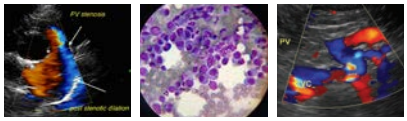
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

DATE

6/7/22

PATIENT

Lilly Byrne

SPECIES

Canine

BREED

Spitz

SEX

Spayed Female

AGE

11/10/15

WEIGHT

26.7 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Rachel Brilhart RDMS

HOSPITAL NAME

Pleasantville AH

REFERRING VET

Dr. Gounaris

INVOICE

38463

PRESENTING CLINICAL SIGNS

ADR for several weeks, decreased appetite. Large mid abdominal mass palpated believed to be spleen on PE remaining PE unremarkable

Current Medications: None.
Lab Results: Blood chem and cbc largely WNL mild ALP elevation
Radiographs: Show large mid abdominal mass in the area of the spleen
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Declined.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic contents. No masses or inflammatory changes. Several approximately 0.5 cm, mineral shadowing cystoliths are settled on the dependent wall. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The right kidney is normal in size (5.82cm), 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 (5.27 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 normal in size (2.16 cm long x 0.73 cm at the cranial pole and 0.63 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 (1.54 cm long x 0.54 cm at the cranial pole and 0.51 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). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

The left caudal liver architecture is completely disrupted by a large 8.0 cm x 13.0 cm mixed heterogeneous, partially cavitated mass. Several small 1-2 cm hypoechoic nodules are present within an otherwise normal appearing right side of the liver.

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 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.

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 or pericardial effusion. There is no apparent lymphadenopathy.

PRIMARY FINDINGS

- Large, heterogeneous, cavitated left liver mass – most concerning for infiltrative neoplasia.

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.

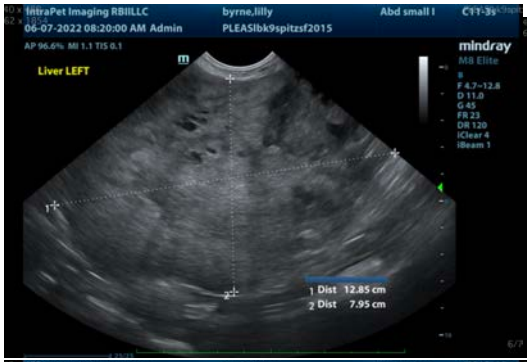
- Urinary bladder cystoliths

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Recommendations include:

1. 3-view thoracic radiographs for further evaluation of possible metastatic disease, if not recently evaluated.

2. Surgical laparotomy for excisional biopsy to address the large liver mass. Due to the caudal pedunculated location of the mass, torsion is considered a risk without surgery. Pre-surgical CT scan could be considered for surgical planning. If surgery is elected, removal of the cystoliths is recommended at the same time.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byrne,lilly
Abd small I
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Liver LEFT
mindray
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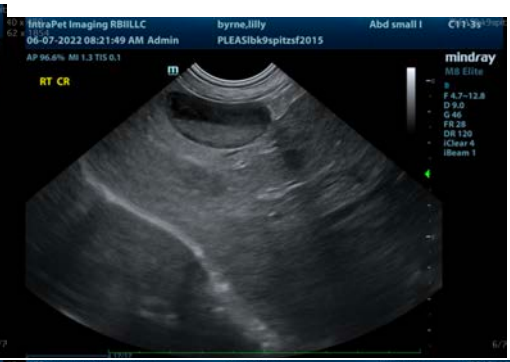
2 Dist 7.95 cm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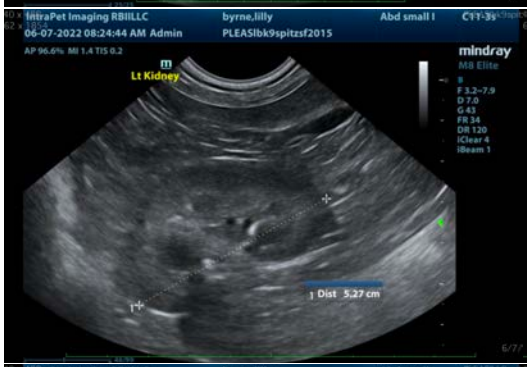
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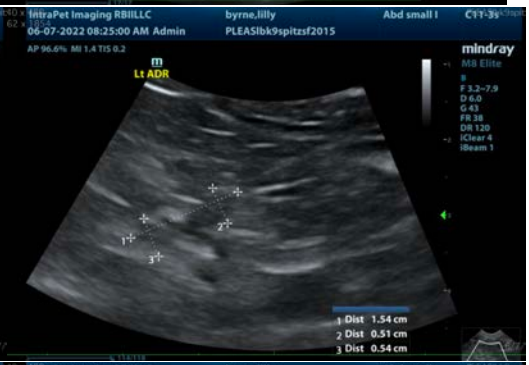
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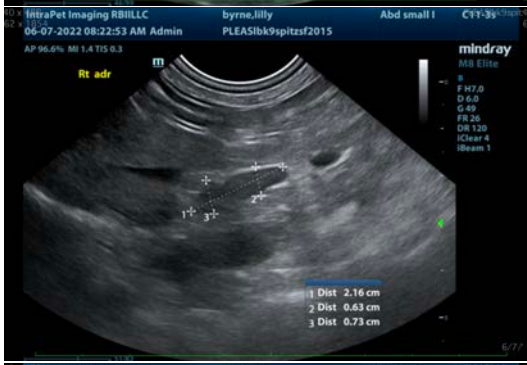
2 Dist 0.51 cm
3 Dist 0.54 cm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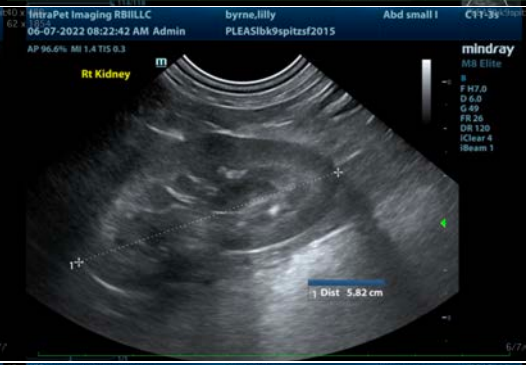
3 Dist 0.73 cm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Rt Kidney
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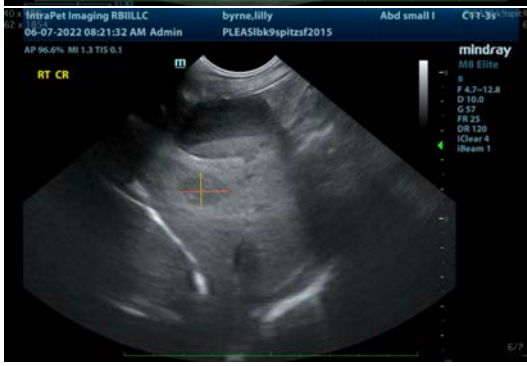
1 Dist 5.82 cm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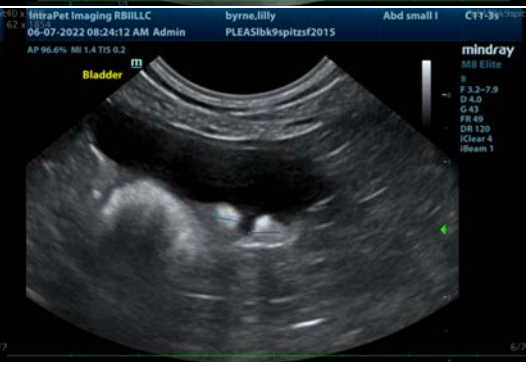
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Bladder
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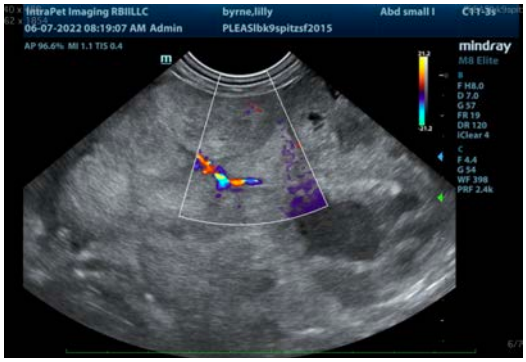
M8 Elite



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