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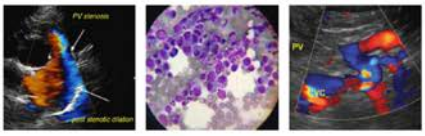

SonoPath
Clinical Sonography & Telecytology
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PATIENT
Lucy Haggarty

SPECIES
Canine

BREED
Pomeranian X

SEX
Spayed Female

AGE
7 Years

WEIGHT
13.4 Pounds

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Amy Mayhew, LVT

HOSPITAL NAME
SVS Imaging MI

REFERRING VET
Family Pet Practice

INVOICE
44267

DATE
1/17/23

PRESENTING CLINICAL SIGNS

Current Medications: revolution Patient History: AUS on 1/17/23 for met check prior to removal of caudally mammary mass (2.5cmx 3.5cm) No pulmonary nodules noted on recent chest rads, but hepatomegaly noted and left sided heart enlargement also noted. Initially presented to FPP for recheck following otitis treatment from prev DVM. Mammary mass noted on exam. See attached cytology results.

Abnormal PE/Chem/CBC/UA Results: Exam 1/12/23 1. BAR 2. Intermittent clear nasal discharge- Per O not noted at home, likely due to stress. 3. Incipient cataracts OU 4. AD- Significant improvement, able to visualize a portion of the tympanic membrane, remainder not visible due to debris in canal. Medication visible in canal, small amount of bleeding noted after cotton swab for ear cytology. AS- NSF, intact tympanic 5. Mild tartar dental performed within last year 9/10. Abdominal palpation unremarkable. mammary mass caudal right mammary gland- expressed serosanguinous fluid from gland 12. MLP bilaterally, non-reactive on palpation 13. Overweight- Prev recommended HP small dog **Please see attached rads and rad interpretation report.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The right kidney is normal in size (5.11 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal in size (4.58 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

The left adrenal gland is plump/swollen in size. Normal shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. The left adrenal gland measures 1.1 cm at the cranial pole and 0.45 cm at the caudal pole.

The right adrenal gland is enlarged, primarily at the cranial pole (2.0 cm at the cranial pole and 0.44 cm at the caudal pole) with mild heterogenous parenchymal changes. Swollen capsular expansion is noted (again primarily at the cranial pole) without evident capsular escape or vascular invasion.

Spleen

The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). A 0.60 cm non-capsule disrupting hypo- to anechoic nodule is noted near the head of the spleen. Splenic vasculature appears normal.

Liver

The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and

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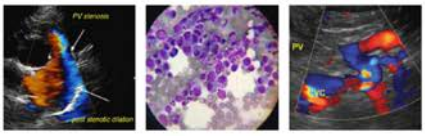

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homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering. Hyperechoic mucosal fogging or speckling is noted. Small intestinal motility appears adequate (1-3 contractions per min). The lumen is empty with no evidence of obstruction or foreign material.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The observed pancreas appears appropriately isoechoic to surrounding omental fat. The capsule is mildly irregular in shape. Parenchyma is mildly heterogenous and coarse. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is no evidence of free peritoneal effusion noted in these images.

A left medial iliac lymphadenopathy is noted with a lymph node measuring 0.45 cm thick.

PRIMARY FINDINGS

- **Right adrenal mass** – This may represent adrenal hyperplasia secondary to pituitary dependent hyperadrenocorticism, given the concurrent adrenomegaly on the left side as well, or could represent an adrenal adenoma additionally. Stress versus normal patient variant is also possible. Early pheochromocytoma cannot be ruled out but is considered less likely.
- **Mucosal speckling –** Mucosal speckling is often present with inflammatory bowel disease (IBD). It is not specific for type or severity of disease. Mild speckling change can occur as a normal patient variant in the post-prandial state.
- **Mild left medial iliac lymphadenopathy –** likely reactive. However, metastatic neoplasia cannot be differentiated without tissue sampling.

SECONDARY FINDINGS

- **Hypo to anechoic splenic nodule** – likely represents a benign lesion such as a cyst, hematoma, nodular hyperplasia, extramedullary hematopoiesis, etc., however while considered less likely, infiltrative neoplasia can mimic benign lesions, and cannot be ruled out.
- **Pancreatic age-related remodeling –** Mild irregularities are consistent with benign age-related change. Low-grade smoldering chronic pancreatitis cannot be ruled out and should be suspected in the face of appropriate clinical signs.

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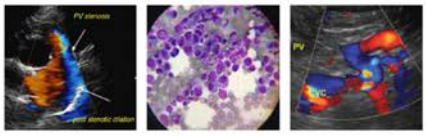

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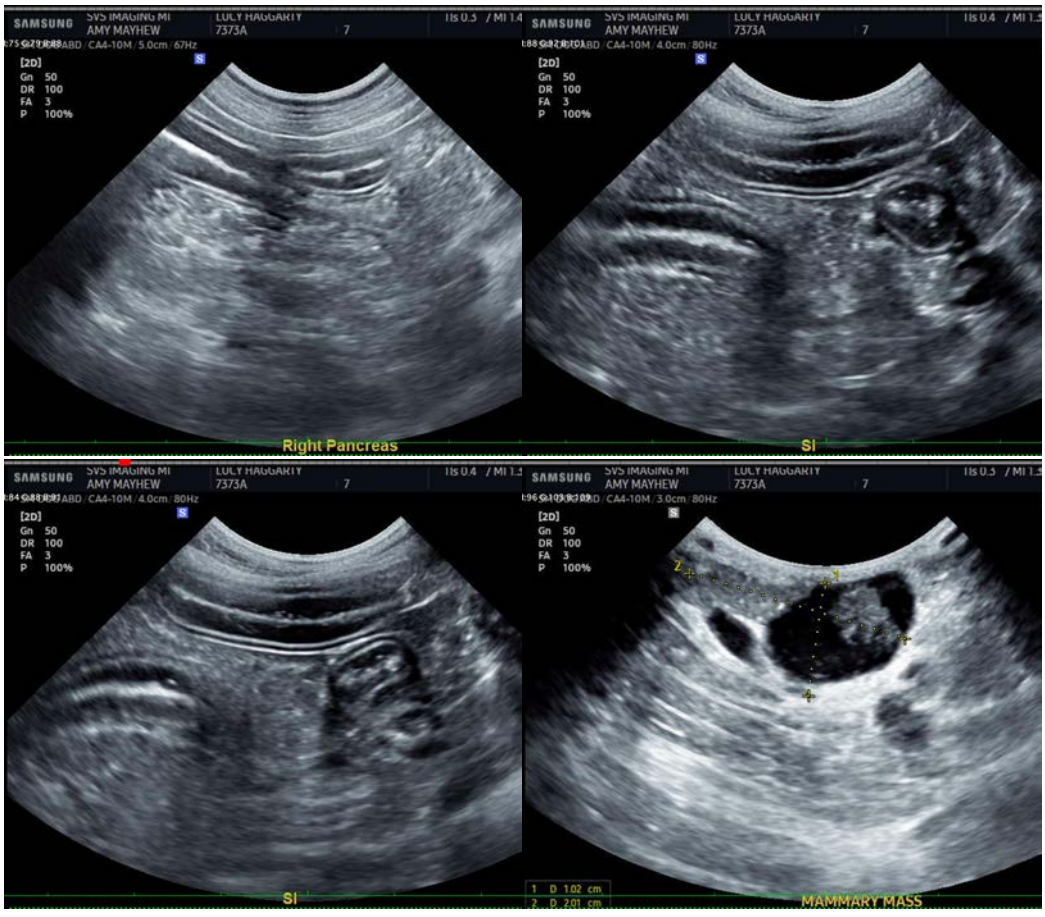
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is no definitive evidence of intraabdominal metastatic disease as a result of the reported mammary gland tumor. If possible, to safely reach, the mildly enlarged medial iliac lymph node could be aspirated if patient coagulation status is appropriate to definitively rule out metastatic disease. Alternatively, if it can't be reached, monitoring of the lymph node for progression in size, etc. following removal of the mammary gland mass (if indicated based on histopath results) is recommended.

The remainder of the pathology described above should be interpreted in combination with clinical signs. For example, if this patient has clinical signs of hyperadrenocorticism, further testing could be considered in the form of a low-dose Dexamethasone suppression test. However, without supporting clinical signs, the adrenal pathology is considered less significant, and testing is not indicated. Similarly, with clinical signs of gastrointestinal disease, further evaluation beginning with a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory could be considered. However, without supporting clinical signs, the reported speckling is likely post-prandial.



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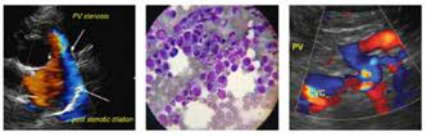

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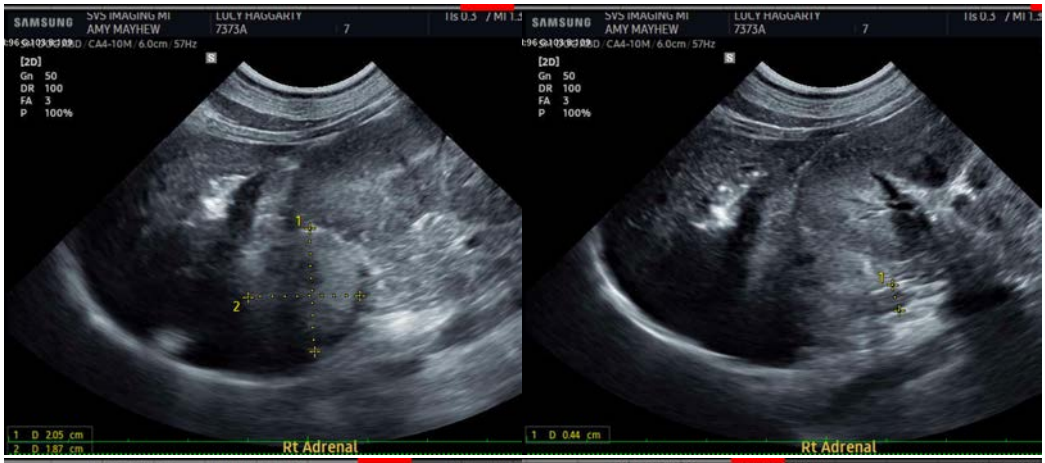

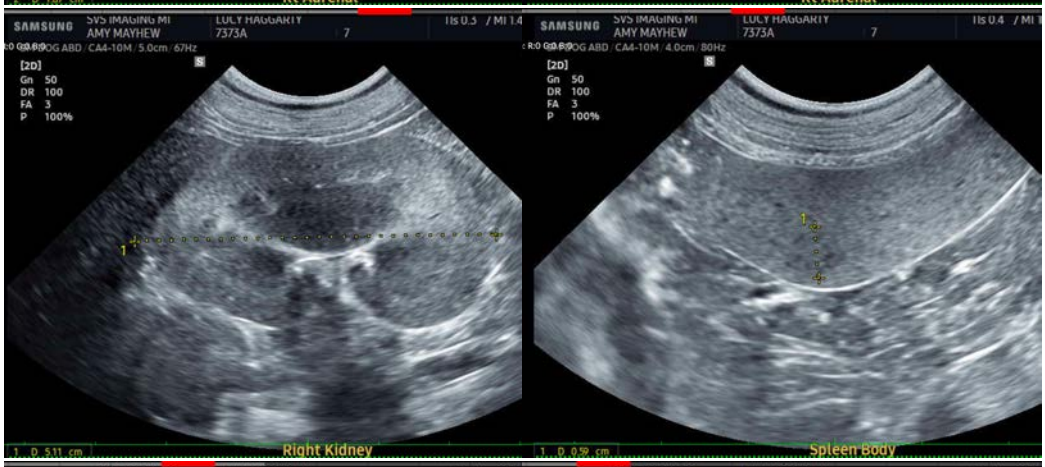

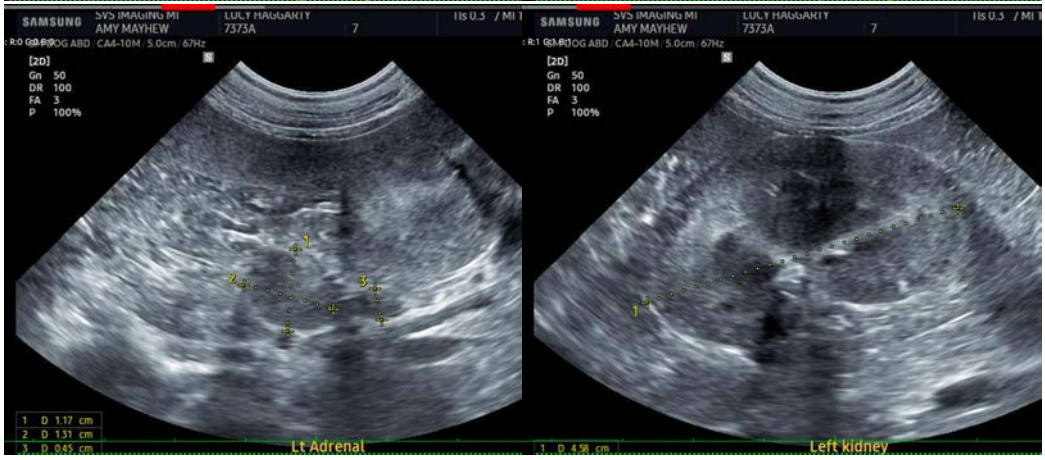

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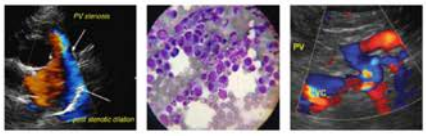

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM
Beth.Johnson@sonopath.com