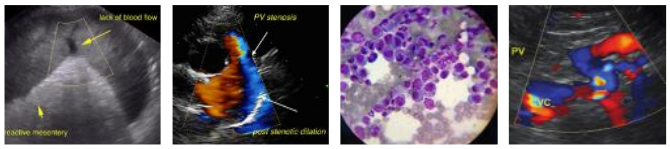
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Sophie Foster

SPECIES

Canine

BREED

Cocker

SEX

Spayed Female

AGE

13

WEIGHT

11.9

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Natasha Stanley

HOSPITAL NAME

Viking VH

REFERRING VET

Natasha Stanley

INVOICE

21629

DATE

3/14/23

PRESENTING CLINICAL SIGNS

History: Chronic off/on vomiting. Thought it was diet and now not so sure. Has been on z/d - helped symptoms for a bit but now they are back. Taking amantadine and gabapentin for pain, adequan injections monthly, acupuncture prn. had AUS at WestVet

Abnormal PE/Chem/CBC/UA Results: attached labs and previous AUS report

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is only mildly distended (empty). Visible contents are anechoic. Urinary bladder wall is unable to be fully assessed for pathology without further distension. No visible masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface.

If there are urinary signs and/or concern for urinary bladder pathology, reassessment after complete filling is recommended.

Left kidney is normal in size (5.12 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.

Right kidney is normal in size (4.95 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

Left adrenal gland is normal in size (0.85 cm at cranial pole and 0.56 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.54 cm at cranial pole and 0.68 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

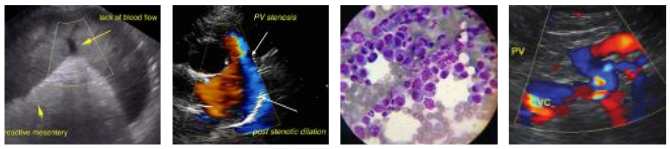
Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). A 1.6 cm x 1.8 cm non-capsule-disrupting hypoechoic nodule is noted in the mid body. Splenic vasculature appears normal.

Liver

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.

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



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The visible stomach wall is normal in thickness 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. 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 and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The observed pancreas appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is no evidence of peritoneal effusion. There is no apparent lymphadenopathy. There are images provided of a discrete, approximately 7.0 cm in size, iso- to hyperechoic homogenous mass, however, the location and origination cannot be determined in these images.

ULTRASONOGRAPHIC 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.

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

- The homogenous iso- to hyperechoic mass pictured is of unknown origination. Differentials include lymph node vs bowel vs spleen vs liver vs other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If possible, additional ultrasonographic images of the mass described above with location identified, and if possible, tracing to organ attachment, etc., could be considered or if not possible, an abdominal CT scan could be considered. Additionally, a fine needle aspirate of the structure is recommended, if patients coagulation status is appropriate.

In the meantime, given this patients reported gastrointestinal signs, and the previous partial improvement with transition to a z/d diet, a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function, followed by empirical deworming with a 5-day course of Panacur, as well as transition to an alternate hydrolyzed protein diet, as some patients respond better to one brad vs another of a hydrolyzed protein diet.

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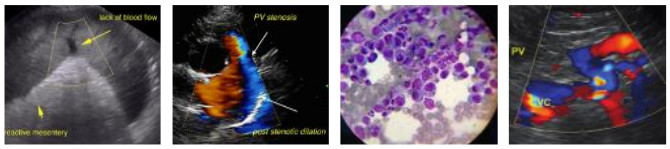

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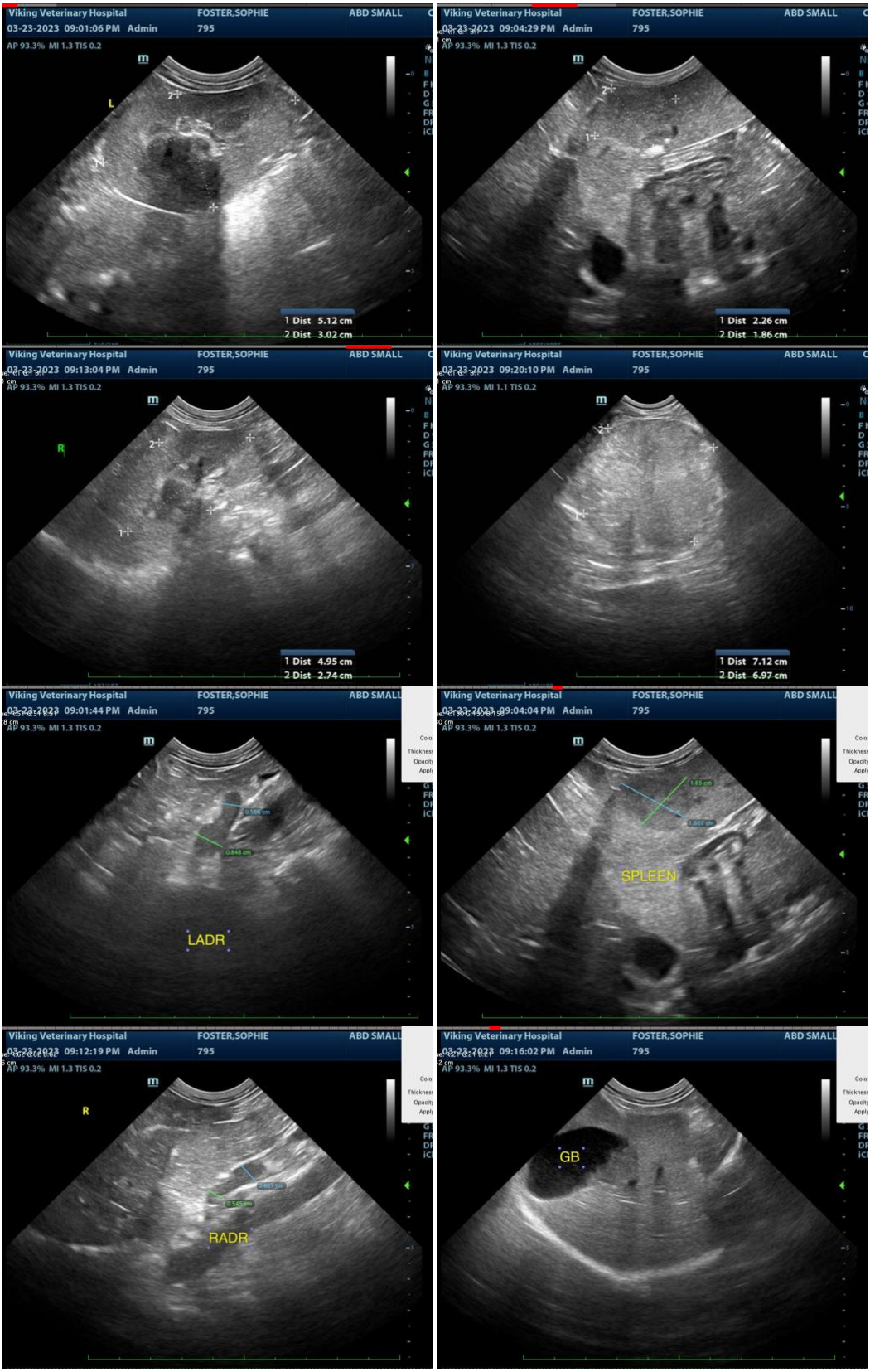

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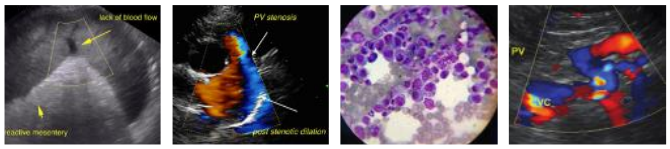

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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