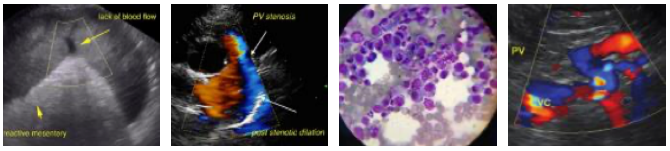
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Frankfurt Costanza

SPECIES
Canine

BREED
Dachshund

SEX
Male, neutered

AGE
17 Yrs.

WEIGHT
12 lbs.

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

IMAGING PERFORMED BY
Diane McFadden, RVT

HOSPITAL NAME
Newton VH

REFERRING VET
Dr. Kim

INVOICE
14174

DATE
11/7/22

PRESENTING CLINICAL SIGNS

History: vomiting, diarrhea, lethargic. seizure activity. on metrondazole, ondansetron, denamarin, keppra
Abnormal PE/Chem/CBC/UA Results: platelets slightly low, ALT 1052, ALKP 248, GGT 33, tbili 1.5, BUN 58.9, Cr 1.5, phos 7.7

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder and visible portion of the pelvic urethra are normal for the degree of luminal distension. The urine is mostly anechoic with no evidence of debris. Cystic calculi and discrete masses are not observed. The region of the trigone is normal.

The prostate is normal in size (0.96 cm in width) with a normal shape and smooth peripheral contours. The parenchyma is slightly heterogeneous. The prostatic urethra is not overtly dilated.

The left kidney is normal size (4.56 cm in length) with a normal shape and smooth peripheral contours. The cortex is variably thickened and hyperechoic and there is moderate loss of corticomedullary distinction. A 1.07 cortical cyst is observed at the caudal pole. Several smaller cortical cysts are also seen. Hyperechoic shadowing diverticular foci are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (4.04 cm in length) with a normal shape and smooth peripheral contours. The cortex is variably thickened and hyperechoic and there is moderate loss of corticomedullary distinction. Several small cortical cysts are seen. Hyperechoic shadowing diverticular foci are visualized. Trace pyelectasia is present. There is no evidence of infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.78 cm at cranial pole) (0.81 cm at caudal pole) (2.22 cm in length) with a normal shape and smooth peripheral contours. The parenchyma is slightly heterogeneous with some loss of glandular detail. The phrenicoabdominal vein and surrounding vasculature are normal.

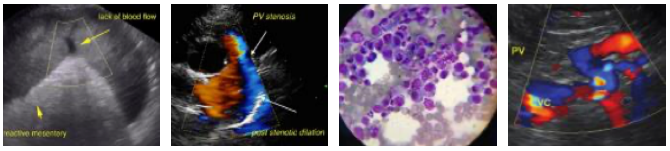
The right adrenal gland is mildly enlarged (0.93 cm at cranial pole) (0.63 cm at caudal pole) (1.80 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (1.09 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 enlarged with swollen, slightly irregular peripheral contours. The parenchyma is isoechoic relative to the spleen. An approximately 6.5 cm ill-defined heterogeneous, cavitated mass is observed on the left side. In the remaining parenchyma, a few ill-defined hyperechoic nodules are seen. Vascular and biliary tracts are of normal volume with no evidence of congestion. The gall bladder lumen



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is mildly to moderately distended. The wall is variably thickened (up to 0.30 cm), irregular and hyperechoic to mineralized. A small amount of 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 is prominent in size with slightly irregular peripheral contours. The parenchyma is mildly hypoechoic relative to surrounding omental fat and subtly mottled in appearance. No distinct focal lesions are observed. The pancreatic duct is not overtly dilated. The mesentery effacing the serosal surface is mildly hyperechoic.

Free Abdomen

Trace free fluid is observed. The abdominal lymph nodes are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

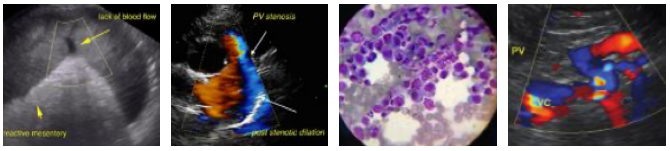
- Left hepatic mass. Neoplasia (i.e., adenocarcinoma, adenoma, hemangiosarcoma, round cell tumor) is considered likely with a lower possibility of benign process (i.e., abscess/inflammatory focus). The diffuse hepatic parenchymal changes are most consistent with a benign process (i.e., regenerative nodular hyperplasia and/or vacuolar hepatopathy.
- The mineralization in the gallbladder wall (aka “porcelain” gallbladder) is most consistent with cholecystitis. However, this finding has been associated with carcinoma in rare instances.
- The pancreatic changes are most consistent with chronic active pancreatitis.
- Trace ascites.

Secondary Findings:

- Bilateral renal changes are most consistent with chronic interstitial nephrosis/nephritis with dystrophic mineralization and cortical cysts.
- Mild bilateral adrenomegaly.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
- Consider a fine needle aspirate of the liver (if clotting status is appropriate). A 25-gauge needle should be used and care should be taken to avoid the cavitated regions. If aspiration is pursued, the patient should be monitored sonographically for at least 5-10 min post-procedure to assess



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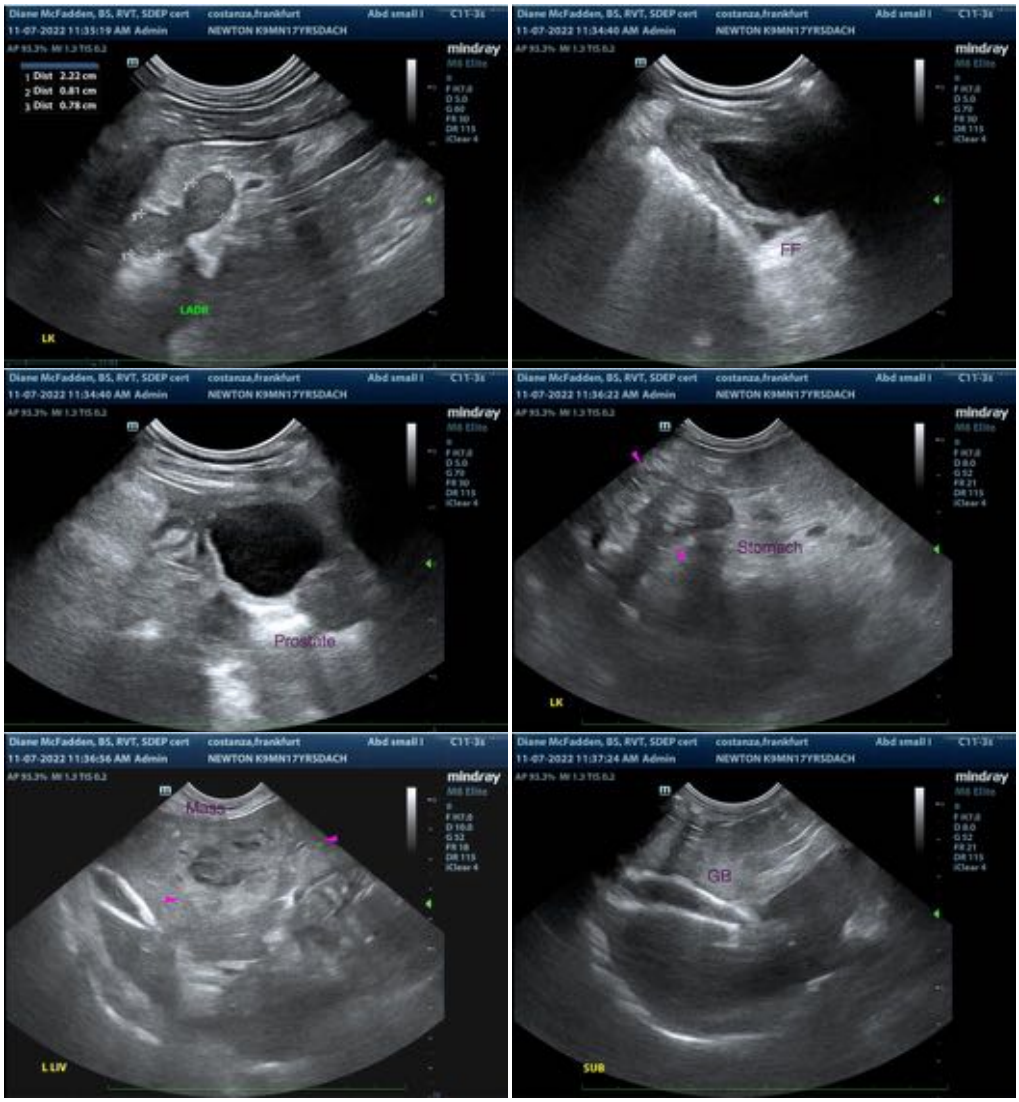
for iatrogenic hemorrhage. If cytology is not pursued or results are inconclusive, consider hepatic mass removal with submission for histopathology +/- cultures.

- Regarding the azotemia, consider the following:

1. Urine culture and sensitivity
2. UPC (if proteinuria is present in the absence of infection)
3. Baseline blood pressure measurement
4. Prescription renal diet when the patient is eating



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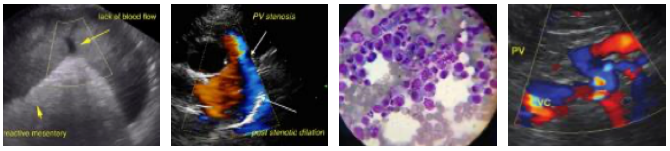

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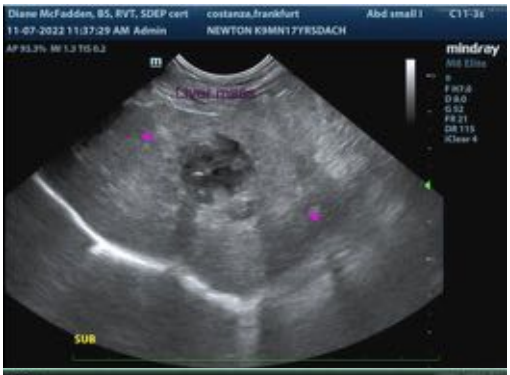

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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