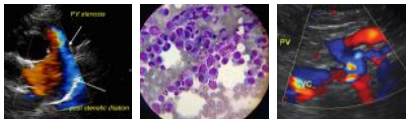
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
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DATE

7/31/23

PATIENT

Tessa Zorn

SPECIES

Canine

BREED

Golden Retriever

SEX

Spayed Female

AGE

5/4/10

WEIGHT

68.7 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Fullerton AH

REFERRING VET

Dr. Unger

INVOICE

23735

PRESENTING CLINICAL SIGNS

History: GI issues still occurring. O reports lose stool. O reports they have well water and fees stool may be improved some with using bottled water but still has soft stools. Issue has been on and off for a few months. Drinking normal. Eating could be better. V/S/C none. O initially thought loose stools were from carprofen and no improvement after carprofen was stopped. Exam unremarkable other than some eyelid masses.

Current Medications: Gabapentin 300mg 1-2 caps BID PRN pain.
Lab Results: unremarkable other than PSL 261 (24-140), Fecals neg. TAMU GI panel pending
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Rachel Brilhart, RDMS.

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.

Left kidney is normal is size (5.71 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.

Right kidney is normal is size (5.75 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

Left adrenal gland is normal in size (0.62 cm at cranial pole and 0.6 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.65 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). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

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. Visible vasculature and biliary tree appear normal without distension or congestion. In the left cranial abdomen, there is a 10+ x 14+ cm heterogenous cavitated vascular mass that can't be definitively attached to the liver but appears most consistent with a left caudal liver mass.

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.

Gastrointestinal

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.

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.

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

Pancreas

The observed pancreas appears appropriately isoechoic to surrounding omental fat. The capsule is mildly irregular in shape. Parenchyma is mildly heterogenous and coarse. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

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

Other

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

Primary Findings

- A large cystic/cavitated mass in the left cranial abdomen, appears to originate from the liver, and is concerning for infiltrative neoplasia, such as sarcoma vs hepatocellular carcinoma vs other. Benign cysts, hematoma, etc., can mimic neoplasia and can't be differentiated without tissue sampling. While the mass is believed to originate from the liver, definitive origin is difficult to determine and should be confirmed with an abdominal CT scan.

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.

- Age-related pancreatic remodeling- Mild irregularities are consistent with benign age-related change. Low-grade smoldering chronic pancreatitis cannot be ruled out and should be suspected in the face of appropriate clinical signs.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

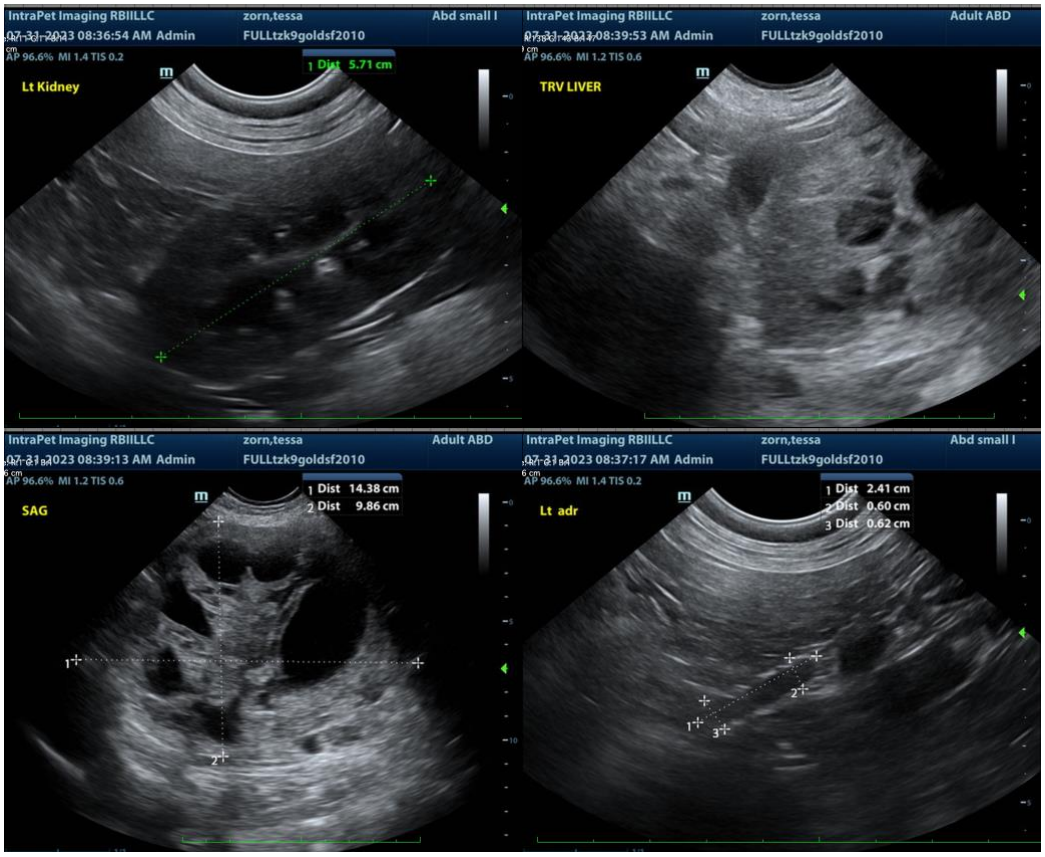
Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

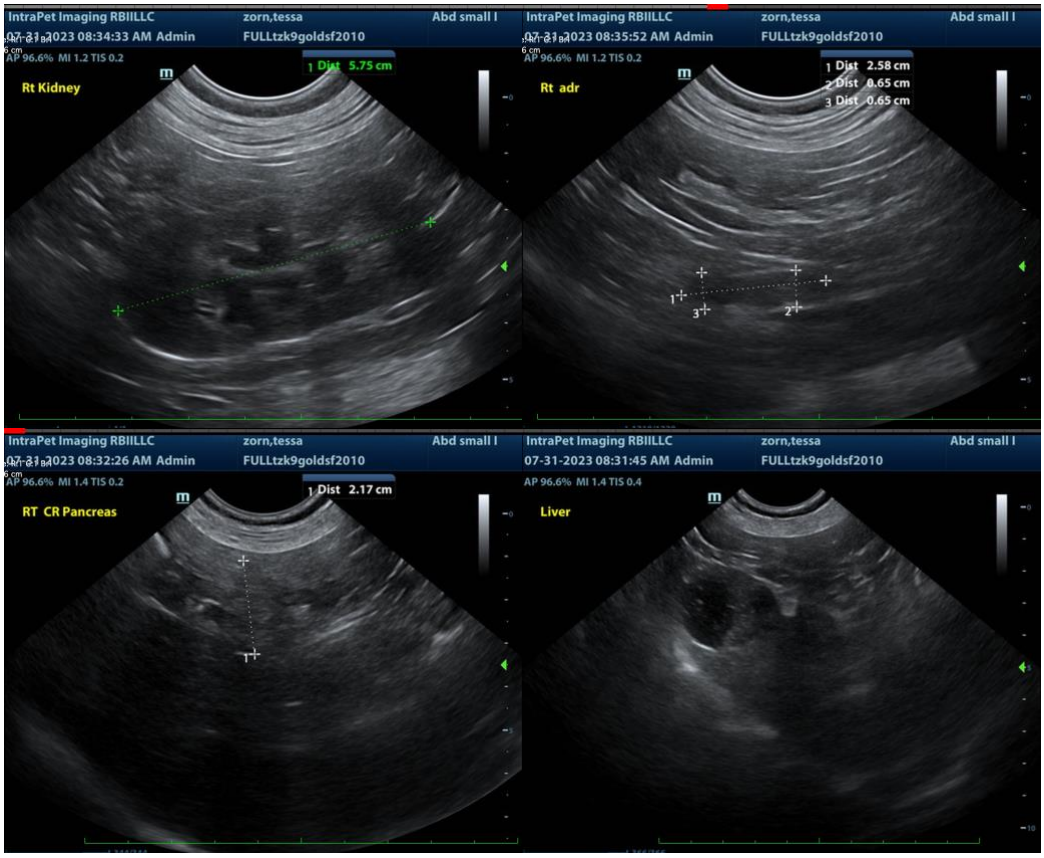
A fine needle aspirate of the mass could be considered if patient coagulation status is appropriate, however, given the cystic/cavitated nature and the risk for hemorrhage with even a benign cavitated mass, alternatively an exploratory laparotomy for planned excisional biopsy could be considered. If surgery is elected, a presurgical staging abdominal CT scan could be considered for more definitive origination, as well as further information regarding resectability, etc.

Having said that, the presence of the mass has unknown, and potentially, no relation to this patients presenting clinical signs of chronic intermittent diarrhea. Further evaluation for the diarrhea, as is reportedly already pending, includes a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory, for further evaluation of GI and pancreatic function.

Additionally, a fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease.

In the meantime, empirical deworming with a 5-day course of Panacur is recommended, as is a probiotic such as Visbiome or Proviable, and if tolerated, transition in diet could be considered, beginning with a hydrolyzed protein diet.





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.

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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