



PATIENT PRESENTING CLINICAL SIGNS

Boba Suffoletta

Presented for sudden lameness which was associated with acute neck pain. Was unable to walk to food dish even though he seemed interested in eating. On examination noted neck pain and possible palpable mid caudal abdominal mass. Weight loss also noted. New pup in house. Was started on Dexamethasone IV then short course of Pred and Gabapentin. Neck pain seems much better today. Was given SQ Torbugesic for the scan for anxiety and comfort.

SPECIES

Canine

BREED

Golden Retriever

Abnormal PE/Chem/CBC/UA Results: B/W mild low HgB, M1 elevation in ALT and ALKPPOS, otherwise NSF. Opted to go straight to Ultrasound.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

SEX

Neutered Male

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.

AGE

11 Years

Prostate is normal in size, echotexture and echogenicity for a neutered male.

WEIGHT

32.3 kg

The right kidney is normal in size (6.3 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 (6.65 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.

INTERPRETED BY

Beth Johnson, DVM
DACVIM

Adrenal Glands

The right adrenal gland cannot be well visualized in these images.

The left adrenal gland is normal in size (1.78 cm long x 0.81 cm at the cranial pole and 0.74 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

IMAGING PERFORMED BY

Crystal Hill

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). Medial to the spleen with an apparent attachment to the head of the spleen, there is an approximately 6.0 cm x 7.5 cm, heterogeneous, partially cavitated mass. Splenic vasculature appears normal.

HOSPITAL NAME

Grand River VH

REFERRING VET

Dr. Robinson

Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion.

INVOICE

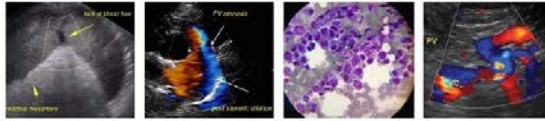
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The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

DATE

11/6/22

Gastrointestinal


PATIENT

Boba Suffoletta

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

SPECIES

Canine

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.

BREED

Golden Retriever

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

SEX

Neutered Male

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.

AGE

11 Years

Free Abdomen

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

There is no apparent lymphadenopathy noted in these images.

WEIGHT

32.3 kg

ULTRASONOGRAPHIC FINDINGS

- **Splenic mass** – Concerning for infiltrative neoplasia such as sarcoma versus round cell neoplasia versus other. Benign splenic masses can mimic malignant disease, especially without a concurrent hemoabdomen, and therefore cannot be differentiated without tissue sampling. Attachment to the liver versus the spleen cannot be definitively ruled out but is considered much less likely based on these images.
- **Heterogenous Liver** – These changes are most consistent with benign processes such as nodular hyperplasia, steroid (vacuolar) hepatopathy, extramedullary hematopoiesis or possibly chronic inflammatory disease and less commonly infiltrative round cell or metastatic neoplasia.

INTERPRETED BY

 Beth Johnson, DVM
 DACVIM

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.

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A fine needle aspirate of the mass could be performed if patient's coagulation status is appropriate. However, given the risk of rupture/hemoabdomen, etc., given the cavitations, exploratory laparotomy with planned excisional biopsy/splenectomy, or in the less likely chance it is attached to the liver it appears resectable, so liver lobectomy would be recommended.

REFERRING VET

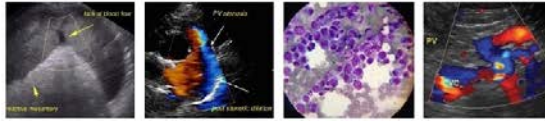
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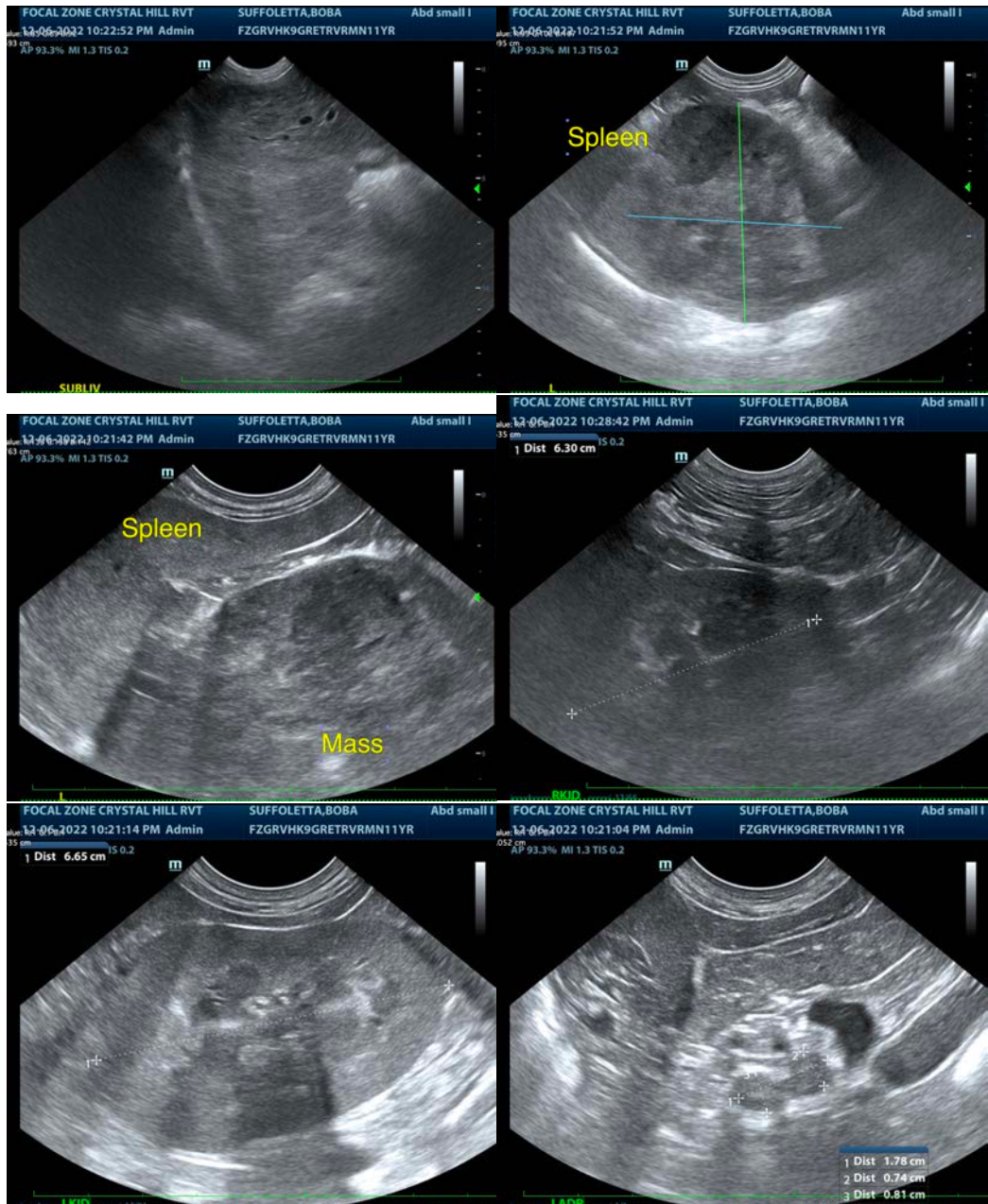
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
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