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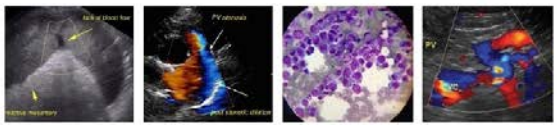


THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Gracie Sebdza

SPECIES

Canine

BREED

Viszla

SEX

Spayed Female

AGE

9 Years

WEIGHT

18 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

Westoak AH

REFERRING VET

Dr. Kohlmaier

INVOICE

40272

DATE

8/9/22

PRESENTING CLINICAL SIGNS

Inappetent

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended with primarily anechoic contents and occasional echogenic non-shadowing debris. Apical urinary bladder wall is diffusely thick (0.63 cm). Mucosa is hyperechoic and irregular. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface.

Kidneys are normal in size and contour. A relatively uniform hyperechogenicity is observed with mildly decreased corticomedullary distinction. No mineral is observed. No overt masses/nodules are observed. The left kidney measures 7.01 cm. The right kidney measures 6.58 cm. Mild pyelectasia noted in the left kidney as well as non-obstructive areas of mineralization/nephroliths.

Adrenal Glands

The right adrenal gland is normal in size (2.49 cm long x 1.56 cm at the cranial pole and 0.96 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 (2.46 cm x 0.78 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.

Spleen

The spleen is subjectively large in size with scalloped or undulating capsular contour. Parenchyma is diffusely coarse/heterogeneous and contains multiple hypo- to anechoic heterogeneous nodules of varying size.

Liver

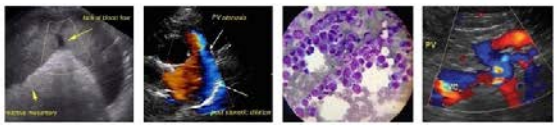
Liver is subjectively enlarged with mildly irregular margins. Parenchyma is mottled by multifocal discrete hypoechoic nodules of varying sizes “moth-eaten”. Specifically, in the mid caudal liver, a 3.0 cm round cavitated mass is noted. Visible vasculature and biliary tree appear normal without distension or congestion.

The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

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.



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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 a large amount of echogenic free fluid.

There is no apparent lymphadenopathy noted in these images.

No pericardial effusion is appreciated. However, in the image provided, there is some suspicion for pleural effusion.

PRIMARY FINDINGS

- **Scalloped, nodular spleen** – most concerning for infiltrative disease such as round cell neoplasia versus other malignant/metastatic neoplasia. Benign disease can't be ruled out, but is considered much less likely, given the concurrent pathology elsewhere.
- **Nodular Liver -** This finding is concerning for infiltrative disease such as round cell neoplasia or metastatic neoplasia. Benign disease (nodular hyperplasia) cannot be ruled out but is considered less likely.
- Echogenic free fluid in the abdomen and some suspicion for possible pleural effusion as well.

SECONDARY FINDINGS

- **Chronic Cystitis -** Urinary bladder wall changes are most consistent with chronic cystitis. Infiltrative neoplasia cannot be ruled out but is considered less likely give the location and diffuse nature of the changes.
- **Nephritis –** This appearance can be consistent with chronic interstitial nephritis or glomerulonephritis. Toxic insult and/or infectious disease (pyelonephritis, Leptospirosis, etc.) cannot be ruled out. This finding should be interpreted in combination with suspicion for renal disease and/or supporting laboratory or urinalysis changes.

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.

Sampling of the abdominal effusion is recommended. Due to the echogenic appearance of the fluid and the cystic appearance to the splenic and liver nodules, there is concern for possible hemoabdomen.

A fine needle aspirate of the spleen and liver could be considered if patient's coagulation status is appropriate to look for evidence of round cell neoplasia, given that the visible disease is too diffuse to be removed surgically. However, alternatively, if a hemoabdomen is present, an exploratory laparotomy may be necessary to find/stop the bleed as well as biopsy both the spleen and liver.

Urinalysis and, if indicated based on urinalysis results, urine culture are recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

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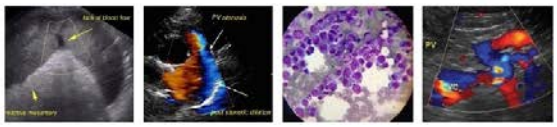

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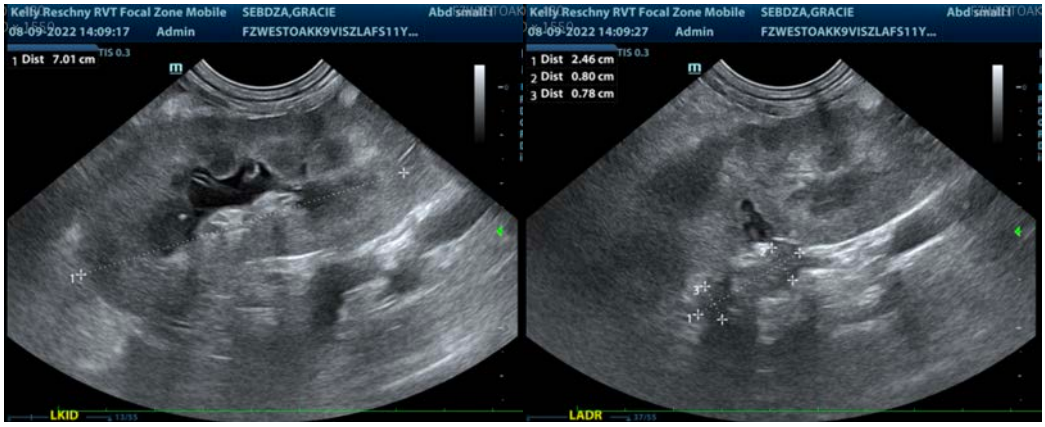

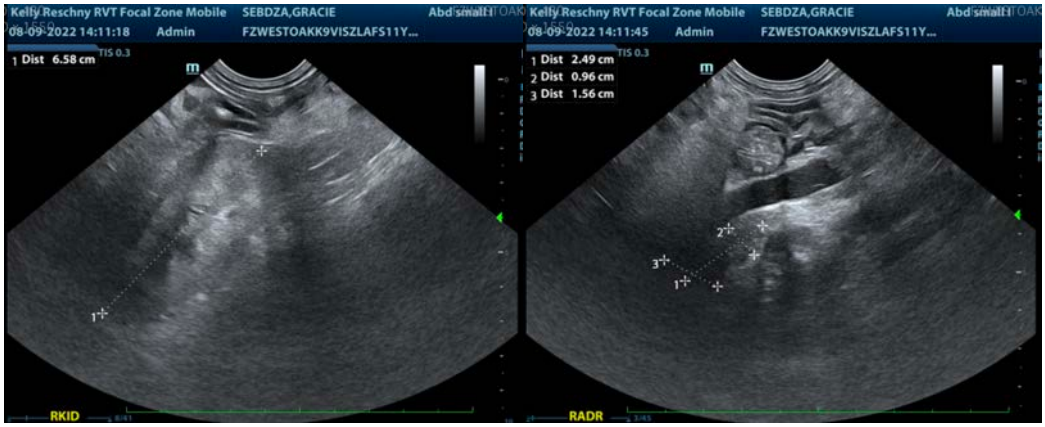

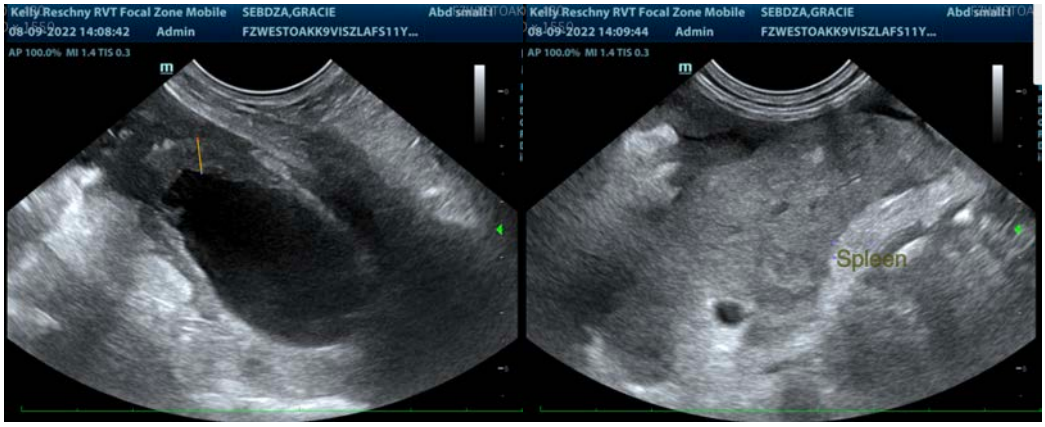

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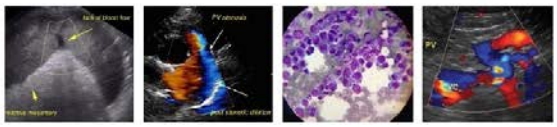

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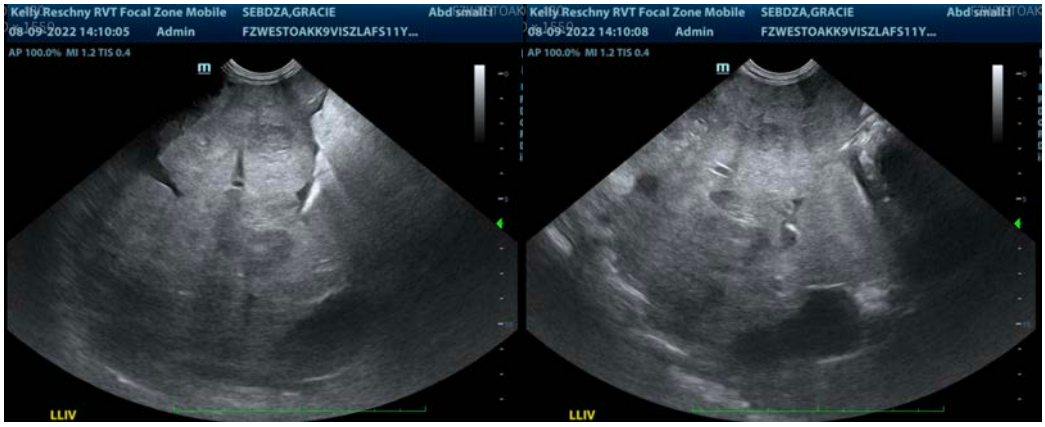

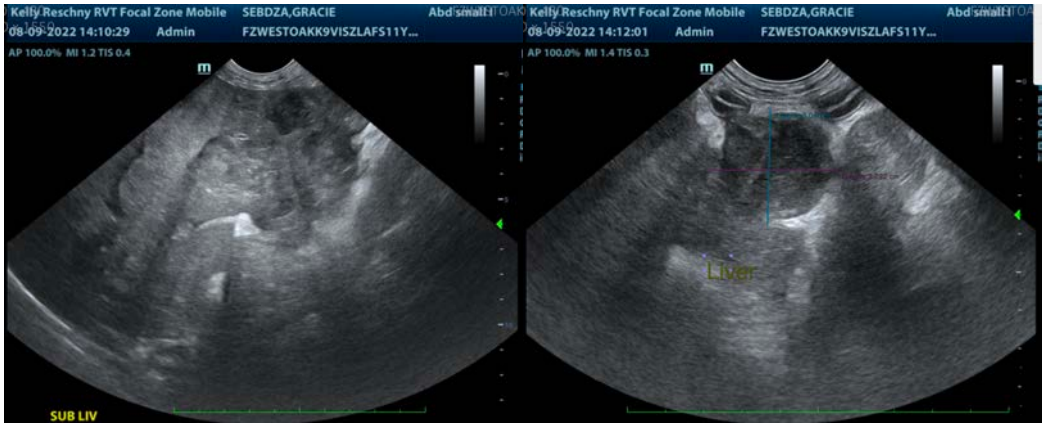

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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