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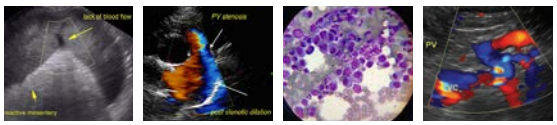

ANIMAL SOUNDS NW
MOBILE VETERINARY ULTRASOUND
IMAGING PERFORMED BY
AnimalSoundsNW.com 541-357-9423

PATIENT

Simon Hiday

SPECIES

Canine

BREED

Labrador Retriever

SEX

Neutered Male

AGE

12 Years

WEIGHT

88.6 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Sara Hansen

HOSPITAL NAME

West Eugene AH

REFERRING VET

Dr. McCurry

INVOICE

43910

DATE

7/11/23

PRESENTING CLINICAL SIGNS

1) PU/PD going on for approx 1 month. increased need to go outside to potty, especially overnight/in the mornings 2) shaking/tilting head for a little less than 1 month, particularly the LEFT ear seems to be bothering pt the most 3) showing signs of aging/poor mobility over the last 2 months, pt has been struggling a bit more getting around, falling/stumbling, mostly in the hind end/hips

Abnormal PE/Chem/CBC/UA Results: ABNORMAL Labratory Findings ALP 2386 K 5.7 Chol 368 T4 0.8 USG 1.010 Current Medications None Radiographic Findings None taken

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.

Kidneys are overall normal in size 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 cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. The right kidney measures 7.96 cm. The left kidney measures 8.31 cm.

Adrenal Glands

The right adrenal gland is normal in size (1.4 cm at the cranial pole and 0.80 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 (0.82 cm at the cranial pole and 0.84 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 6.8 cm x 6.1 cm, markedly heterogeneous, primarily cystic/cavitated, capsule disrupting mass is noted off the head of the spleen. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

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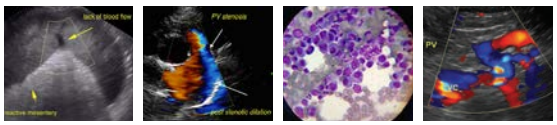

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Gastrointestinal

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 free peritoneal effusion noted in these images.

There is no apparent lymphadenopathy noted in these images.

PRIMARY FINDINGS

- Large cystic/cavitated splenic mass – This could represent infiltrative neoplasia such as a sarcoma. However, cysts, hematomas, extramedullary hematopoiesis, etc. can mimic malignancy and cannot be differentiated without tissue sampling.

- Heterogenous Liver – These changes are most consistent with benign processes such as nodular hyperplasia, steroid (vacuolar) hepatopathy, extramedullary hematopoiesis or possibly chronic inflammatory disease and less commonly infiltrative round cell or metastatic neoplasia.

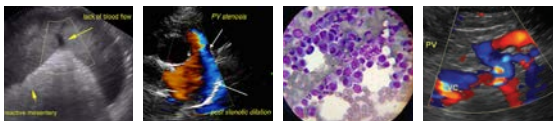
SECONDARY FINDINGS

- Mild 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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The presence of the splenic mass is likely an incidental finding and not related to this patient's PU/PD. Despite that, however, further evaluation is recommended, beginning with three view thoracic radiographs for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

Pending results, an exploratory laparotomy could be considered for planned splenectomy, given the risk of hemorrhage form even a benign cavitated splenic mass. Prior to surgery, a fine needle aspirate of the



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liver could be considered if patient's coagulation status is appropriate to more definitively try to rule out metastatic disease, which is not suspected, but is possible.

Differentials are PU/PD are vast and include, but are not limited to:

Primary polyuria caused by chronic kidney disease, pyelonephritis, liver disease, diabetes mellitus, hyperthyroidism, hypercalcemia, hyperadrenocorticism, hypoadrenocorticism, E.coli infections ie) pyometra in females, polycythemia, central diabetes insipidus or primary nephrogenic diabetes insipidus.

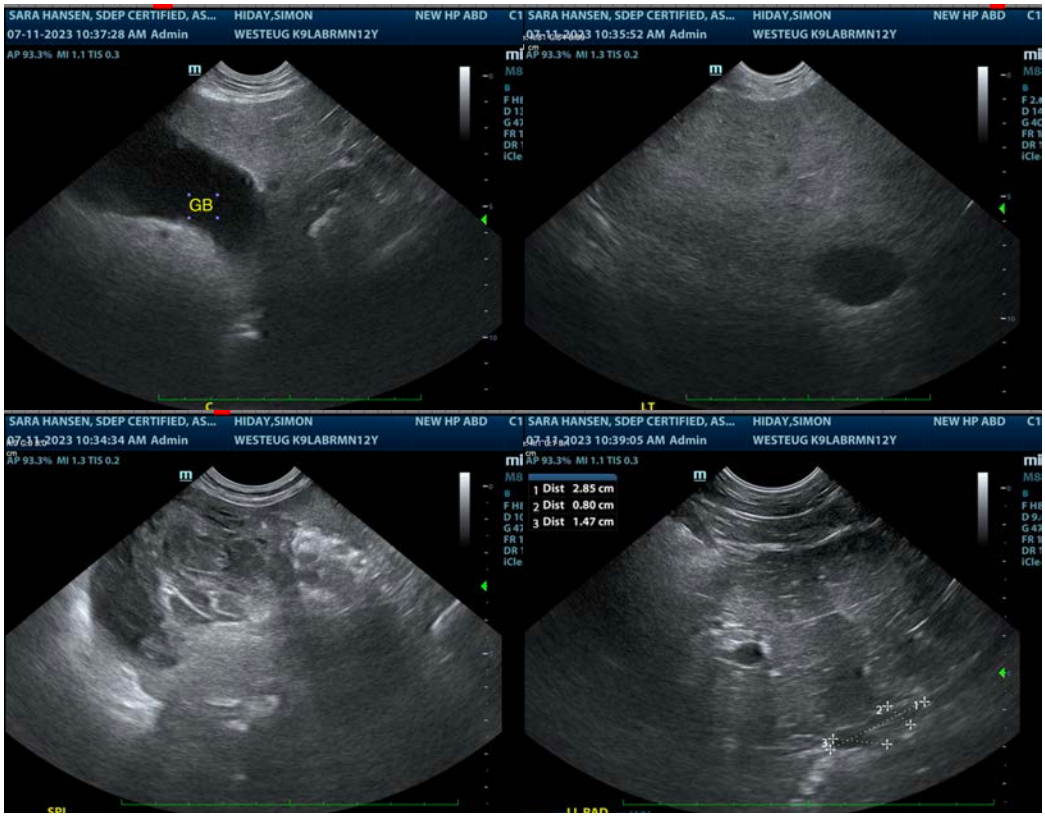
Primary polydipsia caused by psychogenic polydipsia, fever, pain, or central nervous system disease.

Most causes of PU/PD can be diagnosed with a comprehensive history and physical exam, a first AM urine specific gravity to see if urine concentration is possible (as most animals naturally consume less water overnight) followed by a comprehensive CBC, serum chemistry panel, electrolytes, and urinalysis.

If not, next step(s) may include a urine culture, low dose dexamethasone suppression test, T4, bile acids, Leptospirosis testing and/or an empirical course of antibiotics.

If a diagnosis is still not obtained, a more advanced work-up is indicated and consultation with an internist may be warranted.

In this patient specifically, pending choices, results, etc. regarding the splenic mass, a more involved/advanced neurologic workup could be considered, given the additional weakness, falling, etc. reported.



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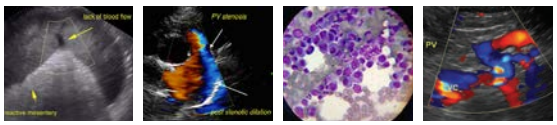

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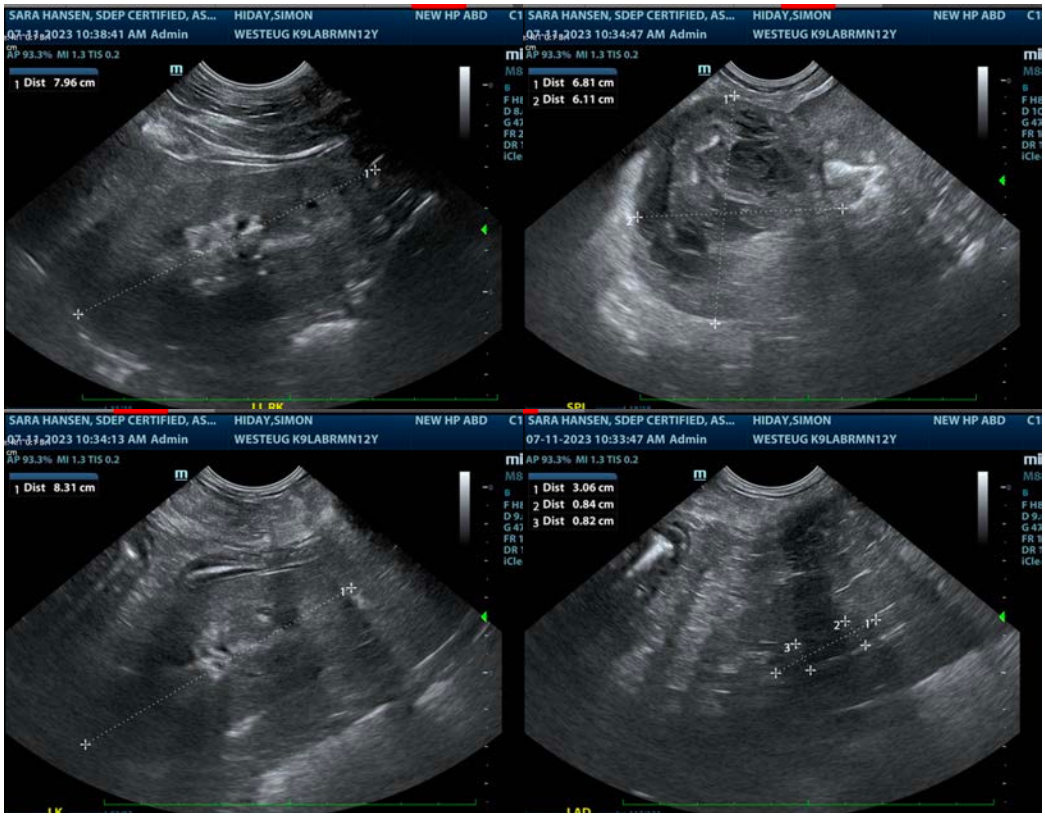

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
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