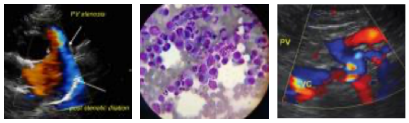
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
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DATE

4.14.2023

PATIENT

Bear Bauer

SPECIES

Canine

BREED

Labrador Retr

SEX

Neutered Male

AGE

7/30/2010

WEIGHT

56.3 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Timonium AH

REFERRING VET

Dr. McIntyre

INVOICE

12728

PRESENTING CLINICAL SIGNS

Severe PU/PD.

Current Medications: Enrofloxacin 204mg SID.
Lab Results: 3/6/23- CBC WNL. Chem: ALP 2100, ALT 360, GGT 33. UA 1.004. 4/11/23 ACTH stim pre 1, post 11.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Andi Parkinson, BS, RDMS.

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.

The prostate is unable to be visualized in these images.

The right kidney is normal in size (7.32 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. A hyperechoic band parallel to the corticomedullary border is present.

The left kidney is normal in size (6.81 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. A hyperechoic band parallel to the corticomedullary border is present.

Adrenal Glands

The area of both adrenal glands is examined without evident adrenal gland pathology.

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). A 3.50 x 2.80 cm mixed heterogenous, primary hypoechoic nodule/mass, non-capsule disrupting near the head 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. Visible vasculature and biliary tree appear normal without distension or congestion. In the cranial abdomen, presumably attached to the liver (based on these images) There is a large 17+ x 14+ cm heterogenous microcystic, primarily hyperechoic mass.

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 visible stomach wall is normal in thickness (canine < 0.5 cm) (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.
There is no apparent lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- A large caudal liver mass. Differentials which include both benign as well as infiltrative neoplastic disease, such as nodular hyperplasia, a benign adenoma/hepatoma, versus hepatocellular carcinoma versus sarcoma, round cell neoplasia, etc. It cannot be differentiated hepatic tissue sampling.

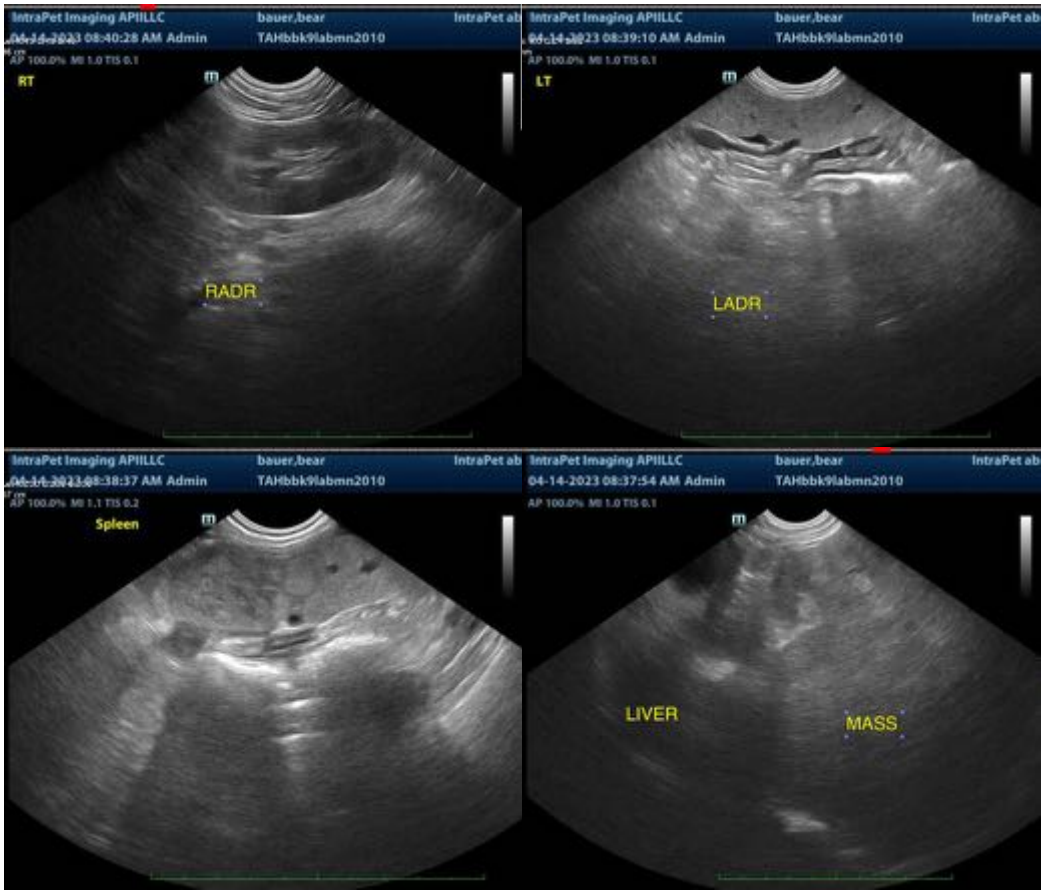
- The liver nodule could also represent a benign lesion such as a cyst, hematoma, nodular hyperplasia, extramedullary hematopoiesis. However, similarly, infiltrative neoplasia can mimic benign lesions and cannot be ruled out without tissue sampling.

- Bilateral medullary rim sign - This finding is of unknown clinical significance and can be a normal variant, often idiopathic. Medullary rim sign can be present with renal disease, lymphoma, hypercalcemic nephropathy, Leptospirosis, tubular disease, other and should be interpreted in combination with other more specific indications of kidney disease such as isosthenuria, proteinuria, azotemia, etc. This is a common incidental finding in patients with diabetes mellitus.

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.

- Fine-needle aspirates of the liver and spleen can be considered if the patient's coagulation status is appropriate. Alternatively, an exploratory laparotomy could be planned for a splenectomy and liver lobectomy/mass removal. The mass is very large, but appears caudal in the liver with normal hepatic parenchyma cranial to it. Definitive resectability cannot be guaranteed via ultrasound alone, but appears possible. If surgery is elected, a pre-surgical planning abdominal CT scan may be helpful.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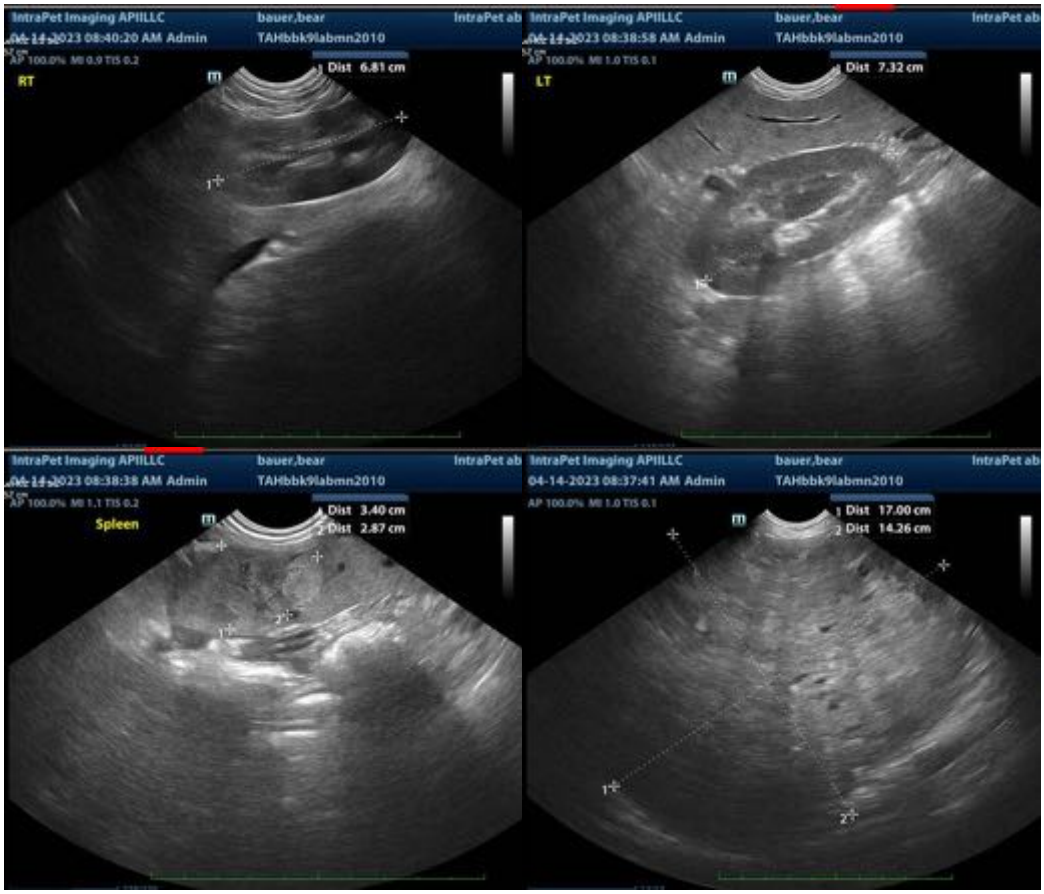
LIVER
MASS



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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