



PATIENT

Harvey Haughey

SPECIES

Canine

BREED

Boxer

SEX

Neutered male

AGE

9 years

WEIGHT

76.8 lbs

INTERPRETED BY

Dr Brittany Sinclair,
BVSc(hons), DACVECC

IMAGING PERFORMED BY

Dr. Carpenter

HOSPITAL NAME

Penridge AH

REFERRING VET

Dr. Carpenter

INVOICE

43290

DATE

3/14/23

PRESENTING CLINICAL SIGNS

History: Signalment: 9 yo MN Boxer 76.8 # Sedated with Butorphanol Hx Hypothyroidism - well controlled. Presented in 1/18/23 for Hyporexia, diarrhea, vomiting. B/w NSF except pos snap CPL. Treated supportively with cerenia, pepcid, proviable, metro. Appetite improved and vomiting stopped but re-presented on 1/14/23 for ongoing diarrhea and hematochezia. Amoxi + longer course metro was rx in addition to gabapentin for abdominal discomfort as well as started on GI LF. Patient is overall doing well except now has chronic SI diarrhea (no increase frequency/urgency - going at normal times with soft serve stool). Chest rads - NSF. Here for AUS for ongoing diarrhea despite GI LF diet and probiotics.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder lumen volume is relatively small and walls are diffusely mildly thickened most consistent with pseudohypertrophy. 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 kidneys have a smooth capsule and with mild hazing of corticomedullary definition. No evidence of pelvic dilation was present. Hyperechoic shadowing in left renal pelvis with no dilation consistent with non-obstructive nephrolithiasis. The left kidney measured 6.88 cm and the right kidney measured 6.55 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 2.18 cm in length and 0.74 cm at the cranial pole and 0.47 cm at the caudal pole. The right adrenal gland measured 1.97 cm in length and 0.81 cm at the cranial pole and 0.81 cm at the caudal pole.

Spleen

Spherical roughly 3.3x3.8cm hypoechoic cavitory mass causing capsular distension near the head of the spleen. No surrounding free fluid. Remainder of splenic parenchyma appears normal to slightly mottled.

Liver

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed. Gallbladder is moderately distended with normal wall thickness and anechoic contents. Common bile duct is non-distended and tapers normally.



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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

No clinically significant lymphadenopathy or abnormalities noted.

Free Abdomen

No masses or free fluid were noted.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

1. Splenic mass
2. Normal GI tract
3. Thickened urinary bladder wall - suspect pseudohypertrophy
4. Degenerative renal changes with nephrolithiasis

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Mass in spleen is cystic and concerning for neoplasia with primary differential being hemangiosarcoma. Splenic aspirate could be done to further characterize, though cavitory masses are at higher risk of bleeding, potentially seeding cancer cells in the abdomen, and potentially of being non-diagnostic. Whether benign or malignant, all cavitory splenic masses are at risk of rupture and if no signs of metastasis are present in the chest and abdomen, splenectomy with histopathology should be considered.

Primary splenic tumors include angiogenic tumors, lymphoid/round cell tumors, and nonangiogenic, nonhematopoietic tumors. Angiogenic tumors include hemangiosarcoma and hemangiomas. Hemangiomas are benign, whereas HSAs are the most common malignant splenic tumor in dogs.



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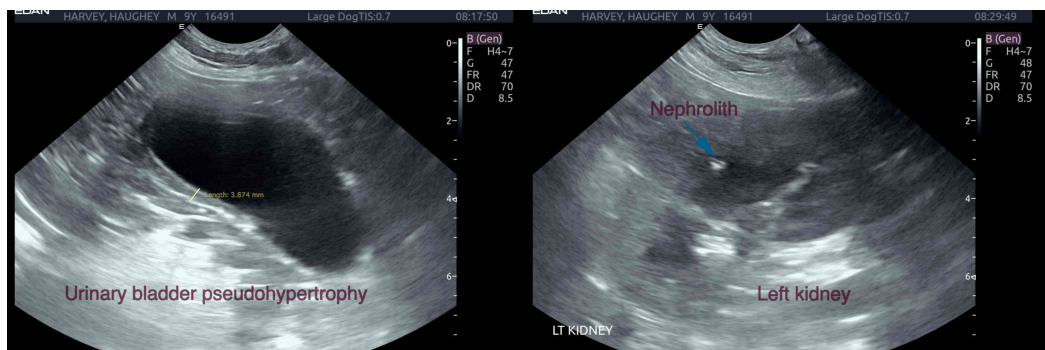
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Lymphoid and other round cell tumors may include lymphoma, leukemia, mast cell tumor, plasma cell tumor/multiple myeloma, and histiocytic sarcoma. Nonangiogenic, nonhematopoietic tumors encompass a long list of uncommon splenic neoplasms, such as leiomyoma, leiomyosarcoma, extraskeletal osteosarcoma, chondrosarcoma, fibrosarcoma, lipoma, liposarcoma, myxosarcoma, rhabdomyosarcoma, undifferentiated sarcoma, melanoma, carcinoma, peripheral nerve sheath tumor, myelolipoma, and mixed mesenchymal sarcoma (mesenchymoma).

Splenic mass may be incidental to described GI signs. If splenectomy is pursued, GI biopsies at the time of exploratory surgery is recommended. Colon and small intestines are ultrasonographically normal with no signs of mural disease. Colonic wall is of normal thickness with no cause of described clinical signs. GI panel (TLI/PL/cobalamin/folate), fecal pathogen PCR, baseline cortisol +/- ACTH stimulation test, and empiric broad spectrum deworming, discontinuation of any antibiotics and treatment with probiotics should be considered. Visbiome is the recommended probiotic in unresponsive cases. A diet trial with hydrolyzed protein or select protein diet could be considered. GI endoscopy (upper and lower) may reveal pathology not visible on ultrasound.

Urinary bladder wall thickening is likely pseudohypertrophy secondary to low volume of urine and lack of luminal distension, however, true mural thickening cannot be definitively ruled out. Re-examination when urinary bladder lumen volume is increased with time and/or fluid therapy should be considered if clinical suspicion for urinary bladder disease is high.

Renal changes are likely age related degenerative changes. Correlate clinical significance with blood work/urinalysis findings and clinical signs. Nephroliths may act as a nidus of infection and predispose to urinary tract infections. They have the potential to move into the ureters or bladder causing obstructive nephropathy.





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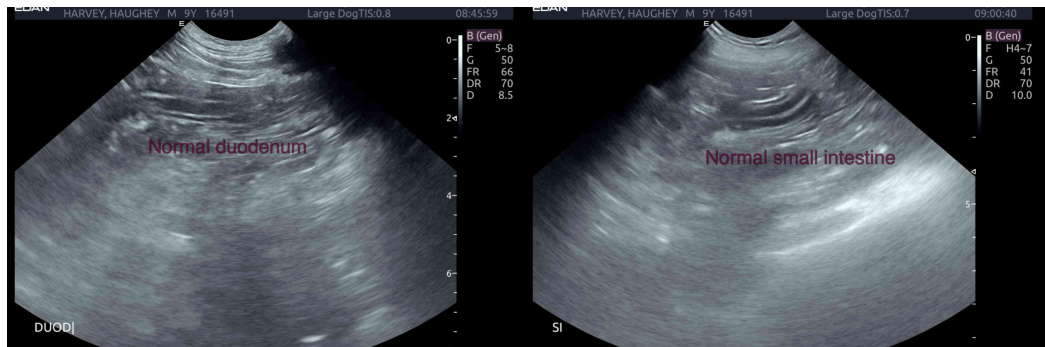
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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