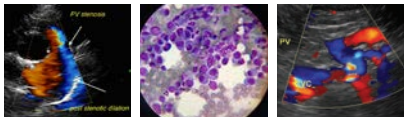
IMAGING PERFORMED BY

IntraPet.com



SonoPath

Clinical Sonography & Telecytology

EDUCATIONAL TELECONSULTATION SERVICES™

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DATE

6/16/22

PATIENT

Sandy Ledlich

SPECIES

Canine

BREED

Puggle

SEX

Spayed Female

AGE

1/30/11

WEIGHT

28.2 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Rachel Brilhart RDMS

HOSPITAL NAME

Parkville AH

REFERRING VET

Dr. Suter

INVOICE

38797

PRESENTING CLINICAL SIGNS

Distended; firm mass effect on the left cranial/mid abdomen.

Current Medications: Galliprant 20mg SID, Thyrotabs 0.25mg BID.
Radiographs: Abdominal radiographs - 12.8 cm mass in the left mid abdomen unable to determine the origin (liver, spleen, or GI).
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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.

The right kidney is normal in size (5.45 cm) and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased echogenicity and mild loss of corticomedullary distinction. There is no evidence of mineral or infarcts observed. Very mild pyelectasia present.

The left kidney is normal in size (5.46 cm) and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased echogenicity and mild loss of corticomedullary distinction. There is no evidence of mineral or infarcts observed. Very mild pyelectasia present.

Adrenal Glands

The right adrenal gland is normal in size (2.0 cm long x 0.69 cm at the cranial pole and 0.70 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 (1.9 cm long x 0.71 cm at the cranial pole and 0.70 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

The spleen contains san approximately 8-10 cm mixed heterogeneous, cavitated splenic mass disrupting the capsule. The remainder of the spleen is normal, and splenic vasculature appears normal.

Liver

Liver is subjectively enlarged with rounded margins. Parenchyma is heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. One specific focal, hypoechoic nodule is noted caudal to the gallbladder, measuring 1.6 cm in diameter. This nodule does not appear to disrupt curvilinear architecture. Visible vasculature appears normal.

GB is moderately distended with anechoic bile and gravity dependent echogenic sediment. 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

The stomach wall is normal in thickness (canine < 0.5 cm and 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 peritoneal effusion. There is no apparent lymphadenopathy.

PRIMARY FINDINGS

- Large, heterogeneous, cavitated splenic mass – most concerning for infiltrative neoplasia such as sarcoma. Benign lesions can mimic aggressive tumors and cannot be ruled out, but is considered less likely.

- Heterogeneous liver with a specific focal, hypoechoic nodule caudal to the gallbladder that likely represents nodular hyperplasia. However, a metastatic lesion cannot be ruled out.

SECONDARY FINDINGS

- 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.

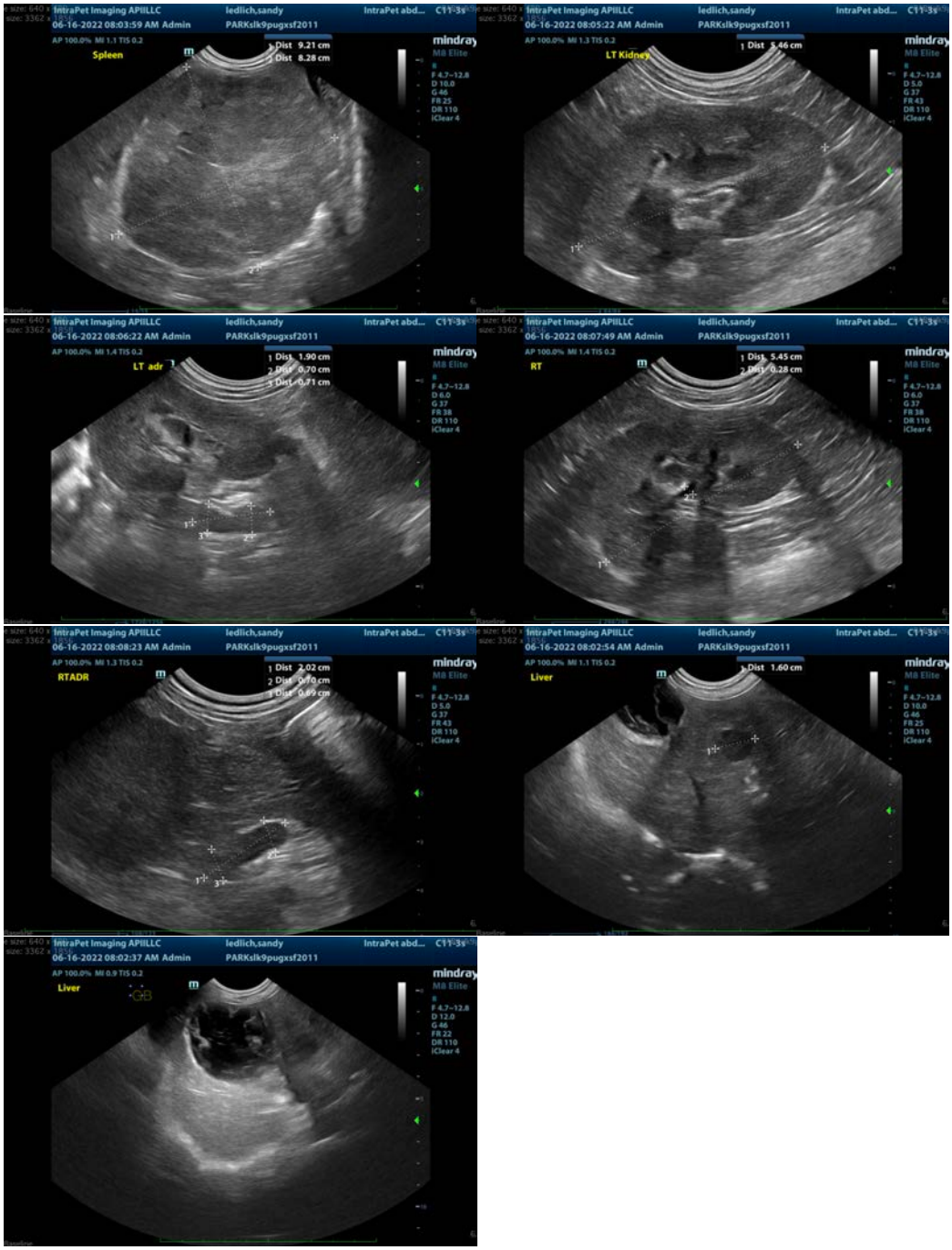
- Chronic Kidney Disease with mild pyelectasia - This appearance of the kidneys is consistent with chronic kidney disease such as chronic glomerular or interstitial nephritis, chronic pyelonephritis, etc.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- 3-view thoracic radiographs are recommended, if not already evaluated, for further evaluation for possible metastatic disease.

- Coagulation panel is recommended to assess coagulation status.

- Surgical laparotomy for splenectomy and liver nodule biopsy.


IntraPet Imaging APIILLC
ledlich,sandy
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PARKslk9pugxsf2011
Spleen
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Dist 8.28 cm
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M8 Elite
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RTADR
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Liver
Dist 1.60 cm
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Liver
GB

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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