately distended. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The prostate is prominent in size with normal curvilinear peripheral contours. The parenchyma is slightly heterogeneous in appearance. No distinct focal lesions are observed. The prostatic urethra is not overtly dilated.

The left kidney is normal size (6.22 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is isoechoic relative to the spleen. 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. Renal vasculature is normal.

The right kidney is normal size (5.98 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is isoechoic relative to the spleen. 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. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is borderline enlarged (0.51 cm at cranial pole) (0.68 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.

The right adrenal gland is normal in size (1.39 cm at cranial pole) (0.64 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 overall normal in size (1.18 cm in width at the level of the hilus). A 2.04 cm irregular hypoechoic to heterogeneous nodule/mass is arising from the parenchyma. The lesion causes slight capsular expansion. In the remainder of the spleen, the margins are curvilinear and the parenchyma is homogeneous. Splenic vasculature is normal with no evidence of thrombosis.

Liver

The liver is subjectively enlarged with slightly swollen peripheral contours. The parenchyma is isoechoic

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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 suspended echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is not distended. 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 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.

*A fine needle aspirate of the splenic lesion was performed at the end of the study without incident.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- Splenic nodule/mass. This is concerning for a neoplastic process (i.e., round cell tumor, sarcoma). However, a non-neoplastic process (i.e., focus of lymphoid hyperplasia or similar) cannot be excluded.
- The hepatic parenchymal changes are most consistent with a benign diffuse hepatopathy. Vacuolar hepatopathy (i.e., endocrine, idiopathic) is suspected with a lower possibility of inflammatory disease or infiltrative neoplasia.
- Gallbladder debris/sludge, non-mucocele.
- Borderline left adrenomegaly.

Secondary Findings:

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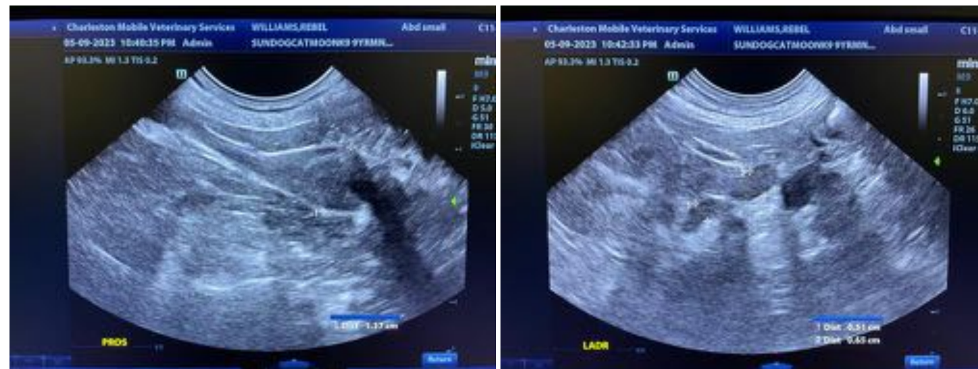
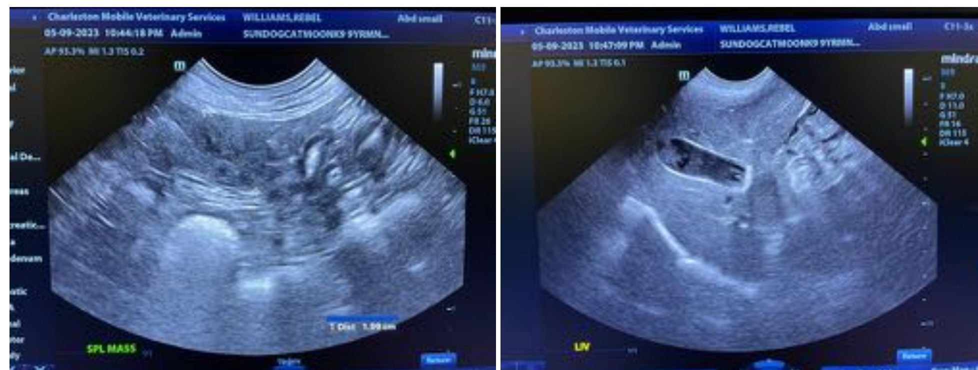
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The prostate changes are most consistent with age-related remodeling along with late-in-life neutering.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- A fine needle aspirate of the splenic nodule is recommended. If neoplasia is found, consider three-view thoracic radiographs +/- splenectomy with submission of the spleen for histopathology.
- Depending on the results from the splenic aspirate, further testing for Cushing's disease (i.e., low-dose Dexamethasone suppression test or ACTH stimulation test) may be warranted.
- Given the history of proteinuria, UPC is also recommended.
- Also consider a baseline blood pressure measurement to assess for systemic hypertension.





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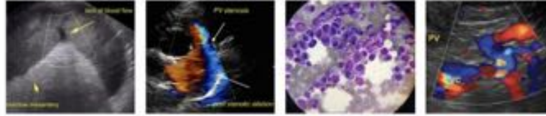

Charleston Mobile Veterinary Services
IMAGING PERFORMED BY
CharlestonMobile.Net 800.403.5408

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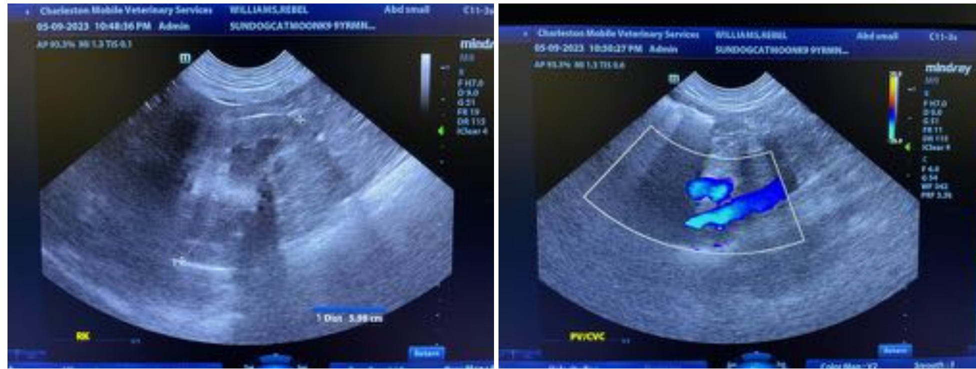
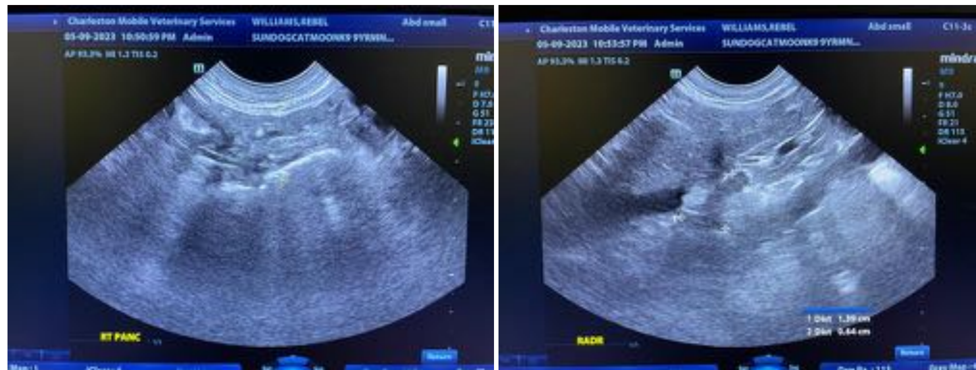
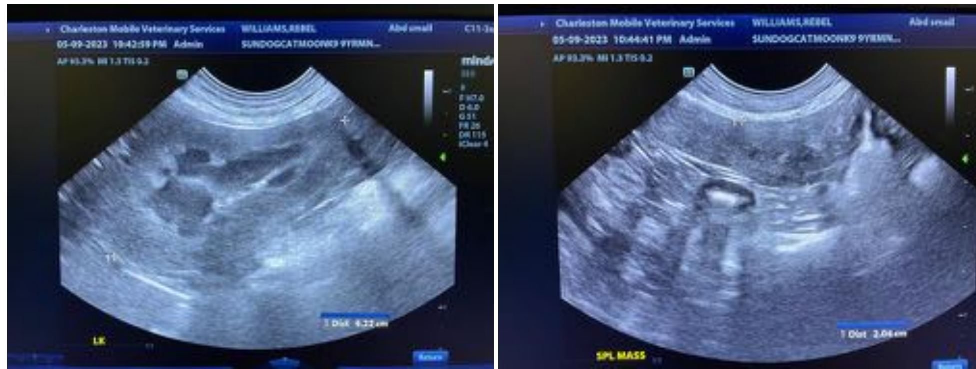
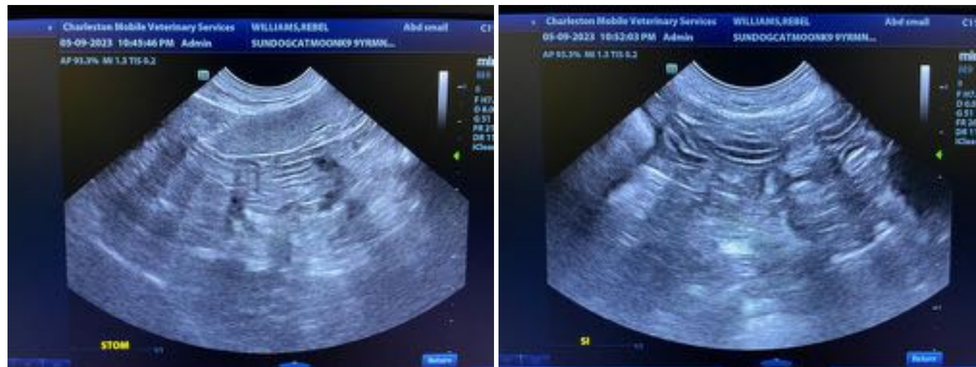
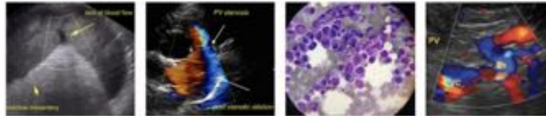








The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.



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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