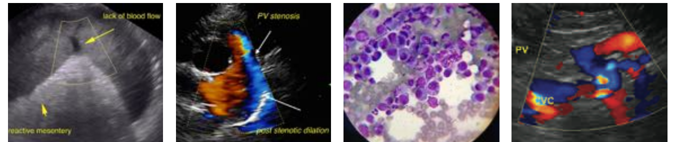


SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Gidget Lavigne

SPECIES

Canine

BREED

Miniature Australian Shepherd

SEX

Spayed Female

AGE

14 years

WEIGHT

8.5 kg

INTERPRETED BY

Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Biederbeck

HOSPITAL NAME

Lomsnes VH

REFERRING VET

Dr. Biederbeck

INVOICE

31141

DATE

6/21/22

PRESENTING CLINICAL SIGNS

History: UTI treated May 17, at that time BUN elevated and owners were worried got toxicity so was tx with IV fluids. Came in again June 17th as licking vulva and concern of continued UTI (no UTI on u/a). When getting cysto sample mass noted in abdomen so here today for full u/s
Bloodwork: (May 16/22) MCV 59.4fL (61.6-73.5), PCT 0.49% (0.14-0.46), SDMA 19ug/dL (0-14), BUN 42mg/dL (7-27), ALT 136U/L (10-125), Urine: (June 16/22) Cystocentesis, pale yellow, clear USG 1.028, pH 5.0, LEU 25Leu/uL, PRO 30mg/dL, KET 15mg/dL, BLD 50Ery/uL USG May 17 was 1.010 and had a UTI at that time

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **bladder** in this patient was mildly thickened with slight echogenic mural changes. No calculi or masses were noted. Slight micropolypoid changes were noted. This is a frequent finding in older animals and may be linked to a history of chronic urinary tract infection or active urinary tract infection. Urinalysis would be recommended with culture if any evidence of inflammatory sediment is present. The region of the trigone and visible pelvic urethra were normal.

The **left kidney** 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 is not visualized.

Adrenal Glands

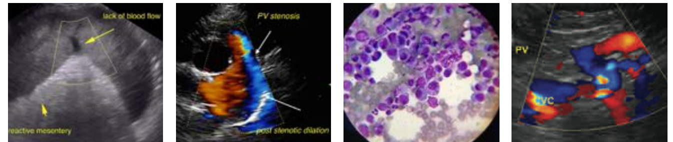
The **adrenal glands** were not visualized.

Spleen

The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes was noted.

Liver

A 6.0 cm cystic and echogenic mass is noted. It appears to be deriving from the caudal aspect of the left **liver**. The mass is pedunculated and at high risk for torsion or rupture. The hepatic mass appears resectable and is peripherally inflamed. Trace amounts of free fluid are noted. The gallbladder presented acceptably thin walls with primarily anechoic content. The cystic and common bile ducts were normal. No pathological hepatic lymphadenopathy was evident.



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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.

Pancreas

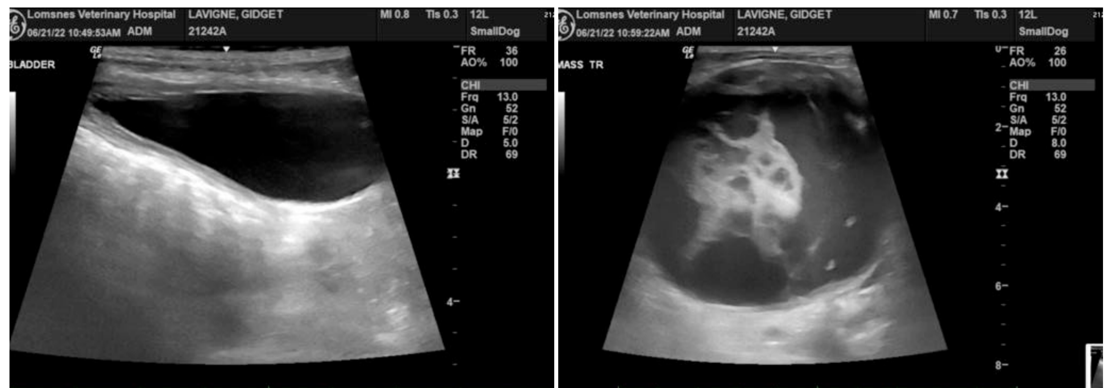
The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour were acceptably normal and parenchyma respected normal curvilinear patterns. No overt evidence of active inflammatory or neoplastic disease was noted.

ULTRASONOGRAPHIC FINDINGS

Mildly inflamed left caudal cystic liver mass, abscess or complex cyst.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Surgical intervention and removal is essential with left lobectomy. Liver biopsy is warranted as well culture of the fluid is recommended. There is a solid possibility that the mass is histopathologically benign, but is highly precarious. Chest radiographs and exploratory surgery with left liver lobectomy is recommended.



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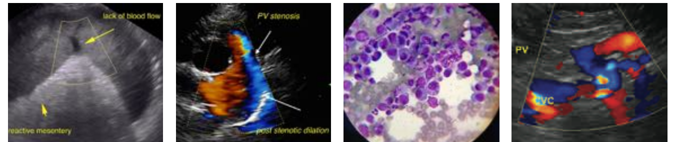

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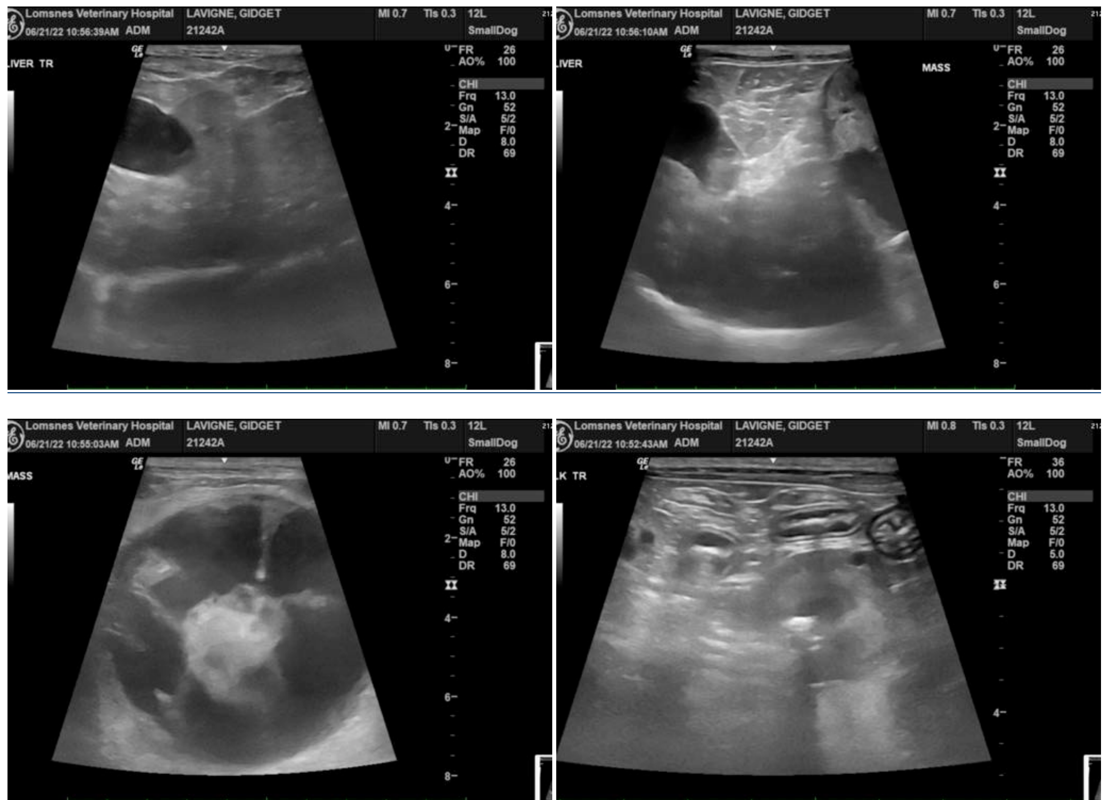

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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