



PATIENT

Lanai Long

SPECIES

Canine

BREED

Golden Retriever

SEX

Female

AGE

6 Years

WEIGHT

79.1 Pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Brian Klug, Tech

HOSPITAL NAME

Sondel Family VC

REFERRING VET

Dr. Jesse Sondel

INVOICE

41391

DATE

9/15/22

PRESENTING CLINICAL SIGNS

Breeding female - Possible ovarian cyst seen on pregnancy ultrasound. Patient was not pregnant. Want to confirm no abnormal pathology elsewhere in the abdomen prior to spay. Had a surgical AI done a month prior to pregnancy ultrasound with no abnormalities noted. Rest of exam is unremarkable.

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.

The right kidney is normal in size (7.53 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.

The left kidney is normal in size (7.16 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 right adrenal gland is normal in size (0.60 cm at the cranial pole and 0.67 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 (0.57 cm at the cranial pole and 0.65 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large in size with a mildly swollen but smooth capsule. Parenchyma is normal and homogenous in echogenicity and echotexture. A 0.6 cm hypo- to anechoic mid body nodule is noted, non-capsule disrupting. 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. No focal lesions are observed. 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 visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is 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



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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.

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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.

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Free Abdomen

A cystic right ovary is observed caudal to the right kidney. A larger 3.0 cm x 5.0 cm fluid-filled structure is noted caudal and lateral to the left kidney, believed to be associated with the left ovary.

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The uterus is visible and mildly, but not overly, fluid distended.

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There is no evidence of free peritoneal effusion noted in these images.

There is no apparent lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

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- **Hypersplenism** – can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.

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- **Hypo to anechoic splenic nodule** – likely represents a benign lesion such as a cyst, hematoma, nodular hyperplasia, extramedullary hematopoiesis, etc., however while considered less likely, infiltrative neoplasia can mimic benign lesions, and cannot be ruled out.

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- **Bilaterally cystic ovaries suspected** – The larger lesion described above in the area of the left ovary cannot be definitively attached to a specific organ, but an ovarian cyst is believed to be most likely.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A fine needle aspirate of the spleen could be considered if patient's coagulation status is appropriate, prior to surgery. However, the lesions trend toward the benign, and a spay is recommended regardless. Therefore, an alternative approach is a possible biopsy of the splenic nodule at the time of the spay. There are no ultrasonographic contraindications to proceeding with the planned spay.

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If desired prior to surgery, three view thoracic radiographs could be performed 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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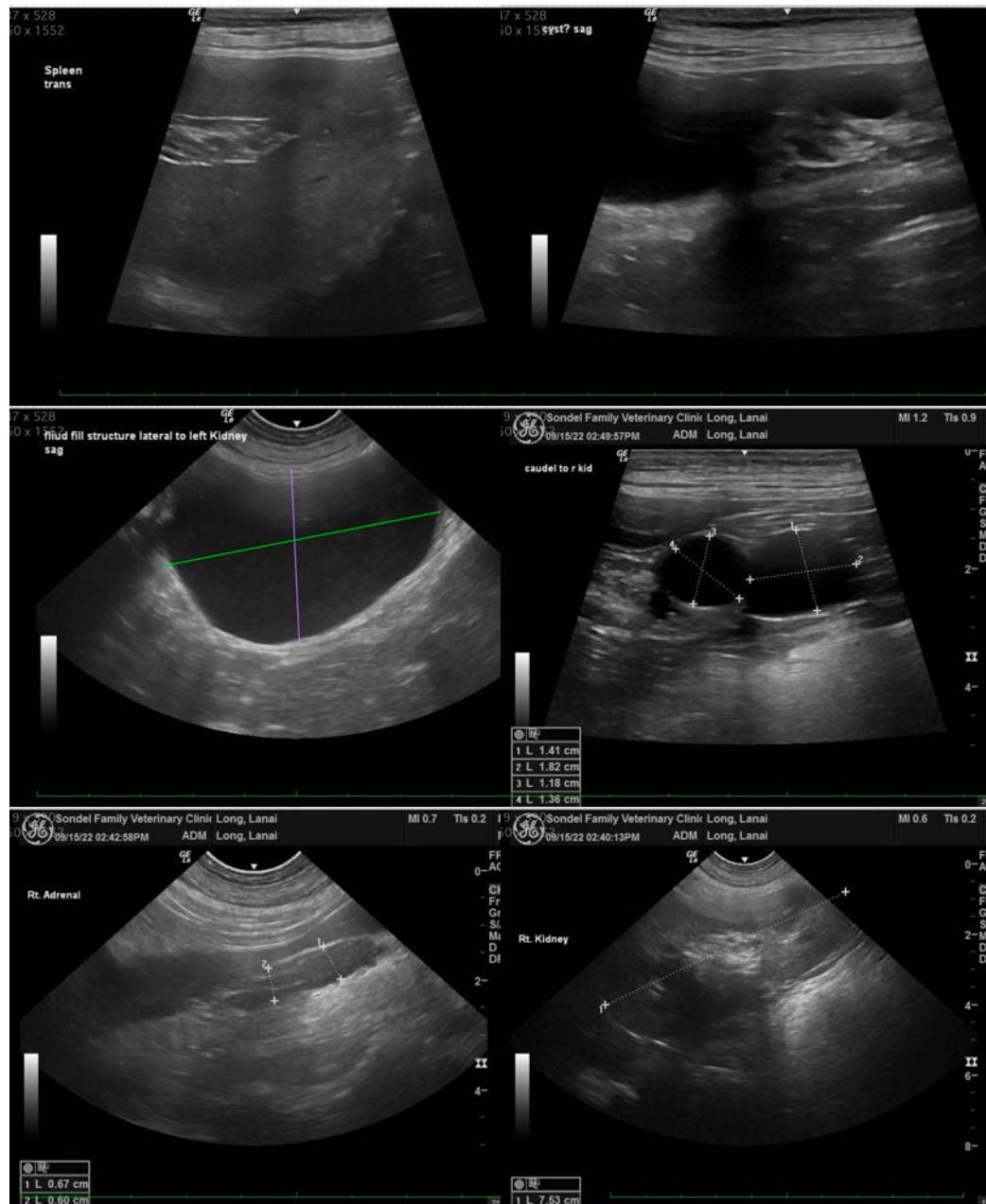
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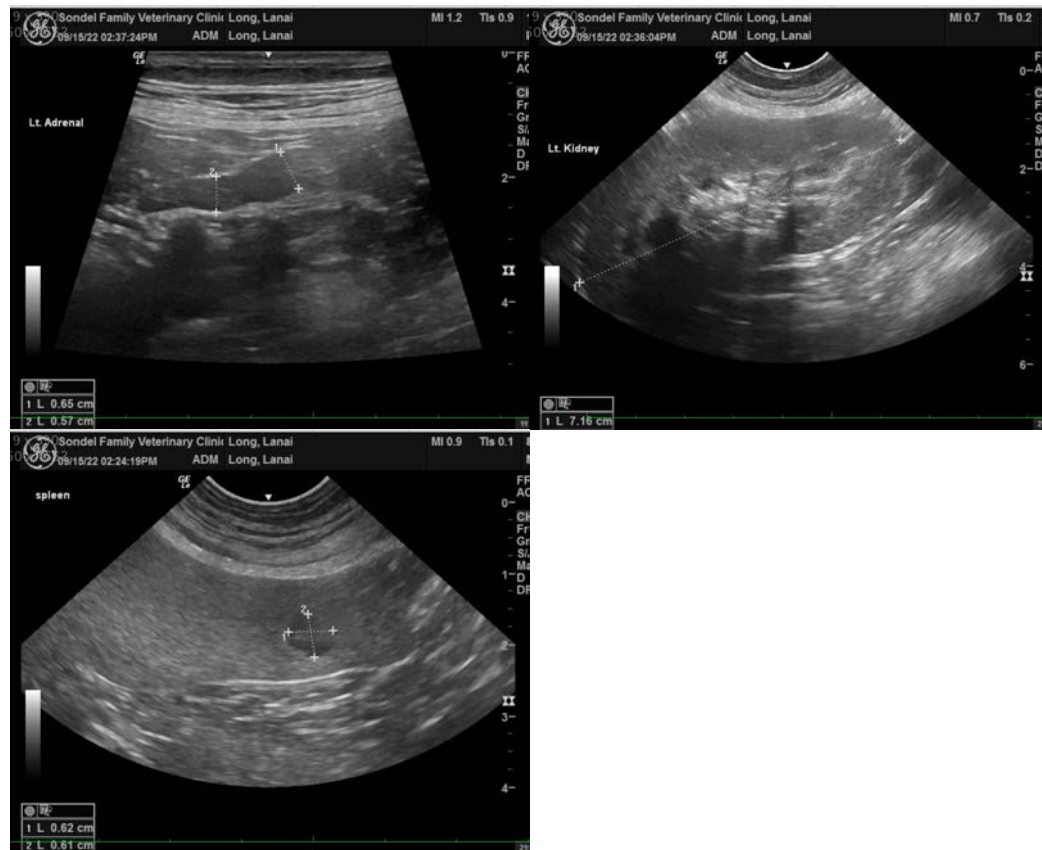
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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