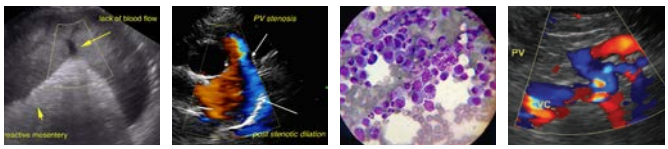
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Bonita Baker

SPECIES
Canine

BREED
Basset Hound

SEX
Female

AGE
10 Years

WEIGHT
15 kg

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Dr. Laura De Cordon

HOSPITAL NAME
Mason Dixon Animal Emergency

REFERRING VET
Dr. Laura de Cordon

INVOICE
39090

DATE
6/29/22

PRESENTING CLINICAL SIGNS

-Sr. pet--patient appears stable overall but slightly increased resp. effort and duller lung sounds -rule out possible aspiration
Abnormal PE/Chem/CBC/UA Results: EENT - very small amount of clear nasal discharge from the left nostril head wrap remains in place (from laceration repair on Monday 6/27) RESP - Abnormal slightly increased resp. effort and dull lung sounds in all fields INTEG Abnormal AS--ear laceration site healing well; sutures remain intact and no swelling or discharge noted SPO2 at presentation--98%

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is mildly to moderately distended with anechoic contents. Apical urinary bladder wall is diffusely thick (0.38 cm thick). Mucosa is hyperechoic and irregular. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface.

The right kidney is normal in size (5.6 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 (5.3 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 visualized.

The left adrenal gland is normal in size (0.53 cm at the cranial pole and 0.68 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

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 3.0 cm round, isoechoic, homogeneous mass is noted in the mid body, disrupting the capsule. Splenic vasculature appears normal.

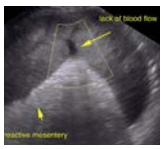
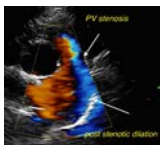
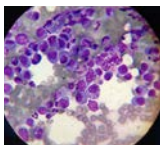
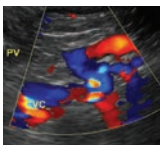
Liver

The liver is subjectively enlarged in size with irregular margins. Parenchyma is heterogeneous, characterized by multifocal discrete hypoechoic nodules within an otherwise normal parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion.

The gallbladder is non-distended in size. The wall is edematous. 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 mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is 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 (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

A scant amount of anechoic free fluid was present in the abdomen. Pericardial effusion is present, as is a scant amount of suspected pleural effusion.

PRIMARY FINDINGS

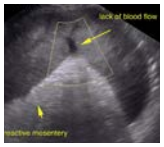
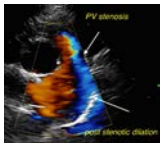
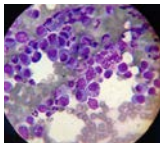
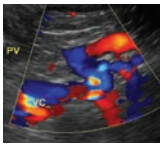
- Tri-cavitary effusion – suspected to be secondary to cardiac tamponade from the pericardial effusion. Rule outs include heart base mass not visible in these images versus idiopathic pericardial effusion versus other.
- Splenic mass – concerning for infiltrative neoplasia such as round cell neoplasia or hemangiosarcoma can't be ruled out, despite the lack of cavitations. Benign lesion such as extramedullary hematopoiesis, nodular hyperplasia, etc. can't be ruled out, but is considered less likely, especially given the presence of pericardial effusion.
- Hypoechoic liver nodules – concerning for infiltrative neoplasia or metastatic disease. Benign nodular hyperplasia can appear similar and can't be ruled out, but this finding is considered more serious, given the concurrent splenic and pericardial changes.

SECONDARY FINDINGS

- Chronic Cystitis – Urinary bladder wall changes are most consistent with chronic cystitis. Infiltrative neoplasia cannot be ruled out but is considered less likely give the location and diffuse nature of the changes.
- Edematous gallbladder wall – likely secondary to the tamponade.

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.
- Echocardiogram for further evaluation of the heart and heart base.
- In the meantime, pericardiocentesis to remove the pericardial effusion and therefore eliminate the tamponade, is warranted. **Prior to pericardiocentesis, platelet count and coagulation panel are recommended to rule out a coagulopathy as a source of possible hemorrhage.

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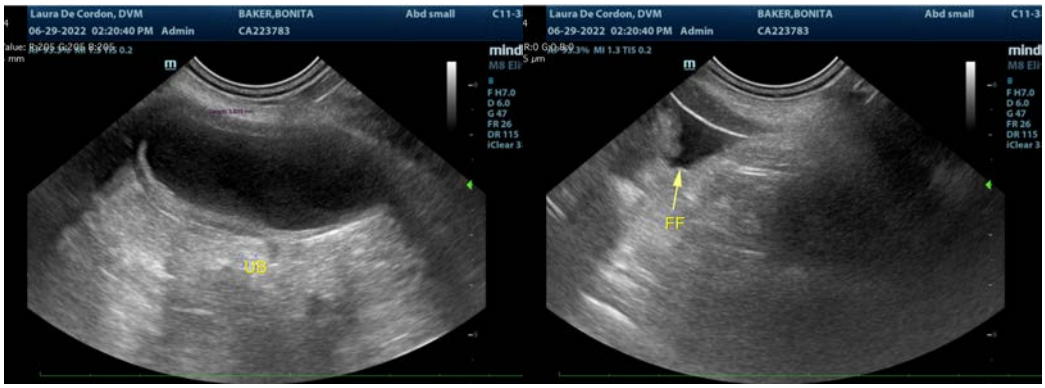
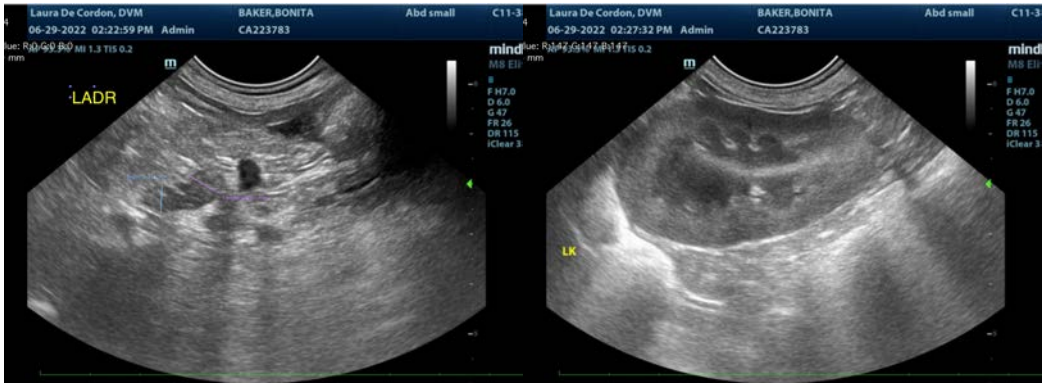
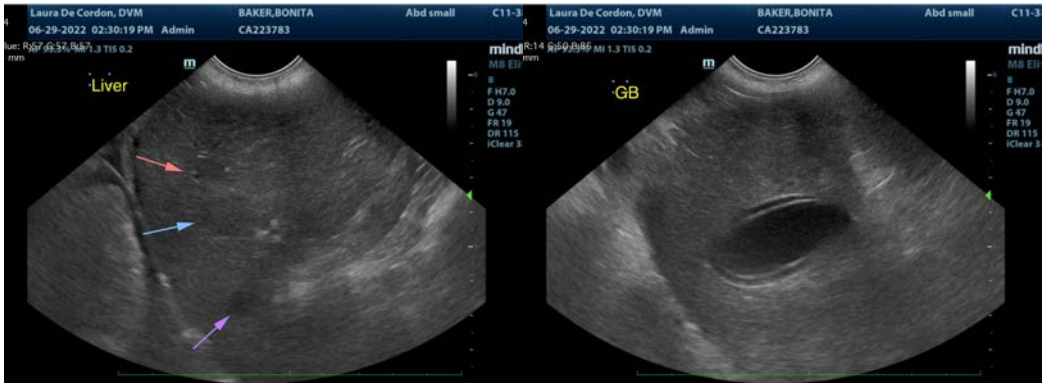
- After the patient is stable, and if coagulation status is appropriate, a fine needle aspirate of the splenic mass and liver could be considered for further definitive diagnosis of suspected infiltrative disease.







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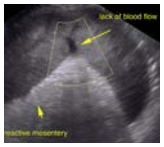
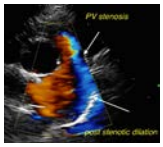
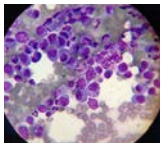
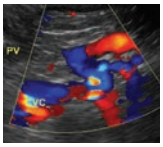

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
Beth.Johnson@sonopath.com