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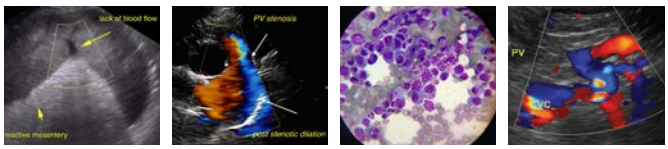

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1-800-838-4268 info@sonopath.com

PATIENT
Walter Hanley

SPECIES
Canine

BREED
Shar Pei X

SEX
Neutered Male

AGE
10 Years 11 Months

WEIGHT
Not Provided

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Shari Reffi, CVT

HOSPITAL NAME
Well Pet AH

REFERRING VET
Dr. Wellington

INVOICE
40363

DATE
8/11/22

PRESENTING CLINICAL SIGNS

Hx of MCT. AUS recommended by eye specialist. OD: Incipient cataract, retinal hemorrhage, pinpoint OS: Anterior Uveitis. Current meds: Prednisolone Acetate, Doxycycline 100mg.

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.

Prostate is normal in size, echotexture and echogenicity for a neutered male.

The right kidney is normal in size (6.94 cm) with normal echogenicity, but disruption of normal corticomedullary architecture caused by multifocal heterogeneous, primarily hypoechoic nodules of varying sizes, most approximately 1.0-1.5 cm in diameter. No mineral is observed.

The left kidney is normal in size (6.72 cm) with normal echogenicity, but disruption of normal corticomedullary architecture caused by multifocal heterogeneous, primarily hypoechoic nodules of varying sizes, most approximately 1.0-1.5 cm in diameter. No mineral is observed.

Adrenal Glands

The right adrenal gland is enlarged in size (3.0 cm long x 1.56 cm at the cranial pole and 1.33 cm at the caudal pole), with moderate heterogeneous parenchymal changes, swollen capsular expansion, and suspect early capsular escape. No evident vascular invasion is definitively identified at this time, but cannot be definitively ruled out.

The left adrenal gland is normal in size (2.8 cm long x 0.81 cm at the cranial pole and 1.0 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

The spleen is subjectively large in size with a swollen and scalloped/undulating capsular contour as a result of multifocal hypo- to anechoic nodules measuring between 1.0-1.5 cm in diameter, some of which have a target lesion appearance with hyperechoic center and hypoechoic rim. Splenic vasculature appears normal.

Liver

The 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. Several hypo- to anechoic 1.0 cm nodules are noted. 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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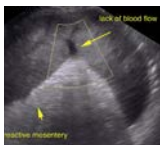
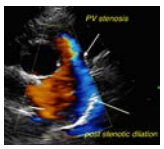
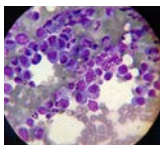
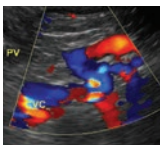

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Gastrointestinal

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.

Mild hepatic lymphadenopathy is noted. No other lymphadenopathy is present in these images.

Thorax

In the caudal thorax, pushing on the diaphragm, there is a 5.0 cm x 7.0 cm homogeneous, hypoechoic mass, and scant pleural effusion noted around the mass. No evidence of pericardial effusion or heart base pathology noted.

ULTRASONOGRAPHIC FINDINGS

- Apparent right caudal lung mass with scant pleural effusion – Primary differential includes primary infiltrative malignant lung tumor versus possibly round cell neoplasia.
- Nodular changes to the spleen, liver and kidneys – suggestive of metastatic neoplasia versus concurrent infiltrative round cell neoplasia.
- Right adrenal tumor – concerning for aggressive disease as well, with pheochromocytoma and/or adenocarcinoma being differentials, or metastatic neoplasia from the primary pulmonary pathology elsewhere also being considerations. Benign adenoma or even hyperplasia can't be ruled out, but is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The multifocal appearance of this pathology is atypical for mast cell tumor, although given this patient's history, mast cell tumor can't be ruled out. Round cell neoplasia such as lymphoma is considered a more likely round cell tumor type versus possibly metastatic disease from the primary pulmonary tumor, or from a primary right adrenal tumor.

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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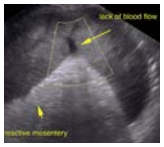
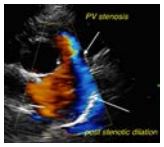
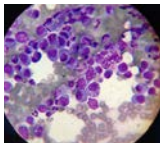
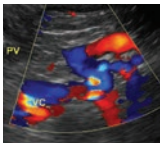

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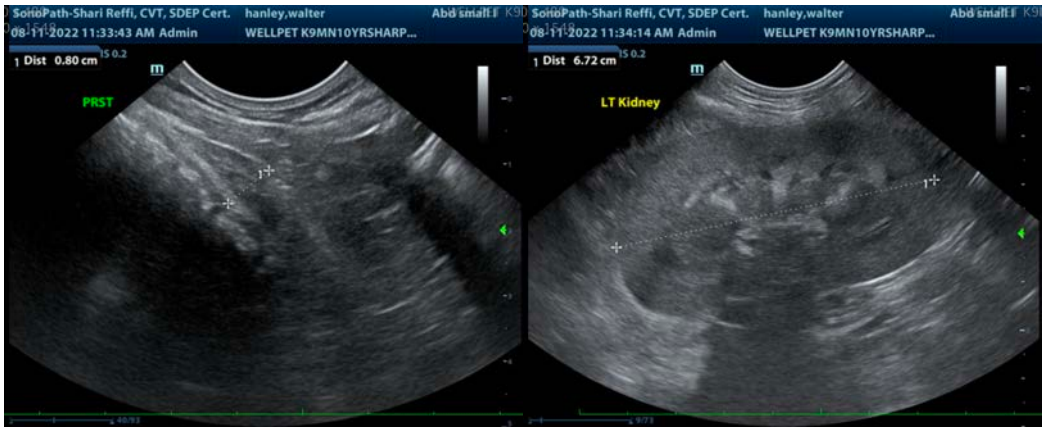
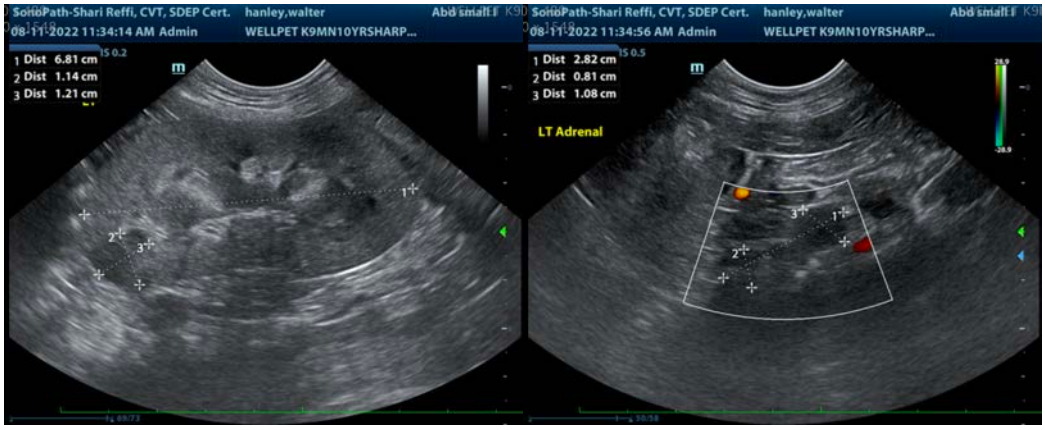
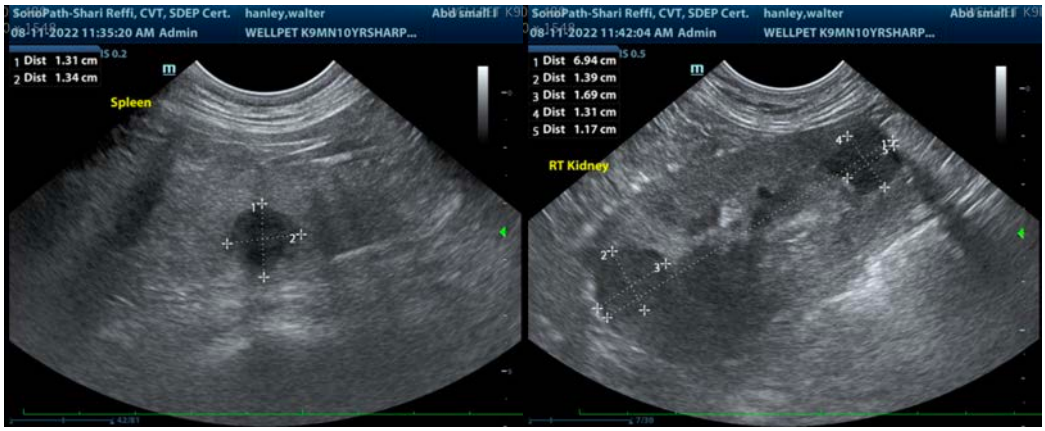
A cytologic diagnosis via fine needle aspirate is likely possible, and therefore recommendations are to perform a fine needle aspirate of the kidneys, spleen +/- liver, and the caudal pulmonary mass, if possible, and if patient's coagulation status is appropriate.

Pending cytologic diagnosis, a thoracic CT scan may be warranted for surgical planning, etc. if surgery is part of the recommended therapy once a cytologic diagnosis has been obtained.







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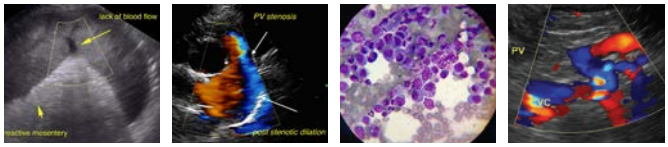

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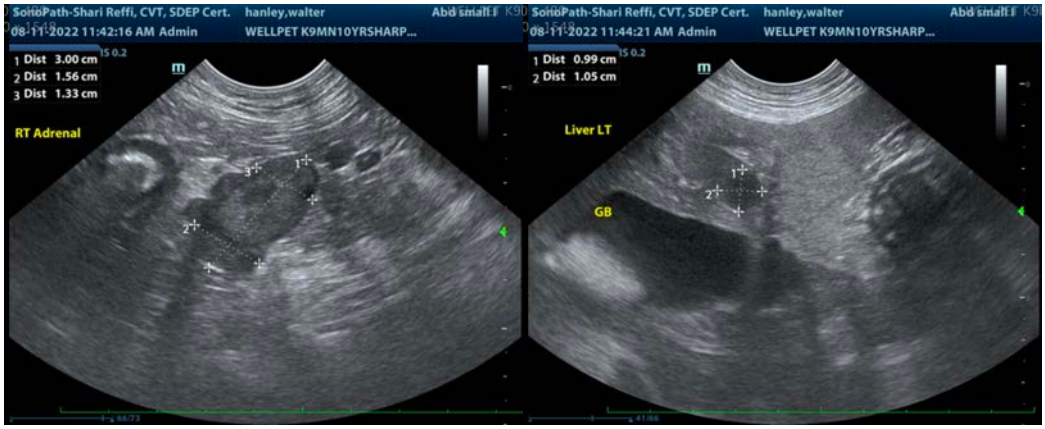

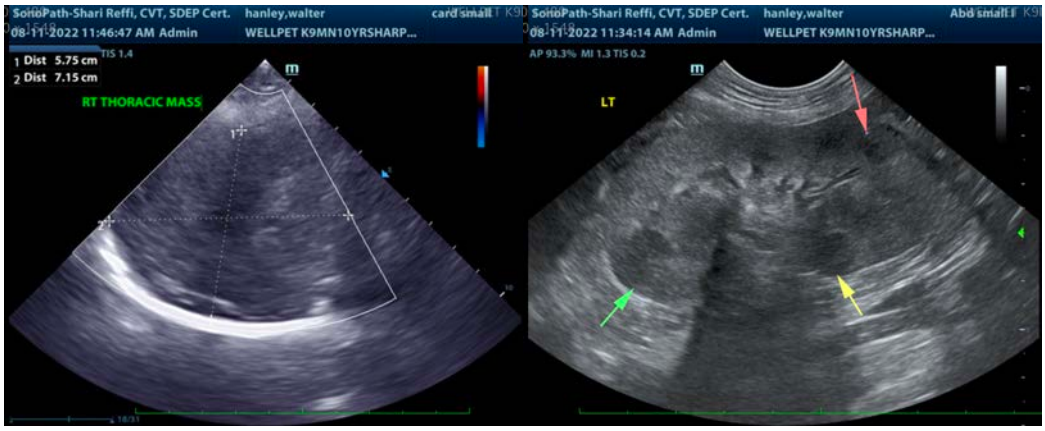

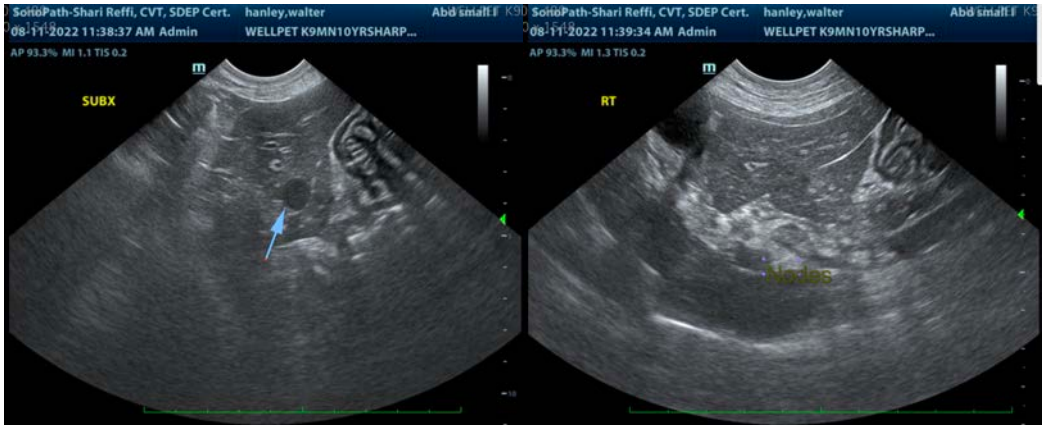

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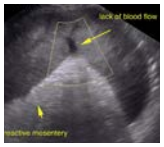
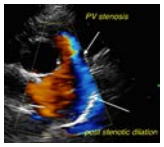
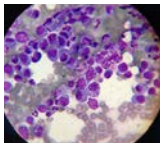
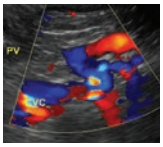

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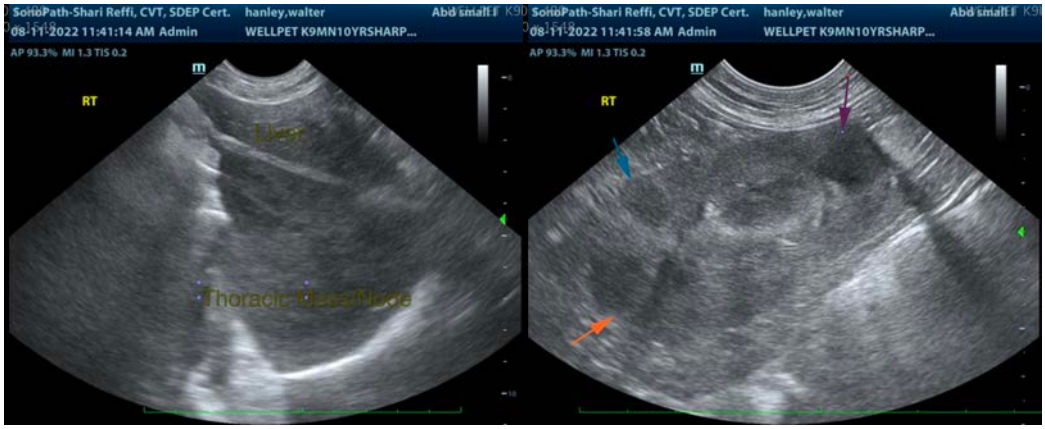

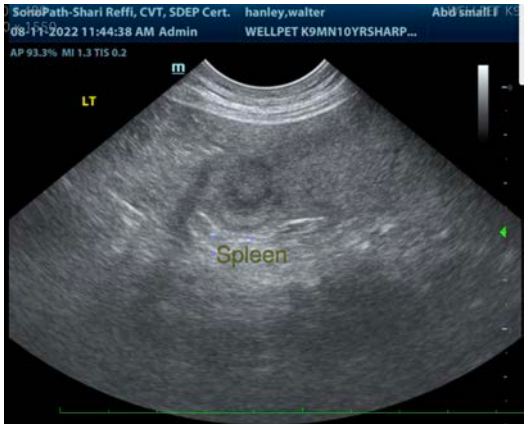

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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