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Clinical Sonography & Telecytology
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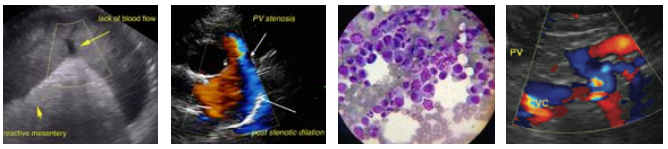

PATIENT
Fred Walters

SPECIES
Canine

BREED
Standard Poodle

SEX
Neutered male

AGE
14 years

WEIGHT
42 lbs

INTERPRETED BY
Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY
Dr. Ebersole

HOSPITAL NAME
Scanvet

REFERRING VET
Dr. Bennett

INVOICE
30004

DATE
4/28/22

PRESENTING CLINICAL SIGNS

History of bladder polyp. Concern for TCC. **History of splenectomy (benign changes), chronic IBD, colitis/constipation and FB surgeries. Red rubber urinary catheter used to drain bladder and aspirate mass w/US guidance after AUS.
Abnormal PE/Chem/CBC/UA Results: PE: thin, very weak in rear legs. BW: chronically elevated ALP and ALT. UA: Transitional cells, hematuria with UTI (rod bacteria).

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** polyp is now comprising a 3.27 x 3.0 cm polypoid mineralizing mass. The mass occupied the apical aspect of the bladder. Concurrent bladder sand was also noted and non-obstructive. The cystourethral junction and urethra were free of evident pathology. The mass appears persistently resectable; however, it is not likely responsible for the clinical signs.

The **kidneys** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some age-related loss of curvilinear patterns regarding the capsule and C/M junction. The cortices presented largely uniform texture with some increased echogenicity expected for this age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. The right kidney measured 5.68 cm.

Adrenal Glands

The right **adrenal gland** was mildly enlarged and heterogenous measuring 1.72 cm at the cranial pole and 0.92 cm at the caudal pole. The left adrenal gland was normal in size and contour measuring 0.72 cm at the caudal pole and 0.69 cm at the cranial pole.

Spleen

The **spleen** was not visualized as it was previously removed. The region of the splenic fossa was unremarkable.

Liver

The right cranial **liver** revealed an expansive mass measuring approximately 6.0 cm and deviated the gallbladder caudally. The expansive mass is comprised of coalescing nodules and is a new development. It does not appear resectable. Other heterogenous changes were noted in the liver. The gallbladder and common bile duct were unremarkable.

Gastrointestinal

Examination of the **gastrointestinal tract** revealed a stomach and intestine free of stasis, of normal wall thickness, acceptable curvilinear mural detail, and peristaltic activity. Small and large intestine demonstrated normal luminal chyme and stool consistency respectively. No obstructive or overt infiltrative disease was noted. No associated abnormal lymphatic activity was noted.

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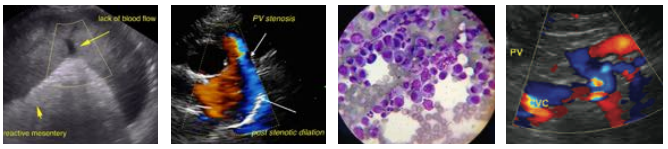

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Pancreas

The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour were acceptably normal and parenchyma respected normal curvilinear patterns. No overt evidence of active inflammatory or neoplastic disease was noted.

ULTRASONOGRAPHIC FINDINGS

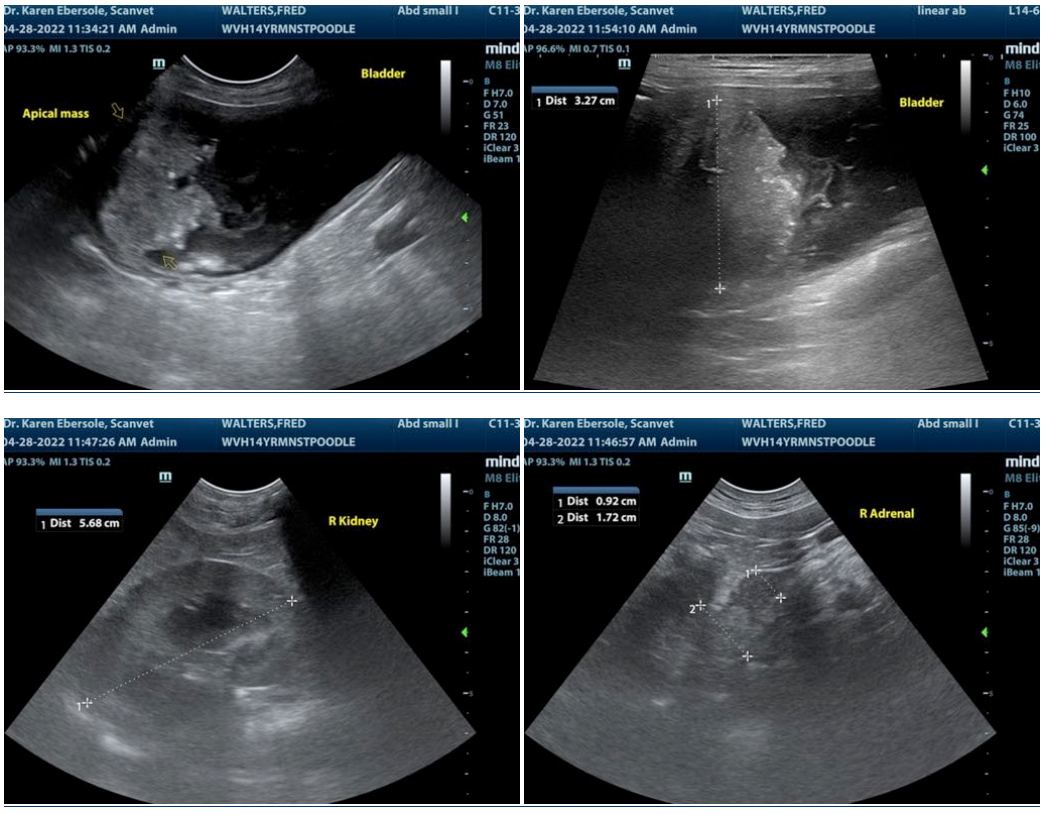
Right cranial liver mass. May be responsible for the clinical signs.

Apical bladder mass, strongly consistent with transitional cell carcinoma with concurrent bladder sand. Bladder mass appears resectable.

Irregular right adrenal gland, hyperplasia, pheochromocytoma and adenocarcinoma are all possible. This appears resectable.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The cystourethral junction, urethra and ureteral papillae appear unaffected. Serial blood pressure measurements are warranted in this patient. Bile acid profile would be appropriate. The weakness in the rear legs may be spinal or CNS related. The abdominal findings may be completely incidental compared to the overall generalized weakness noted in the history. Differentials on the liver include large hepatoma less likely hepatocellular carcinoma carcinoma is more likely.



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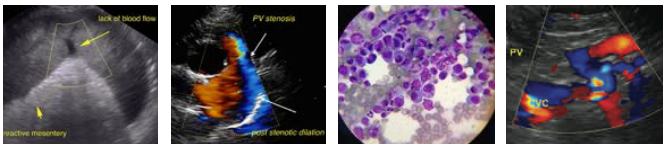

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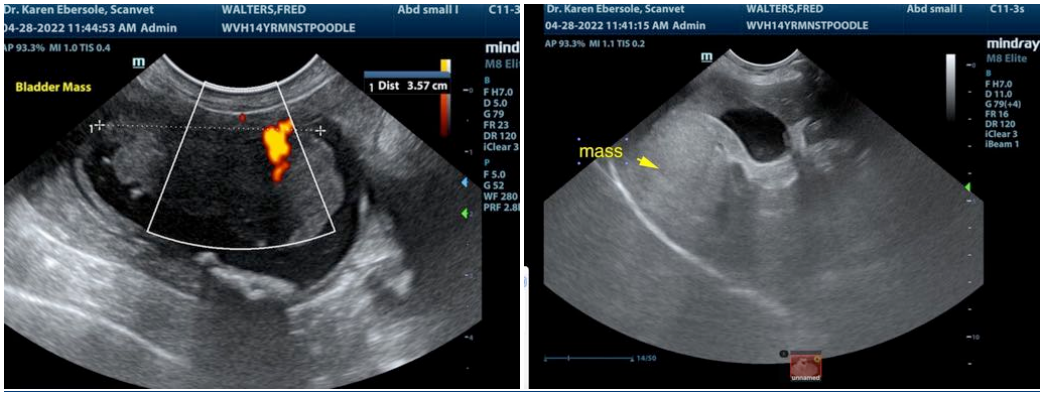

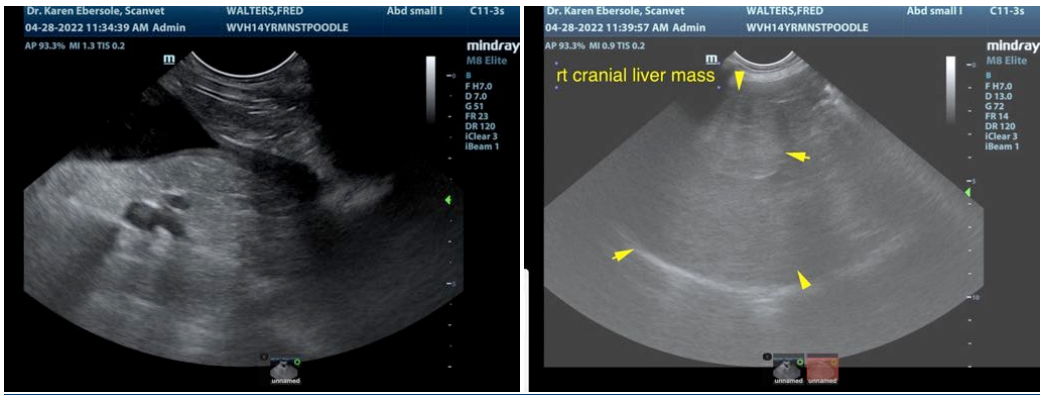

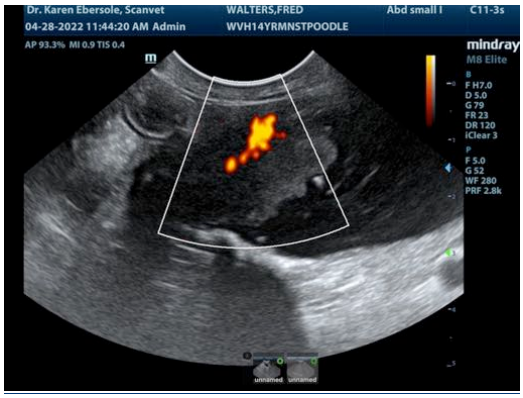

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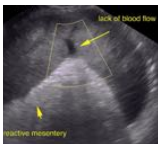

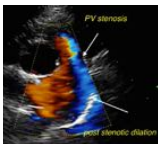

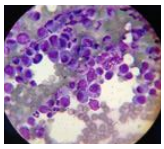
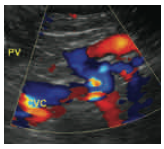

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Eric Lindquist, DMV, DABVP, Cert. IVUSS, CEO of SonoPath.com
info@SonoPath.com