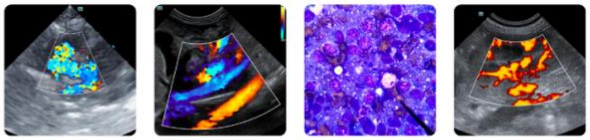


PATIENT

Panchita Cardona

SPECIES

Canine

BREED

Mixed

SEX

Spayed Female

AGE

14 Years

WEIGHT

40 pounds

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Dr. Gabriel Ferrer DVM

HOSPITAL NAME

Pulse Pet Ultrasound Services

REFERRING VET

Dr. Javier Rodriguez

INVOICE

14358

DATE

03/16/26

PRESENTING CLINICAL SIGNS

- Px presented as a referral for an abdominal ultrasound due to Hx of lethargy and elevated hepatic enzymes
- Px presented with lethargy and abdominal pain
- When Px was not being handled she stayed in lateral recumbency and when she was to be handled would show signs of pain
- Px had urinary incontinence, and the urine had a strong smell
- Dx with Pancreatitis
- rDVM wanted to rule out a possible hepatic mass

Abnormal PE/Chem/CBC/UA Results: Bloodwork and radiographs attached below for your reference

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and visible pelvic urethra were of normal thickness. The ureters were not visible which is normal. There was normal wall layering with no masses, uroliths or abnormal thickening visualized. Urine was anechoic. No evidence of inflammatory or neoplastic changes were noted.

The right kidney has a smooth capsule and with mild hazing of corticomedullary definition. The right kidney measured 5.87 cm in length. Spherical anechoic fluid accumulation consistent with cortical cysts were present in the right kidney. Hyperechoic, shadowing foci present in renal parenchyma and calyces consistent with nephrocalcinosis.

The left kidney has a smooth capsule and with mild hazing of corticomedullary definition. left kidney measured 6.12 cm in length. Spherical anechoic fluid accumulation consistent with cortical cysts were present in the left kidney.

Adrenal Glands

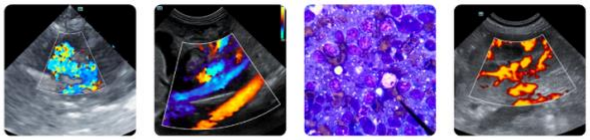
Both adrenal glands were visualized and recognized as having normal shape, size, position and echogenicity for this breed and age. The visible phrenic vasculature was unremarkable. The left adrenal gland measured 2.69 cm in length and 0.63 cm at the caudal pole and 0.51 cm at the cranial pole. The right adrenal gland measured 1.57 cm in length and 0.56 cm at the caudal pole and 0.83 cm at the cranial pole.

Spleen

The spleen was normal with age-appropriate homogeneous parenchyma and a smooth capsule with normal splenic vasculature with no signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarct changes were noted.

Liver

The liver has a very large, generally solid mass measuring at least 6.05 cm x 6.69 cm on the right side of the liver. There are multiple roughly spherical anechoic structures consistent with liver cysts noted throughout the liver.



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The gall bladder is moderately distended with anechoic fluid, with hyperechoic non-shadowing gravity dependent debris present. There is no surrounding free fluid or signs of active inflammation.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis: mucosa layer ratio. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was not visualized. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The left limb of the pancreas is prominent with a diffusely heterogeneous architecture with multifocal spherical anechoic fluid accumulations most consistent with pancreatic cysts.

Lymph Nodes

No clinically significant lymphadenopathy or abnormalities noted.

Free Abdomen

No masses or free fluid were noted.

ULTRASONOGRAPHIC FINDINGS

- Cystic pancreas.
- Large right-sided liver mass with multiple hepatic cysts.
- Degenerative renal changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Mass in the liver is most concerning for neoplasia. Malignant tumors are more common in the dog and may be of hepatocellular, cholangiocellular, mesenchymal, or neuroendocrine origins. Hepatocellular carcinoma is the most common primary hepatic malignancy of the dog. Metastatic rates are relatively low, although rates are higher with nodular and diffuse forms. Hepatocellular adenoma (i.e. hepatoma) is a benign hepatocellular tumor that is commonly found as an incidental finding in dogs at necropsy. Other include cholangiocellular carcinoma, hemangiosarcoma, leiomyosarcoma, fibrosarcoma, hemangioma, histiocytic sarcoma, osteosarcoma, lymphoma and myelolipoma. Secondary hepatobiliary tumors are more common than primary tumors as the liver is one of the most common sites of metastasis. Carcinomas metastasize to the liver more often than sarcomas. Common metastatic tumors include lymphoma, hemangiosarcoma, islet cell carcinoma, exocrine pancreatic carcinoma, intestinal carcinoma, renal carcinoma, and mast cell tumors.

Aspirate should be attempted for further information. Ultimately surgical removal should be considered because of risk of rupture and abdominal hemorrhage, and this may be both diagnostic and

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curative. Pre-operative abdominal CT may be considered for surgical planning to confirm hepatic origin and thoracic CT could be used to screen for thoracic metastasis that may be missed on thoracic radiographs. Serial monitoring with follow up sonograms could be considered to monitor for progression if definitive removal is not desired at this time.

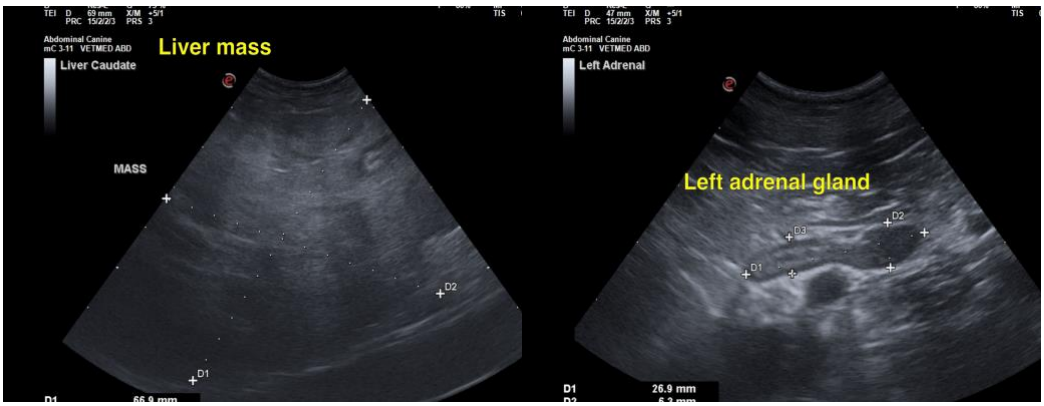
Changes to the left limb of the pancreas are most consistent with pancreatic cysts. While there is not distinct signs of significant surrounding inflammation, chronic or recurrent pancreatitis is likely in this patient. Pancreatitis is more likely cause of reported clinical signs than the large liver mass, though both may be contributing to clinical signs.

Renal changes are likely chronic, age-related degeneration. In light of azotemia, acute on chronic renal insult is likely. Progression of chronic renal disease, toxin exposure, leptospirosis, bacterial pyelonephritis, other infectious insults, recently resolved ureterolithiasis, among other things are all possibilities.

Additional diagnostics to be considered include urine culture (even if no bacteria on UA), leptospirosis testing, and careful questioning for the possibility of exposure to renal toxins (NSAIDs, grapes/raisins, cream of tartar, tamarind, vitamin D, rodenticide, etc). Doppler blood pressure measurement is recommended to screen for hypertension which can be present in both acute and chronic renal disease and worsens renal function.

Treatment with intravenous fluid therapy, GI support as needed including enteral nutrition and monitoring for stabilization or resolution of azotemia every 24-48 hours is recommended. Antibiotics are reasonable while awaiting infectious disease testing.

Management for any patient with chronic renal dysfunction includes renal specific diet (protein and phosphorus limited), encouraging increased water intake with canned food and providing clean, running water source, and management of proteinuria and hypertension with ACE-inhibitor with addition of more anti-hypertensives as required. Monitoring of bloodwork, urinalysis and blood pressure every 3-6 months, or sooner if feeling unwell, is recommended.



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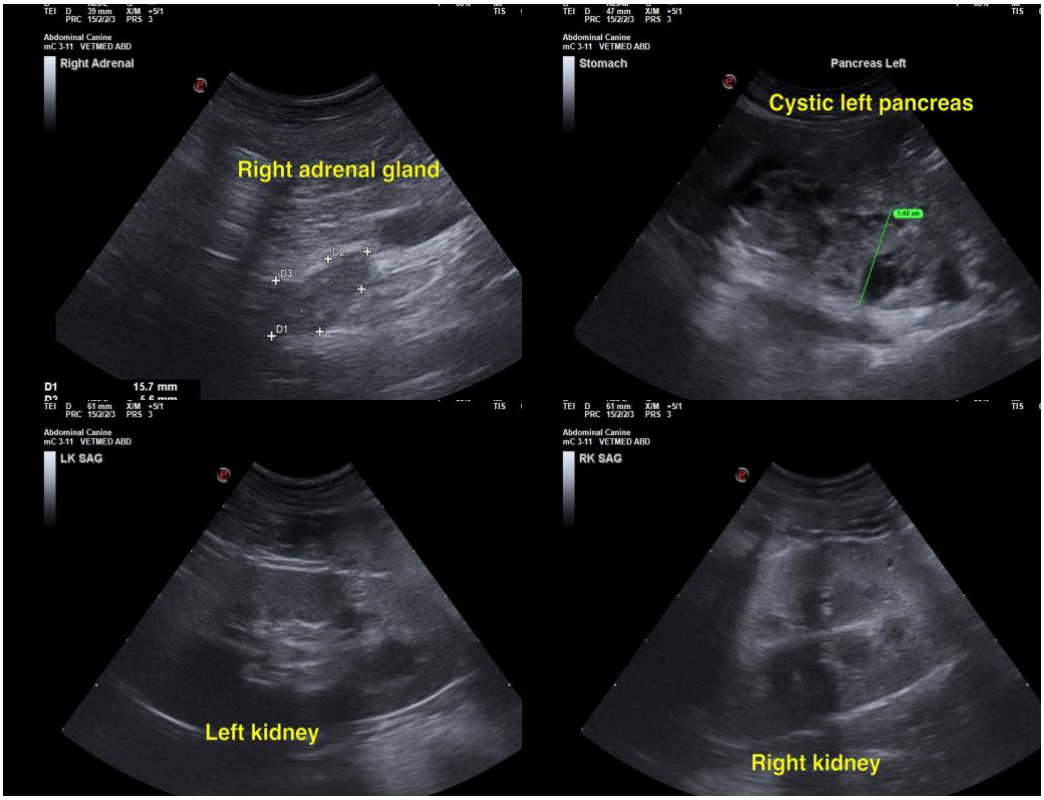

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Dr Brittany Sinclair, BVSc(hons), DACVECC

info@SonoPath.com