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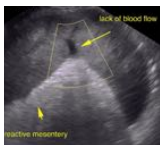

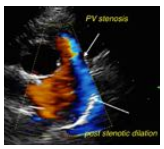

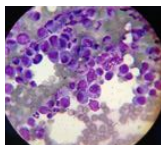
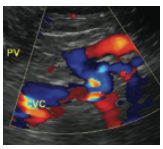


SonoPath.com
1-800-838-4268 info@sonopath.com

**PATIENT**
Peannt Wright

**SPECIES**
Canine

**BREED**
Chihuahua Cross

**SEX**
Spayed female

**AGE**
6 years

**WEIGHT**
11 lbs

**INTERPRETED BY**
Dr Brittany Sinclair, BVSc(hons), DACVECC

**IMAGING PERFORMED BY**
Dr. Favis

**HOSPITAL NAME**
Ruidoso AH

**REFERRING VET**
Dr. Favis

**INVOICE**
42756

**DATE**
2/13/23

## PRESENTING CLINICAL SIGNS

History: Weight loss, decreased appetite, lethargy
Abnormal PE/Chem/CBC/UA Results: CBC - mild lymphopenia, Chemistry Globulins 4.6, FNA of nodular mass in the caudal abdomen - inflammatory cells, no overt bacteria - monocytes and neutrophils

## 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. Mobile debris present in the urinary bladder. Correlate clinical significance with urinalysis findings. No evidence of inflammatory or neoplastic changes were noted.

The kidneys were both normal size and structure, with smooth capsule and normal corticomedullary definition and ratio (cortex 1/3 of medulla). Medullary structure differed distinctly from that of the cortex. No evidence of pelvic dilation was present. The right kidney measured 3.99 cm. The left kidney measured 4.2 cm.

### *Adrenal Glands*

Both adrenal glands were visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The left adrenal gland measured 1.2 cm in length and 0.25 cm at the cranial pole and 0.43 cm at the caudal pole. The right adrenal gland measured 1.3 cm in length, 0.4 cm at the cranial pole and 0.48 cm at the caudal pole.

### *Spleen*

The spleen was normal with a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma and 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*

Thee liver is subjectively normal in size with normal contours and structure. The parenchyma is slightly heterogenous with a coarse appearance. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed. The gall bladder is moderately distended with anechoic fluid, with hyperechoic non-shadowing debris present. There is no surrounding free fluid or signs of active inflammation.

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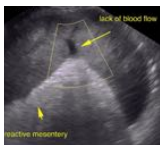
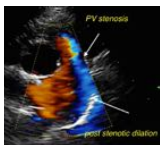
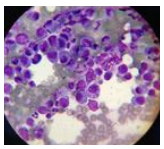
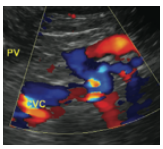

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### *Gastrointestinal*

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 and there is no impression of reduced peristaltic activity. 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. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed. The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. 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 base and limbs of the pancreas were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour and parenchyma were normal. No overt evidence of active inflammatory or neoplastic disease was noted.

### *Lymph Nodes*

Enlarged, rounded and hypoechoic sublumbar lymph node measuring 1x0.9cm with surrounding hyperechoic mesentery.

### *Free Abdomen*

No masses or free fluid were noted.

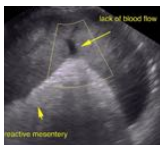
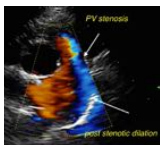
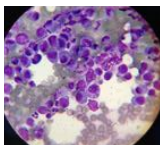
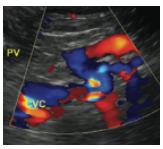
## ULTRASONOGRAPHIC FINDINGS

### Primary Findings

1. Sublumbar lymphadenopathy with surrounding inflammation
2. Coarse liver parenchyma
3. Gall bladder debris
4. Urinary bladder debris

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Reported caudal abdominal nodular mass reported is strongly suspected to represent an enlarged sublumbar lymph node. Lymphadenopathy with these parenchymal changes and loss of normal length to width ratio is most concerning for infiltrative disease (lymphoma, MCT, other) though this is not suggested by reported cytology findings. Other possible causes include infectious lymphadenitis (bacterial, viral, protozoal or less likely fungal infection) or reactive lymphadenitis (parasitism, migrating foreign body). No other local or distant abdominal changes are suggestive of a source of inflammation to explain this lymphadenopathy. It is possible this nodule represents a walled off granuloma or less likely free neoplastic mass (sarcoma, extrasplenic tissue, etc). Submission of cytology to a veterinary pathologist (if not yet done) and culture is recommended. Empiric broad spectrum antibiotic therapy

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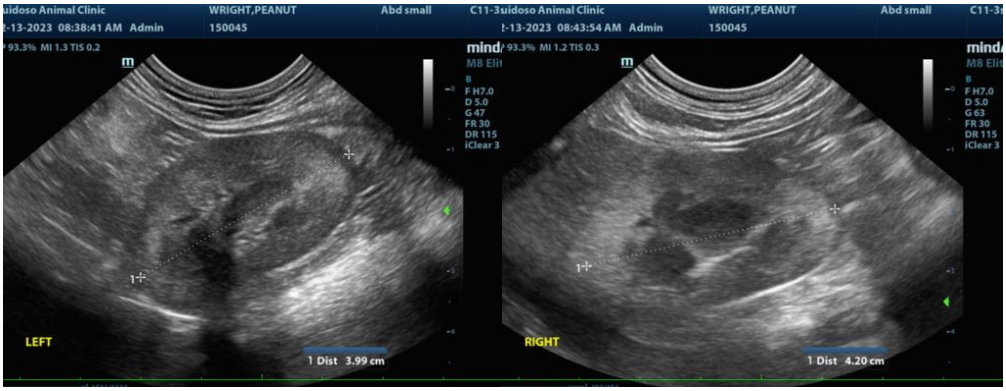
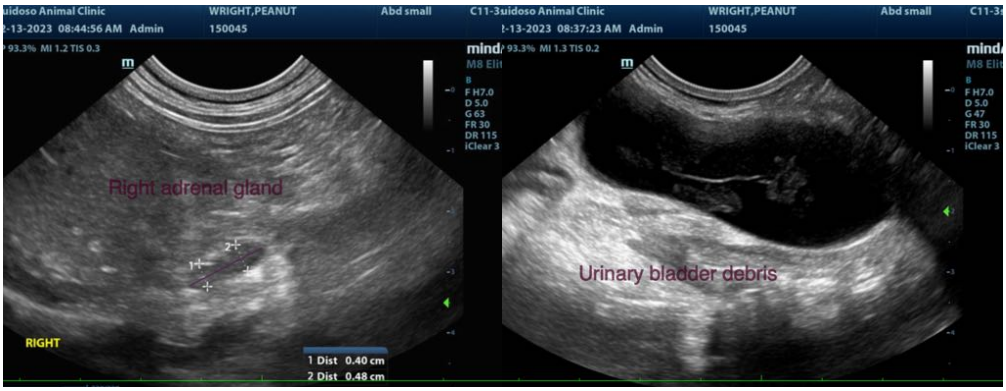
could be considered despite the lack of infectious organisms seen given the patient's clinical signs. Ultimately abdominal exploratory surgery for lymph node biopsy and/or removal may be considered if there is no response to supportive therapy and repeat FNA/culture remains non-diagnostic.
Liver changes are mid and a common benign age related change, but infiltrative disease (lymphoma, MCT, other) cannot be definitively ruled out. No significant disruption of architecture noted to suggest significant pathology. Fine needle aspirate could be considered to further characterize parenchymal changes if clinically indicated, especially if any weight loss is noted or for baseline cytological assessment.

Gall bladder debris is likely an incidental finding and is often subclinical and often does not warrant specific treatment or further investigation. Correlate clinical significance with bloodwork findings and clinical signs. Serial imaging for monitoring could be considered especially if liver enzymes subsequently become elevated. If otherwise clinically indicated, investigation for endocrinopathy such as hyperadrenocorticism or hypothyroidism could be considered as an underlying cause predisposing to gall bladder debris accumulation.

Correlate clinical significance of urinary bladder debris with blood work/urinalysis findings and clinical signs.



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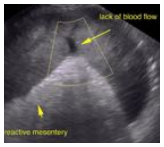
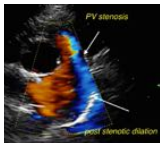
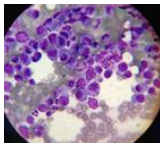
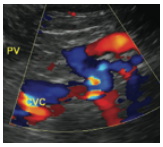

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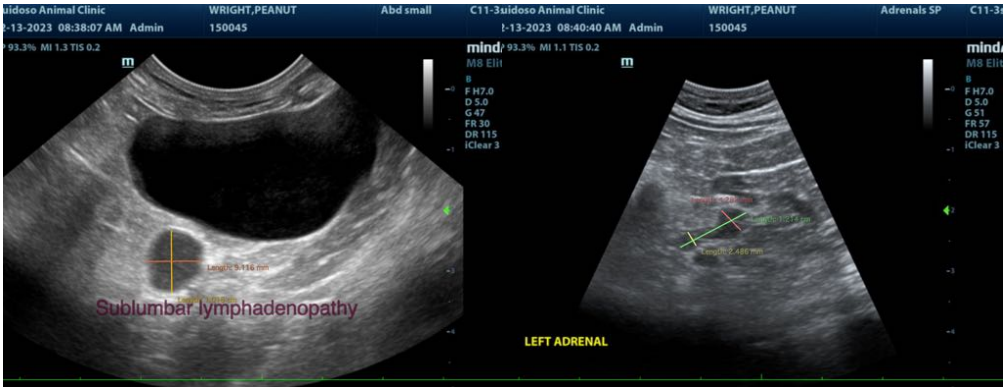


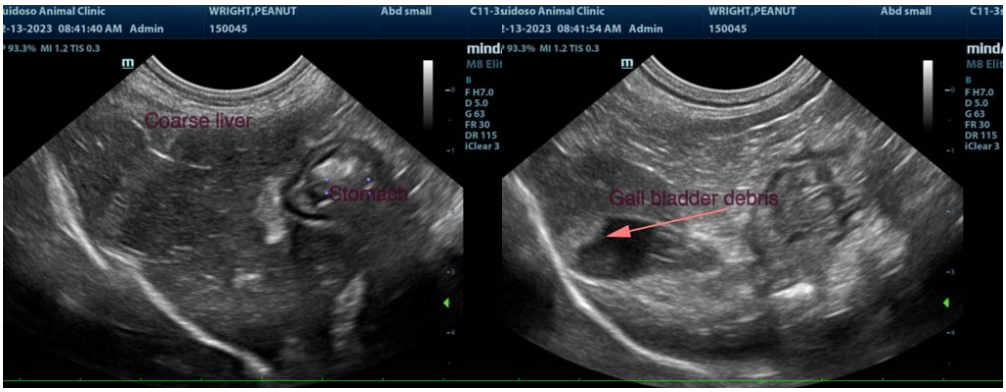



**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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.

Dr Brittany Sinclair, BVSc(hons), DACVECC
info@SonoPath.com