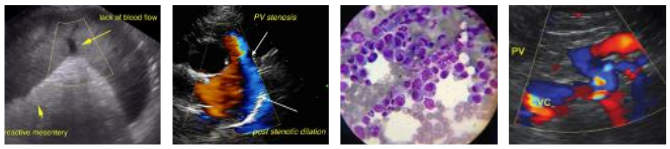

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PATIENT

Malachai Gul

SPECIES

Canine

BREED

German Shepherd

SEX

Neutered Male

AGE

9 Years 10 Months

WEIGHT

143 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

PMVU

HOSPITAL NAME

Banfield PH: Leesburg Village

REFERRING VET

Dr. Cathy Jarrett

INVOICE

16801

DATE

8/8/22

PRESENTING CLINICAL SIGNS

History: Very large mass (7 cm x 4 cm x 2 cm, approximately) on the ventral floor of the rectum right next to the anus, this mass protrudes out of the anus as pet strains to defecate. The mass is separate from the anal glands on palpation. Stools are soft and struggling to pass around the mass. Abdominal rads sent to a radiologist: 1. Thorax was unremarkable 2. Mid to caudal abdominal mass may represent a splenic mass. There is a smaller cranial abdominal mass that may represent a hepatic or additional splenic mass. 3. Nonspecific peritoneal effusion.

Abnormal PE/Chem/CBC/UA Results: anemia, non-regenerative 32.2. Mild stress leukogram. Hyperglobulinemia 4.7.

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.

The prostate is unable to be well visualized in these images.

Left kidney is normal is size (9.48 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 (8.73 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 adrenal glands are unable to be well visualized in these images.

Spleen

In the area of the spleen, what appears to be attached to the spleen, is a huge (at least 15 cm) round mixed cavitated mass, that extends from the liver to the urinary bladder, across the right and left abdomen.

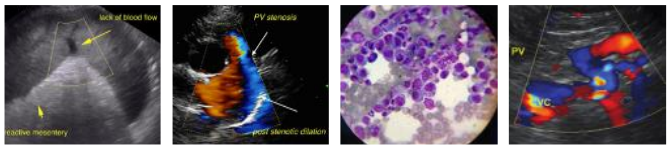
Liver

There is normal liver on both the left and the right abdomen and no evidence of nodules or masses in the liver. However, given the size of the splenic mass, it is difficult to fully assess organ differentiation of all of the pathology. While thought unlikely, liver involvement cannot be definitively ruled out.

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 mildly distended with very echogenic reverbation artifact from intraluminal gas. There is no evidence of



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obstruction, foreign material or infiltrative disease; however, complete visualization of far wall is partially inhibited by gas. 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. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. 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.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- A huge mixed cavitated splenic mass. This is concerning for infiltrative neoplasia, such as sarcoma versus other, however, benign cysts, hematomas, abscesses, etc. can have a similar appearance, and therefore cannot be ruled out.

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.

  *Two separate masses are not identified in these images and liver pathology is not identified in these images; however, full evaluation is very difficult due to the size of the splenic mass and it's contact with all four quadrants of the abdomen.

  *There is an image of a fluid filled cystic structure that is reported to be in the anal/perianal area.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A fine needle aspirate of the splenic mass could be considered, if patients coagulation status is appropriate, however, given the size and risk for hemorrhage, necrosis, etc., an exploratory laparotomy with plans to remove the mass and the reported perianal cystic mass at the same time, is recommended. A presurgical planning abdominal CT scan could be considered for more definitive liver evaluation +/- evaluation for the possible secondary mass mentioned in the radiograph report.

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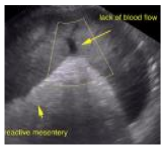
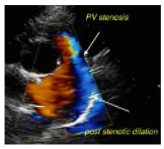
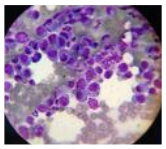
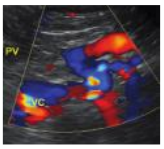

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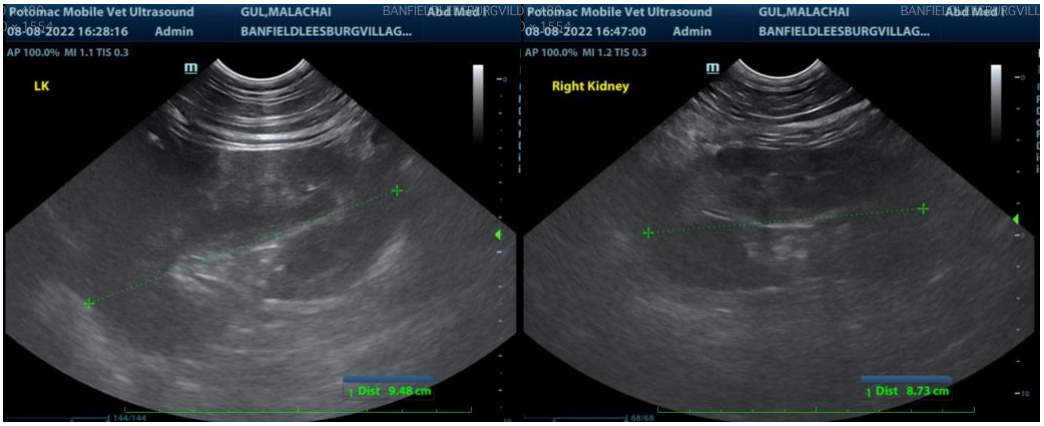

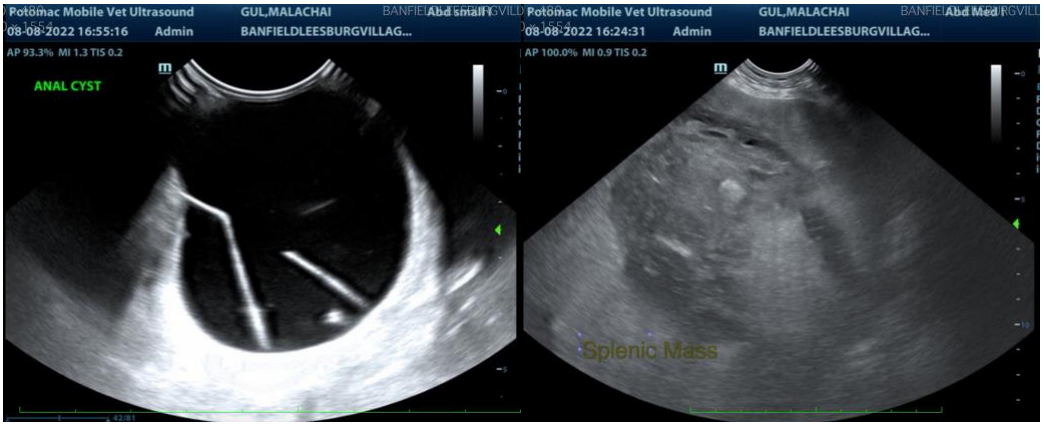

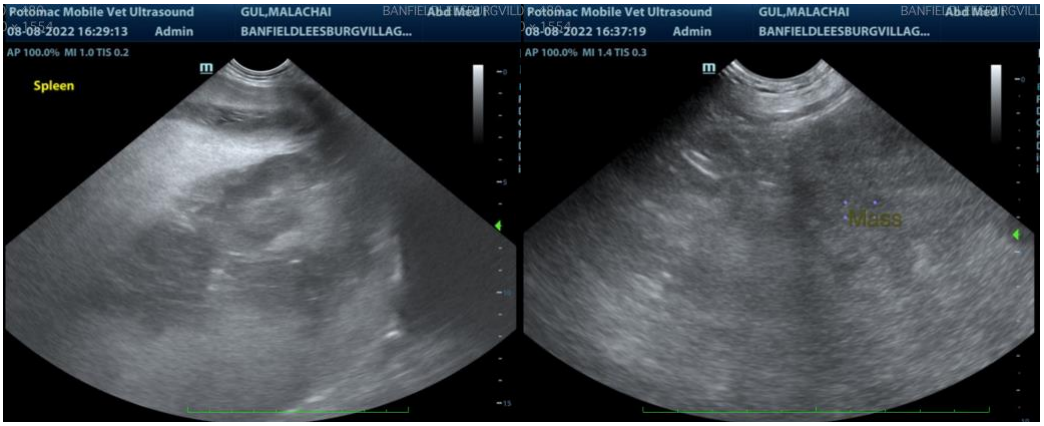

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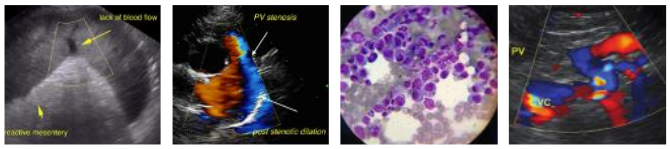

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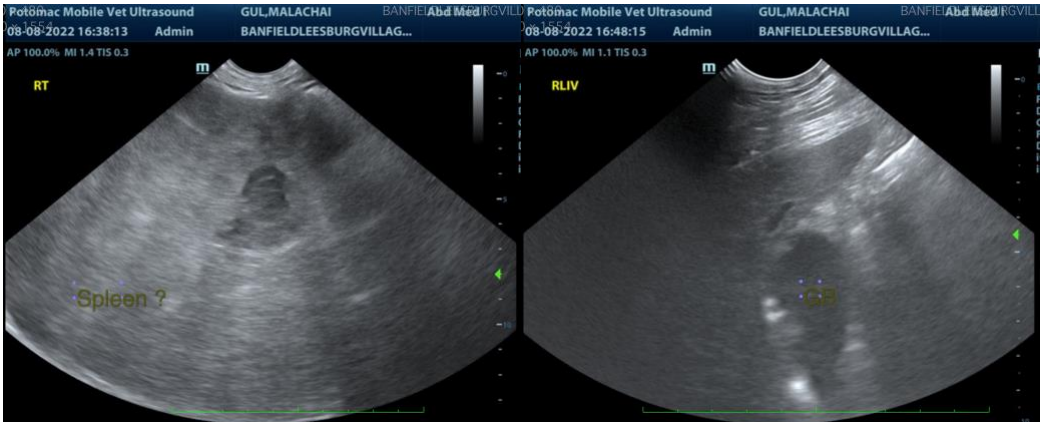

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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