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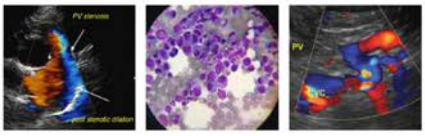

SonoPath
Clinical Sonography & Telecytology
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PATIENT
Sophia Bennett

SPECIES
Canine

BREED
Stabyhoun

SEX
Spayed Female

AGE
11 Years

WEIGHT
54 Pounds

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Amy Mayhew, LVT

HOSPITAL NAME
SVS Imaging MI

REFERRING VET
Wixom Family Pet Practice

INVOICE
43628

DATE
12/21/22

PRESENTING CLINICAL SIGNS

Current Medications: Clavamox 375mg 1 PO BID; Proheart 12; Galliprant 60mg 1 PO SID

Patient History: Left caudal mammary mass present since Feb 2022, cytology revealed an epithelial neoplasm. In the past 2 weeks that gland became painful and there was fluid from the nipple, went to the emergency clinic and they started the Clavamox. On my PE, she has several more masses and evidence of enlarged left inguinal lymph node, so concern for metastasis. Started Galliprant. Chest radiographs had NSF Blood work revealed: ALP 199 (5-131IU/L), Globulins 3.9 (1.6-3.6 g/gL), thrombocytosis 471 (170-400 10^3/uL)

Abnormal PE/Chem/CBC/UA Results: mild diffuse tartar/gingivitis · left caudal/mid mammary chain, round movable sq mass, 6.4cm by 7.5cm by 5.2 cm, not associated with a nipple; left caudal mammary gland has nodular firm mass under the nipple, 2.3 cm by 3.9cm by 1.8cm, feels like it extends into inguinal fat padding; left nipple (4th) has 1.3cm marble sized mass under it; right caudal mammary gland, 1.8cm marble sized mass under nipple, irregular tissue deep into inguinal fat padding · left inguinal lymph node feels enlarged · mild decrease on extension of bilateral hips UA pending

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.

This patient does not have a right kidney.

The left kidney is normal in size (7.59 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

Adrenal glands are plump/swollen in size. Normal shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. Hyperechoic nodules are noted in the caudal poles of both adrenal glands. Nodules do not disrupt normal shape and/or architecture. The right adrenal gland measures 0.88 cm at the cranial pole and 0.47 cm at the caudal pole. Cranial pole of the left adrenal gland measures approximately 1.8 cm, caudal pole 0.60 cm.

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). Approximately 1.5 cm x 1.7 cm mixed heterogeneous, partially mineralized, non-capsule disrupting nodule/lesion noted in the middle 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 homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

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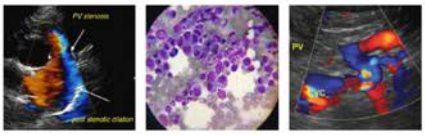

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Gallbladder is moderately distended with anechoic bile as well as mild suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

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 (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

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

Pancreas

The pancreatic parenchyma is appropriately isoechoic to surrounding tissue. Visible capsule is smooth and normal in contour. 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.

Sublumbar lymph nodes are enlarged with swollen irregular capsular contour and loss of normal length to width ratio (rounded in shape). Nodes are hypoechoic with loss of normal parenchymal detail.

ULTRASONOGRAPHIC FINDINGS

- **Aggressive sublumbar lymph nodes –** most consistent with infiltrative round cell or metastatic neoplasia. A benign aggressive inflammatory response cannot be ruled out without tissue sampling +/- culture.
- **Heterogeneous splenic nodule –** This may represent a benign lesion such as a cyst or hematoma, nodular hyperplasia, extramedullary hematopoiesis, etc. However, given the suspicion for metastatic disease, a metastatic splenic lesion cannot be ruled out.
- **Bilateral adrenomegaly –** consistent with adrenal hyperplasia secondary to pituitary dependent hyperadrenocorticism vs stress or normal variant. Interpret in combination with clinical signs of hyperadrenocorticism.
- **Hyperechoic adrenal nodules in the caudal poles of both adrenals –** Differentials include primary adrenal cortical adenoma or adenocarcinoma, pheochromocytoma, myelolipoma, adrenal hyperplasia secondary to pituitary disease or metastatic disease. Ultrasound alone cannot differentiate between functional and non-functional nodules and/or between benign and malignant disease. Small nodules without other evidence of abdominal disease (to suggest metastatic disease) and/or clinical signs (to suggest adrenal disease) are most often incidental and should be monitored.
- **Mild gallbladder debris -** Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial

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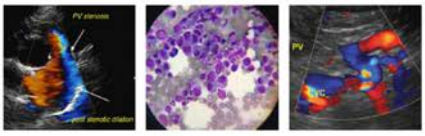

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abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

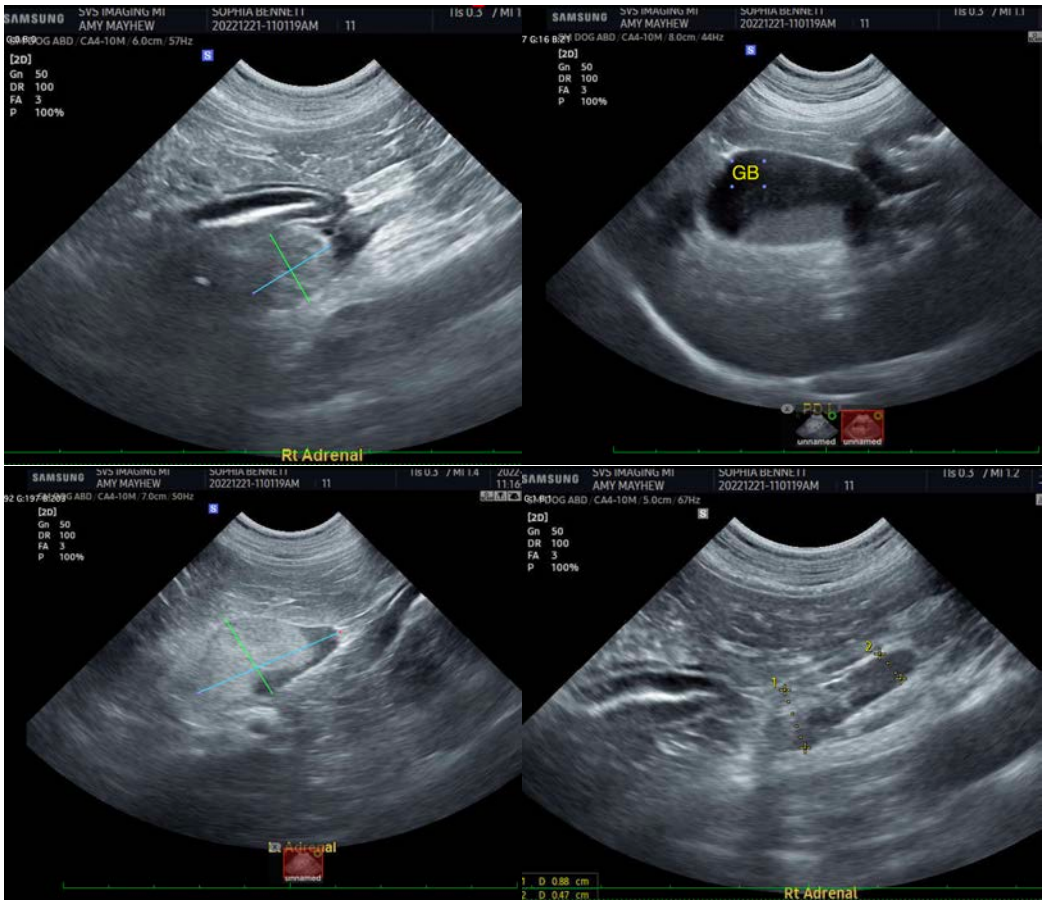
- There is no right kidney.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

A fine needle aspirate of the enlarged sublumbar lymph nodes is recommended if patient's coagulation status is appropriate +/- concurrent aspirate of the splenic nodule.

Ultimately, consultation with a veterinary oncologist is recommended to help further direct therapy of the suspected metastatic mammary neoplasia.



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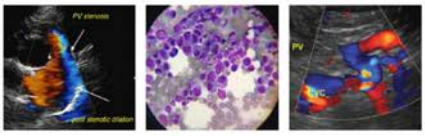

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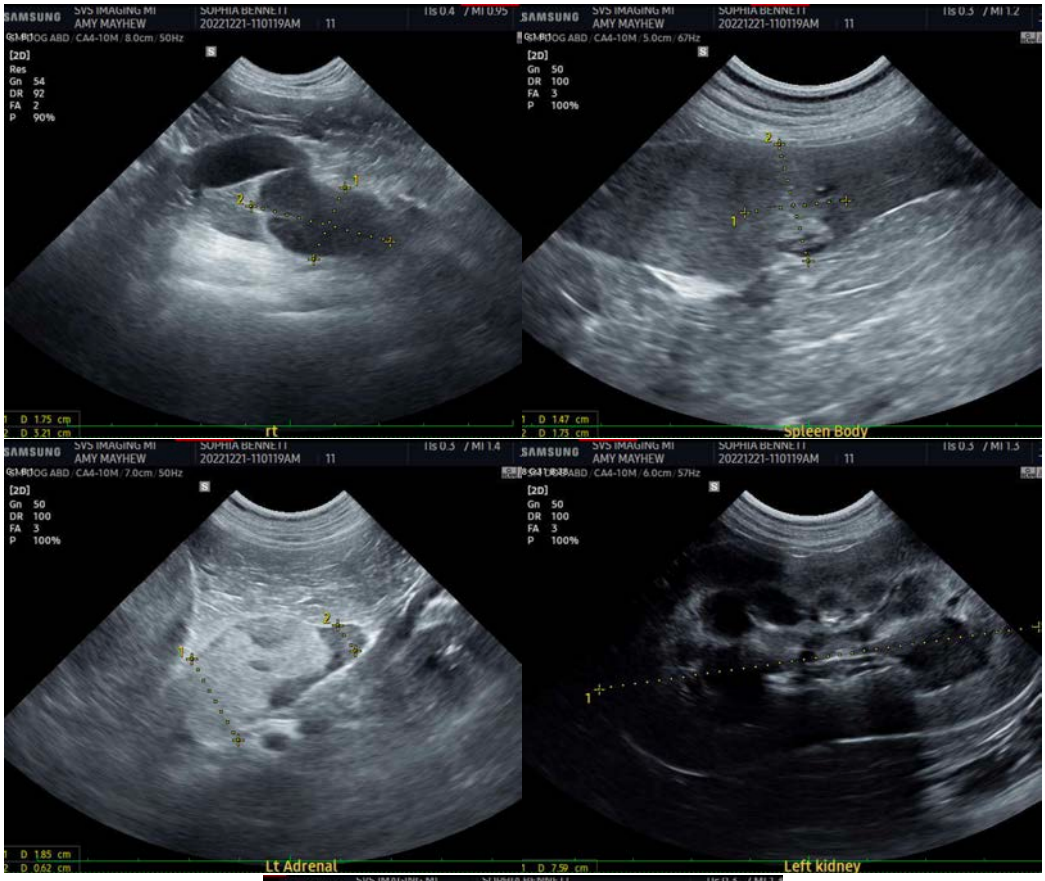

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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