



PATIENT

Satchmo Copper

SPECIES

Canine

BREED

Sheltie

SEX

Neutered Male

AGE

14 Years

WEIGHT

23.4 Pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Meghan Myers, DVM

HOSPITAL NAME

Hershire AH

REFERRING VET

Meghan Myers, DVM

INVOICE

16301

DATE

6/24/22

PRESENTING CLINICAL SIGNS

History: hyporexia for 3 days, was vomiting 4 days ago but none since cerenia given. mild lethargy.

Abnormal PE/Chem/CBC/UA Results: bun increased - 85 sodium increased- 166 amylase increased 1680 snap pancreas- abnormal usg- 1023, cocci (was free catch sample) xrays- hepatomegaly- was present when xrays taken 6 months ago

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately 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 area of the prostate is examined without evidence of evident pathology.

Kidneys are bilaterally normal in size, irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted and no mineral is observed. Bilateral cortical cysts were present. The left kidney measures 3.9 cm. The right kidney measures 4.4 cm.

Adrenal Glands

Left adrenal gland can be partially visualized and measures 0.5 cm thick. The remainder of the gland is unable to be visualized in these images.

Right adrenal gland is normal in size (0.7 cm at cranial pole and 0.65 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 1.0 cm x 1.6 cm hyperechoic nodule was present in the mid body with a slight hypoechoic rim. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged (swollen contour) without disruption of architecture. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen and falciform fat. The right caudal liver appears more discretely round and measures 6.0 cm x 7.0 cm with the appearance of an emerging homogeneous isoechoic mass. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is mildly overdistended with a moderate amount of non-dependent, mildly aggregated/inspissated sludge. Hypo to anechoic cystic areas are noted between the gallbladder sludge and luminal wall. The wall is otherwise smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion.

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.

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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.

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

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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

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There is no evidence of peritoneal effusion. There is no apparent lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

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- 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. The non-dependent nature of this sludge combined with the cystic areas are suggestive, however, of possible emerging cystic mucosal hyperplasia or early gallbladder mucocele.

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- Hyperechoic hepatomegaly. This appearance is most consistent with a benign steroid (endocrine) hepatopathy or reactive or idiopathic hepatopathy. Infiltrative neoplasia such as round cell neoplasia is also possible but considered less likely. Some concern for an emerging mass with both benign, as well as neoplastic differentials being possible., benign hepatoma versus neoplastic well differentiated hepatocellular carcinoma, etc. being differentials.

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- A hyperechoic splenic nodule, which may be a benign myelolipoma or fibrosis or calcification of an old hematoma or infarct, granulomatous lesion, etc. However, the mild hypoechoic rim around the nodule is slightly concerning for a more aggressive nodule, with a metastatic or infiltrative neoplastic lesion unable to be ruled out.

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Secondary Findings

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- The 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

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1. 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.

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2. This patients gastrointestinal signs and reported abdominal pain may be secondary to the emerging mucocele, in which case a cholecystectomy is recommended. However, given the concurrent findings, the potential liver mass and the splenic nodule, as well as the laboratory



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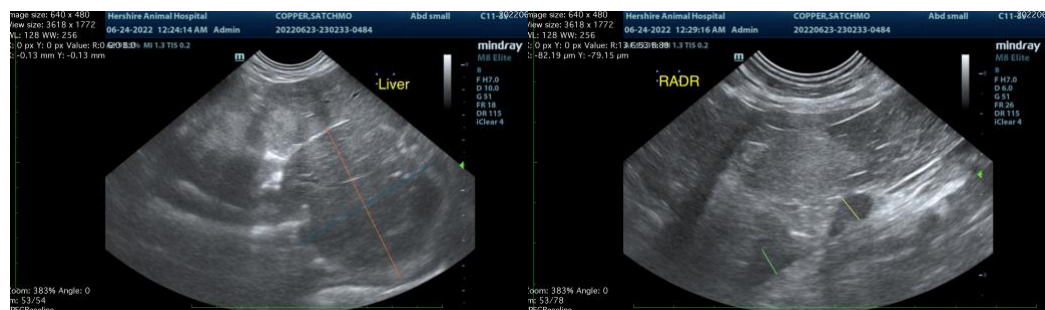
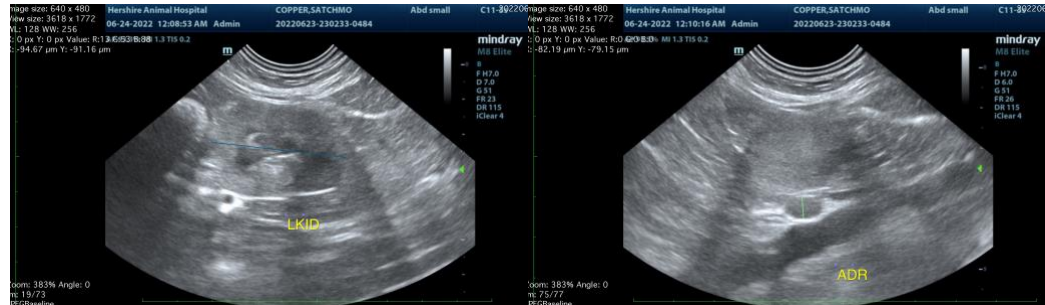
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changes indicative of kidney disease, a more conservative approach including a fine needle aspirate of both the spleen and liver, if patients coagulation status is appropriate, while beginning supportive management of the kidney disease and GI signs with IV fluids, antiemetics, gastroprotectants, appetite stimulants (as indicated), pain management and broad-spectrum antibiotics may be warranted first. If there is not an improvement in clinical signs, pain, etc. and/or a progression, a cholecystectomy is likely the indicated approach.



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.



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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.

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