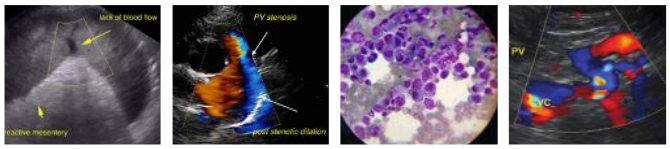
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Rosie Jones

SPECIES
Canine

BREED
GSD

SEX
Female

AGE
12 Years

WEIGHT
67 Pounds

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Amanda Favis

HOSPITAL NAME
Ruidoso AC

REFERRING VET
Amanda Favis

INVOICE
21944

DATE
4/10/23

PRESENTING CLINICAL SIGNS

History: Intermittent urinary incontinence, proprioceptive deficits in LH leg

Abnormal PE/Chem/CBC/UA Results: USG 1.018, no other concerns noted on BW or UA

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 (7.06 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 (7.84 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

Left adrenal gland is plump/swollen in size. Normal shape and contour is maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. The left adrenal gland measures 1.5 cm at the cranial pole and 1.0 cm at the caudal pole.

Right adrenal gland is unable to be well visualized in these images.

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). No focal nodules or masses are observed. Splenic vasculature appears normal.

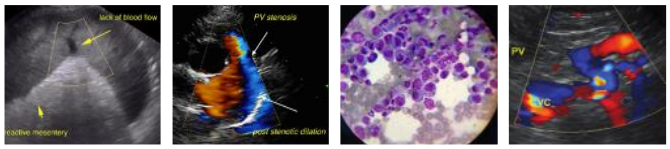
Liver

Liver is relatively normal in size and contour. Parenchyma is mildly heterogenous and coarse with mild likely age-related parenchymal remodeling noted. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

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

Gastrointestinal

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.



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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 a scant amount of anechoic free fluid adjacent to the spleen. In the mid caudal abdomen, just caudal and medial to the spleen, there is a 10.3 cm x 8.2 cm, heterogenous cavitated mass of unknown tissue origin.

Other

The left ovary is visualized and contains multiple anechoic cystic areas. The right ovary is not well visualized in these images. There is no obvious uterine pathology noted in these images but it cannot be ruled out.

ULTRASONOGRAPHIC FINDINGS

- A mid caudal abdominal mass of unknown origin could be a splenic mass without a visible attachment to the spleen present in these images, or given the lack of ability to visualize normal right adrenal gland and right ovary, a right ovarian mass or adrenal mass are differentials, as is lymph node, bowel, uterus, etc. Regardless, infiltrative neoplasia is the top differential. A benign cyst, hematoma or even abscess, however, is possible, and can't be ruled out without tissue sampling.
- Left adrenomegaly is consistent with possible adrenal hyperplasia, secondary to pituitary dependent hyperadrenocorticism vs stress or even normal patient variant. An adrenal adenoma is also possible and would be higher on the list of differentials with a concurrently small right adrenal gland.

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 abdominal mass could be considered if patients coagulation status is appropriate, however, given the concurrently reported mammary mass, as well as the cystic ovary, etc., alternatively, an exploratory laparotomy for planned mass removal, at which time an ovariohysterectomy could be performed, as well as mammary mass removal, may be a better option. If surgery is elected, a presurgical planning abdominal CT scan could be considered for further clarification about tissue origin of the mass described above.

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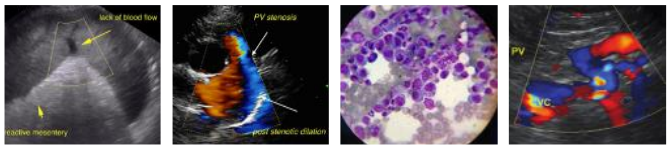

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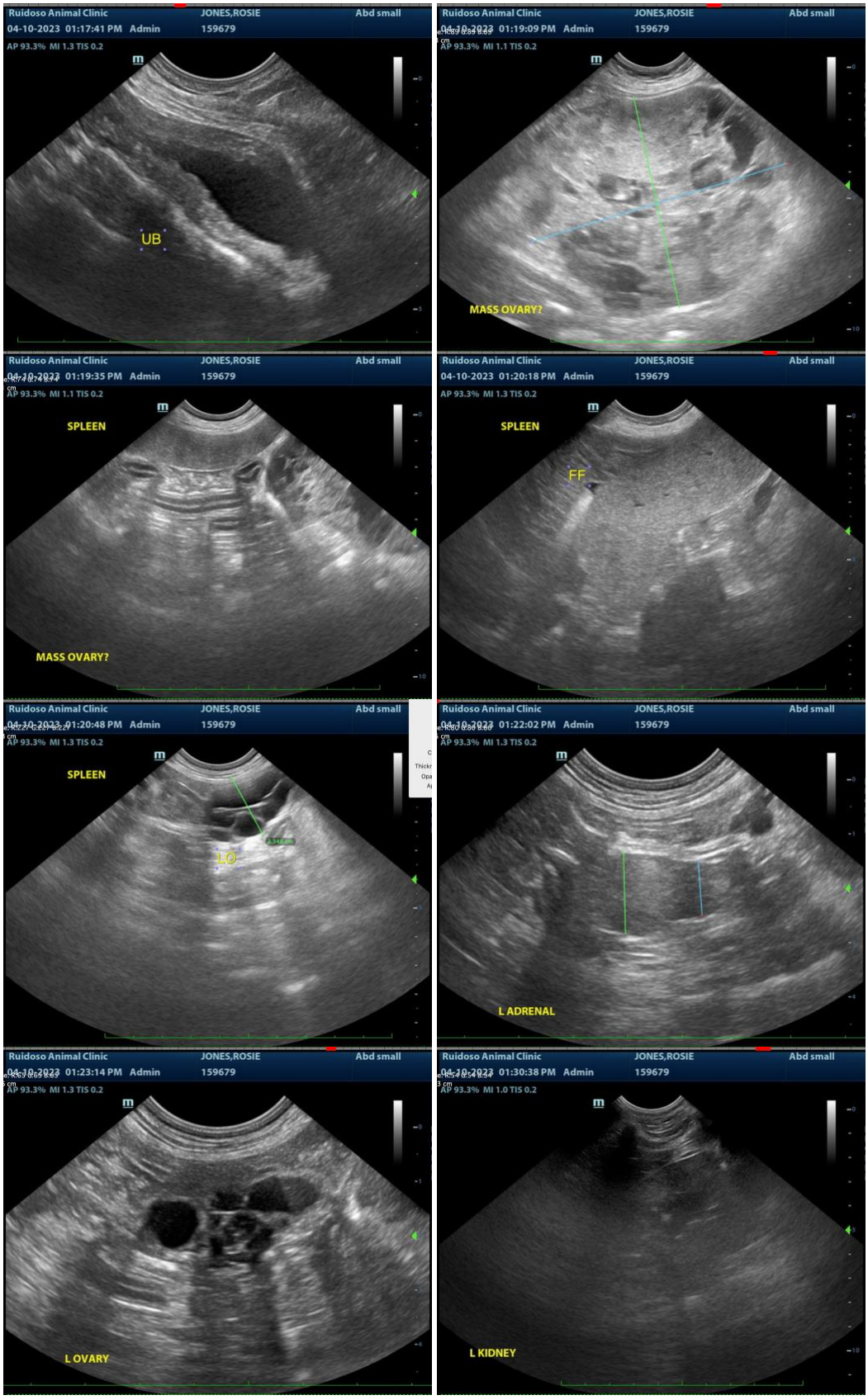

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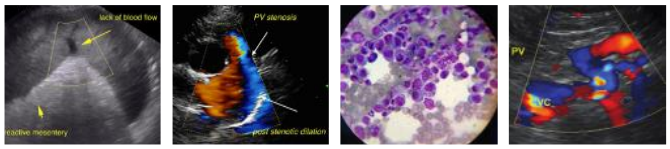

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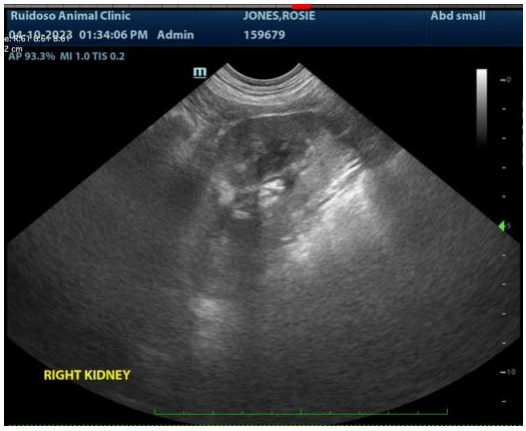

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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