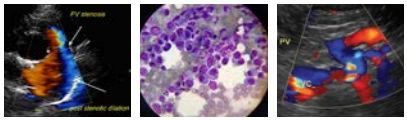
IMAGING PERFORMED BY

IntraPet.com



SonoPath

Clinical Sonography & Telecytology

EDUCATIONAL TELECONSULTATION SERVICES™

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DATE

6/21/23

PATIENT

Gil Palmer

SPECIES

Canine

BREED

Labrador X

SEX

Neutered Male

AGE

7/15/13

WEIGHT

63 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Eldersburg Vet

REFERRING VET

Dr. Alper

INVOICE

43348

PRESENTING CLINICAL SIGNS

Pt has been historically healthy but starting 4 days ago pt was eating less. Pt has progressed to not eating at all. Pt has had some diarrhea in the last 24 hours. Pt has not been vomiting but has been drinking more water.

Current Medications: Entyce, Proviable, Yunnan Baiyoo
Lab Results: CBC: Retic hgb 17.4, WBC 22.1, neut 17.93, Mono 2.31, plt 77k, MPV 16.6, plateletcrit 0.13
PCV/TS: 40%/ 6 g/dL. Chem: Amyl 1630
Radiographs: One large mass, most likely on liver and one moderate size mass most likely on spleen, no free fluid chest or abdomen
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Declined.
Imaging Performed By: Rachel Brilhart, 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 area of the prostate was examined without evident prostatic pathology.

The right kidney is normal in size (6.52 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 (6.95 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

The right adrenal gland is unable to be well visualized in these images without sedation, which was reportedly declined due to the amount of pathology present elsewhere.

The left adrenal gland is normal in size (3.04 cm long x 0.73 cm at the cranial pole and 0.79 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large in size with a swollen and scalloped/undulating capsular contour. Multifocal coalescing nodules are noted throughout the parenchyma. Additionally, there is an approximately 5.0 cm heterogeneous, cavitated mass that results in capsular bulge. Splenic vasculature appears normal. Enhanced hyperechoic surrounding fat is noted.

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. A large 10 cm x 14+ cm heterogeneous, cavitated mass is noted that appears to originate from the mid caudal liver. 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 (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 a trace amount of anechoic free fluid noted in the cranial abdomen.

There is no apparent lymphadenopathy noted in these images.

There is no evidence of heart base or pericardial pathology noted in these images at this time. If cardiac function evaluation is desired a full echocardiogram is recommended.

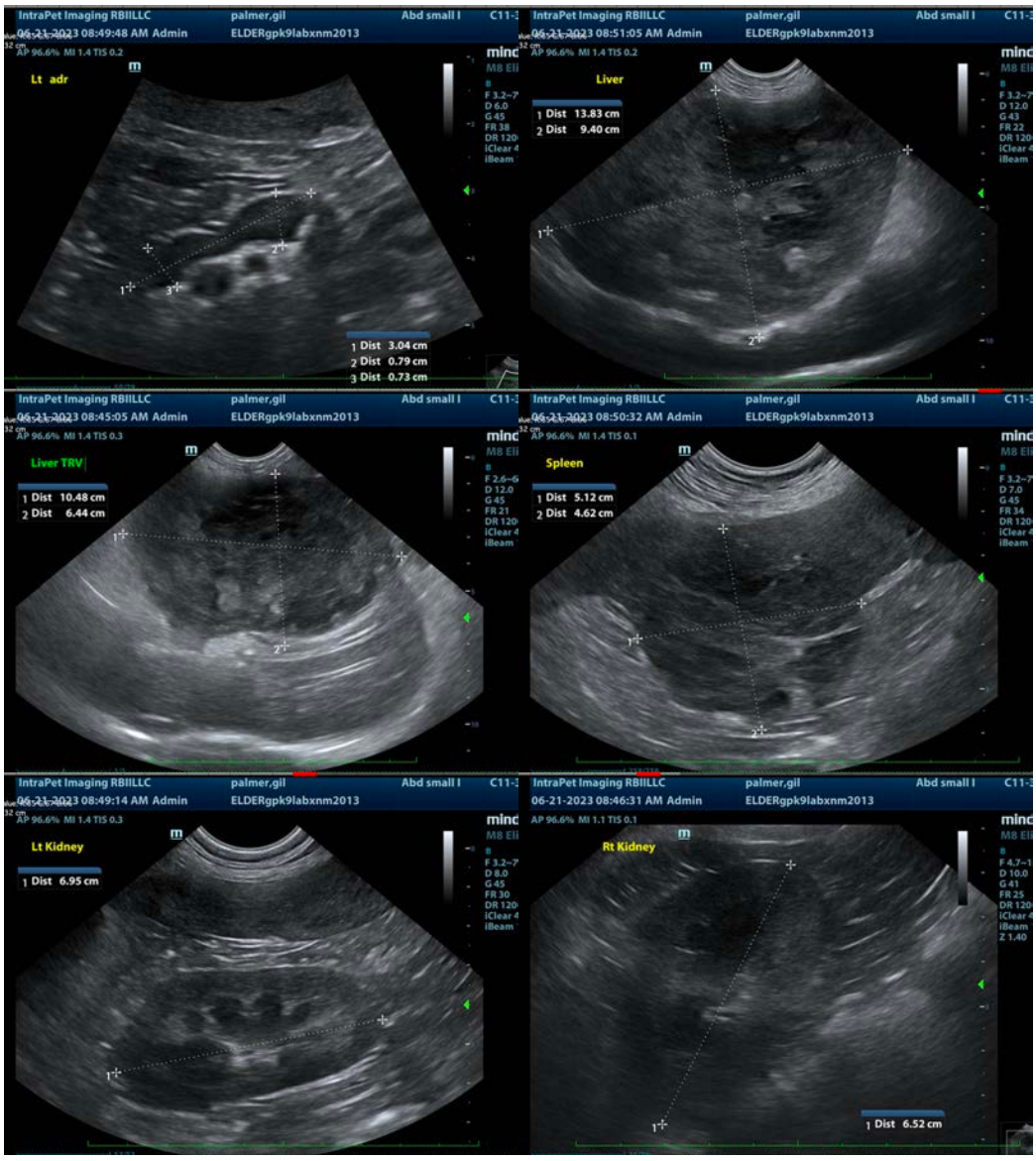
ULTRASONOGRAPHIC FINDINGS

- Cavitated splenic and liver masses with concurrent free fluid – most concerning for infiltrative neoplasia such as sarcoma or potentially less likely round cell neoplasia versus other. Benign cysts, hematomas, extramedullary hematopoiesis, etc. are possible but considered exceedingly less likely, given the multifocal nature of the pathology.

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.

The free fluid is trace, but if possible, sampling would be helpful to know whether or not this patient has a hemoabdomen. If sampling is not possible now, pending further workup and treatment elections monitoring of the amount of free fluid should be considered. A fine needle aspirate of the spleen and/or liver masses could be considered if patient's coagulation status is appropriate. However, given the concern for possible hemoabdomen, alternatively an exploratory laparotomy for planned splenectomy and liver lobectomy could be considered. While the mid caudal liver mass appears to originate from the liver, definitive origin of liver versus a 2nd splenic mass adjacent to the liver can't be 100% definitively determined. Therefore, if surgery is elected and it alters the plan, a pre-surgical planning/staging CT scan could be considered. Additionally, CT scan could help further determine resectability of the liver mass, 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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