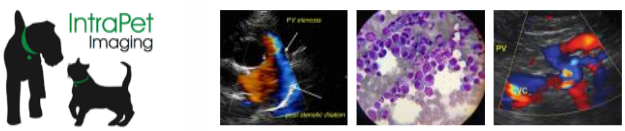
IMAGING PERFORMED BY

IntraPet.com



SonoPath
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DATE
3-11-22

PATIENT
Mason Fleming

SPECIES
Canine

BREED
Labrador

SEX
MN

AGE
4/24/12

WEIGHT
68.8 lbs.

INTERPRETED BY
Beth Johnson, DVM DACVIM

HOSPITAL NAME
Animal Care Center

REFERRING VET
Dr. Muedeking

INVOICE
13477

PRESENTING CLINICAL SIGNS

Appetite decreased. Unable to get comfortable when laying down. Possible abdominal mass.
Current Medications: Gabapentin 300mg BID.
Radiographs: Abdominal mass.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Stephanie Pearce RDCS, RVT.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic contents. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface. No cystoliths are observed. There is an echogenic density on the dependent bladder wall mucosa without acoustic shadowing and without apparent color doppler flow uptake.

The prostate cannot be discretely visualized in these images, however, there is no evidence of pathology in the area of the prostate. “See other.”

The right kidney is normal in size (7.25 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 (6.84 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 right adrenal gland is normal in size (2.47 cm long, x 0.71 cm at the cranial pole and 0.7 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (3.77 cm long x 0.61 cm at the cranial pole and 0.85 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

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). No focal nodules or masses are observed. 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.

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 (< 0.5 cm) 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.

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

“See other”

Other

In the caudal right abdomen cranial and dorsal to the urinary bladder, there is a large (8.0-9.0 cm x 12.0 cm) mixed heterogeneous cavitated mass surrounded by hyperechoic tissue.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Heterogeneous caudal abdominal mass in the area of the medial Iliac lymph nodes of undermined tissue origin - Differentials for which include; lymph nodes vs. primary neoplasia such as sarcoma vs. potentially a retained testicle if this fits with patient history vs. other.

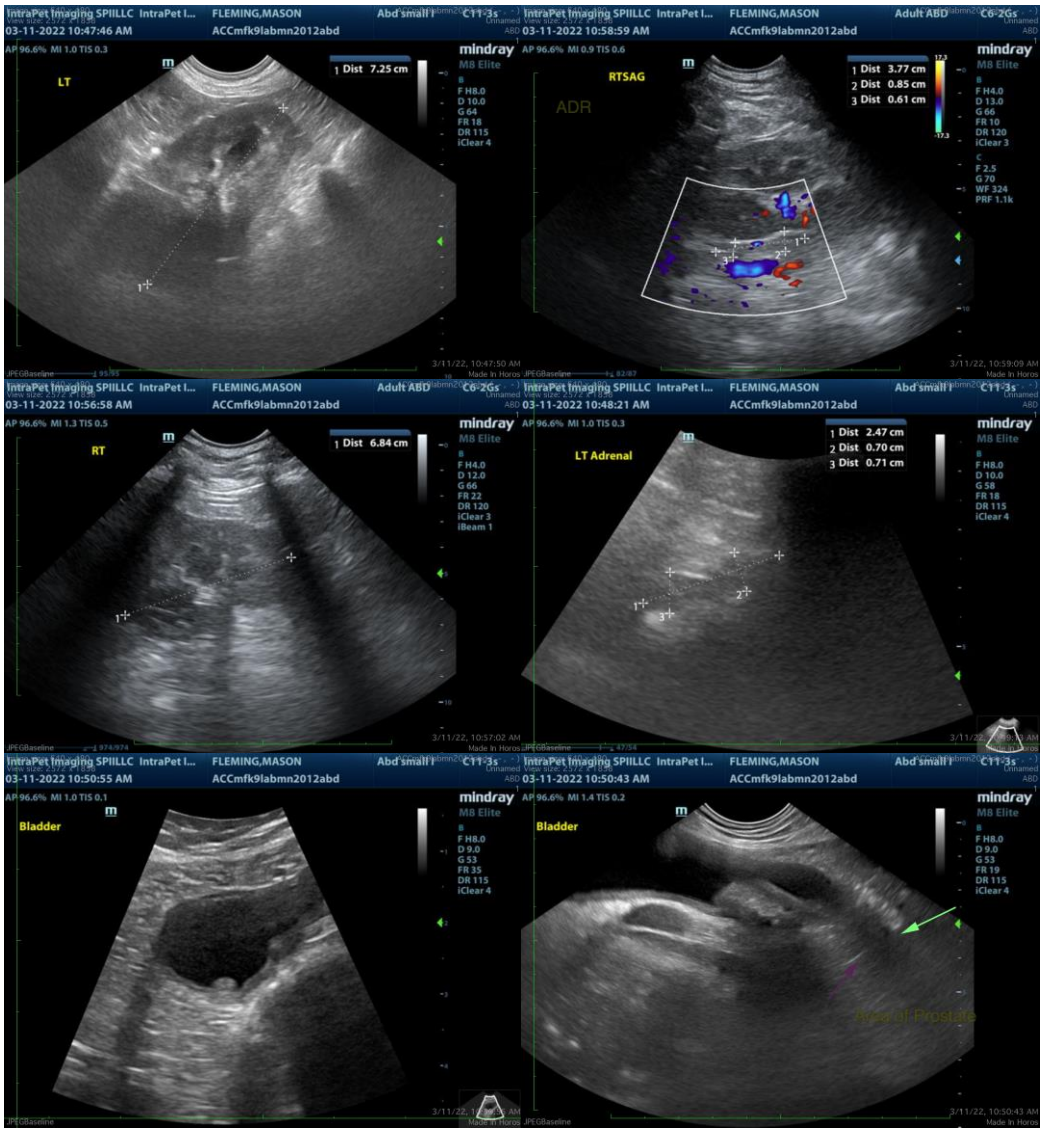
Secondary Findings

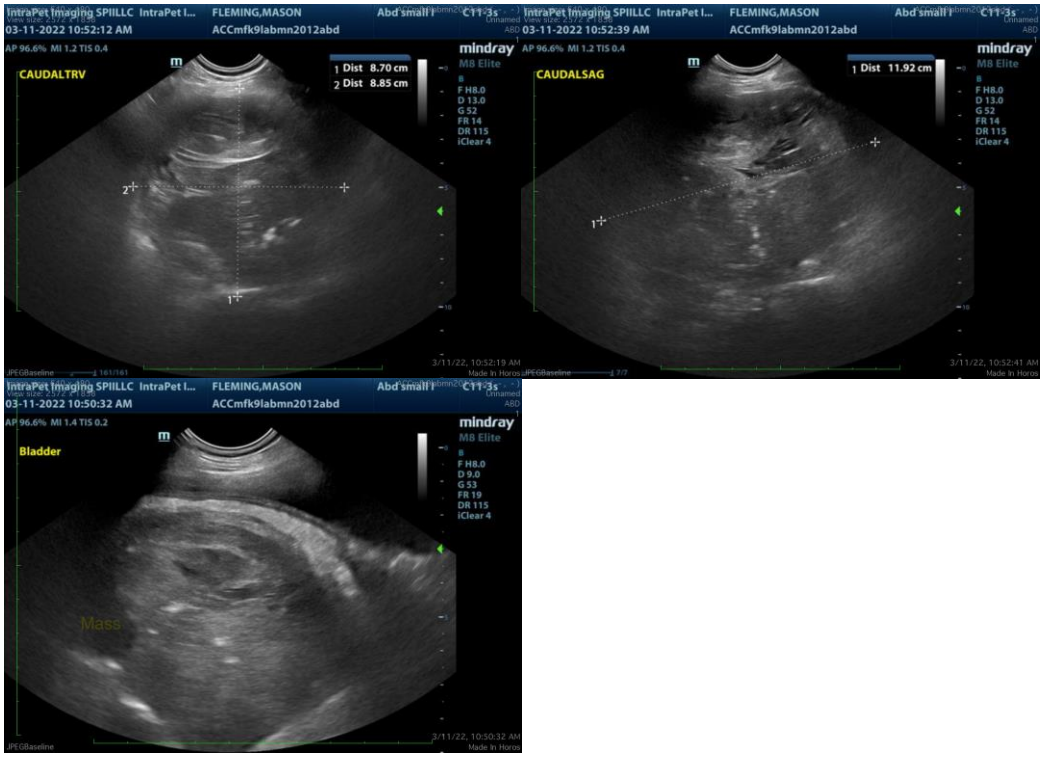
- A urinary bladder density that appears most consistent with mucus or debris vs. tissue. Small nodule or polyp cannot be ruled out, but is considered less likely given the lack of color flow doppler uptake.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Recommendations for this patient include discussion with the owners about the patient's neuter status and if both testicles were descended and removed at the time of neuter, as well as a rectal exam if not already evaluated for assessment of prostate, anal glands, etc., that may be a source of primary disease with a metastatic lymph node.

Three view thoracic radiographs are recommended for further assessment of possible metastatic disease. A fine needle aspirate of the mass could be considered if the patient's coagulation status is appropriate, understanding that hemorrhage is possible given the cavitated nature of the mass. Ideally, a surgical excisional biopsy would be performed for mass removal and biopsy with a potential presurgical planning abdominal CT if elected.





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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