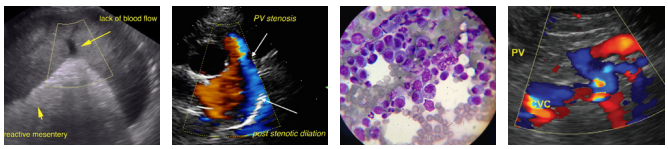

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1-800-838-4268 info@sonopath.com

PATIENT

Nellie Snyder

SPECIES

Canine

BREED

Australian Shepherd

SEX

Spayed female

AGE

11 years

WEIGHT

17 kg

INTERPRETED BY

Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Nack

HOSPITAL NAME

Veterinary Speciality Services Manchester

REFERRING VET

Dr. Nack

INVOICE

75983

DATE

7/7/23

PRESENTING CLINICAL SIGNS

History: History of bladder stone surgery 5 months ago. Has been straining to urinate for last few weeks
Abnormal PE/Chem/CBC/UA Results: CBC: elevated platelets otherwise WNL Chem 20: mildly elevated sodium 161 (144-160) UA (cysto) 3+proteinuria, USG1.030, RBCs 10-15/hpf, WBC 2-5/hpf

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** itself was structurally normal; however, a hypoechoic, undifferentiated tissue measuring approximately 2.0 x 1.5 cm was noted ventral to the bladder wall with enhanced surrounding fat. The mass appears to be deriving from the apical portion of the bladder wall. There is concern for urinary leakage.

The **kidneys** revealed normal size and structure, corticomedullary definition and ratio for this age. The cortices presented largely uniform texture with normal echogenic relationship to liver and spleen. Medullary structure differed distinctly from the cortex and no evidence of pelvic dilation was present. The capsules were acceptably uniform without significant irregularities. The left kidney measured 5.8 cm. The right kidney measured 6.0 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 0.72 cm at the caudal pole and 0.62 cm at the cranial pole. The right adrenal gland measured 0.96 cm at the cranial pole and 0.7 cm at the caudal pole.

Spleen

The **spleen** was mildly enlarged with enhanced mesentery and localized free fluid medial to the spleen.

Liver

The **liver** was uniformly swollen with minor, excessive gallbladder debris and over distension with dependent and suspended bile without evidence of overt mucocele formation. However, excessive sludge was present. Occasional, hypoechoic, non-disruptive nodule was noted. The liver presented coarse architecture with mildly increased portal markings and subtle, mixed echogenic changes. This is consistent with vacuolar hepatopathy and some level of remodeling and history of inflammatory component. There was no overt suspicion of neoplasia.

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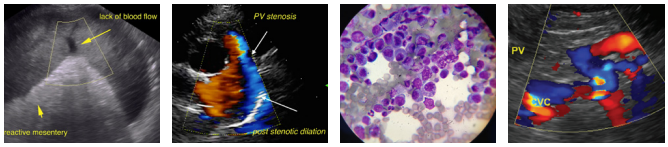

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Gastrointestinal

The stomach was filled with progressively shadowing ingesta. This is consistent with post prandial presentation or delayed outflow. These findings should be paired with feeding history. The intestines were 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.

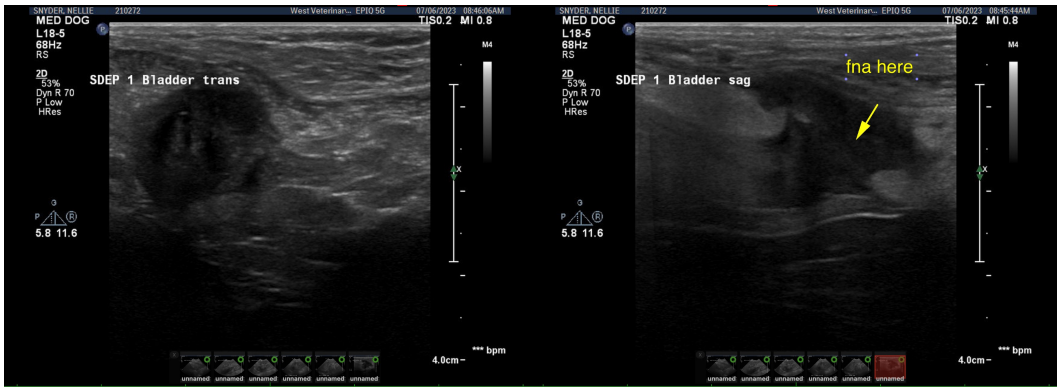
ULTRASONOGRAPHIC FINDINGS

Undifferentiated mass cranial ventral to the urinary bladder, regional omental reactivity and localized free fluid escaping into the region of the medial spleen. Concern for carcinoma spread or granulomatous disease post surgery from possible suture reaction and non-neoplastic presentation, yet urine escape may be an issue.

Free fluid, potential urine leakage or underlying sarcoma.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the patient's surgical history, suture reaction and granulomatous, non-neoplastic proliferative tissue is possible. However, exploratory surgery with expectations towards bladder resection is warranted. Escape into the omentum may be an issue. Screening FNA can be considered, but if this is carcinoma, it may trail. This is likely not critical as if this is a neoplastic presentation it has likely already spread into the regional omentum. Chest radiographs are recommended to assess for comorbidities.



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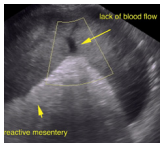

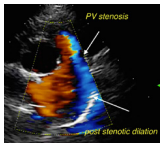

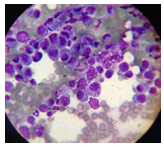
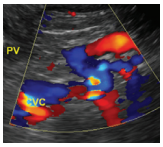

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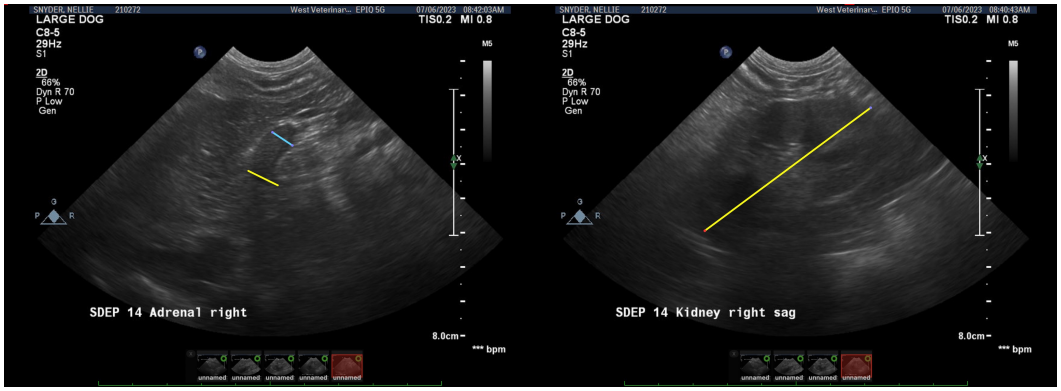

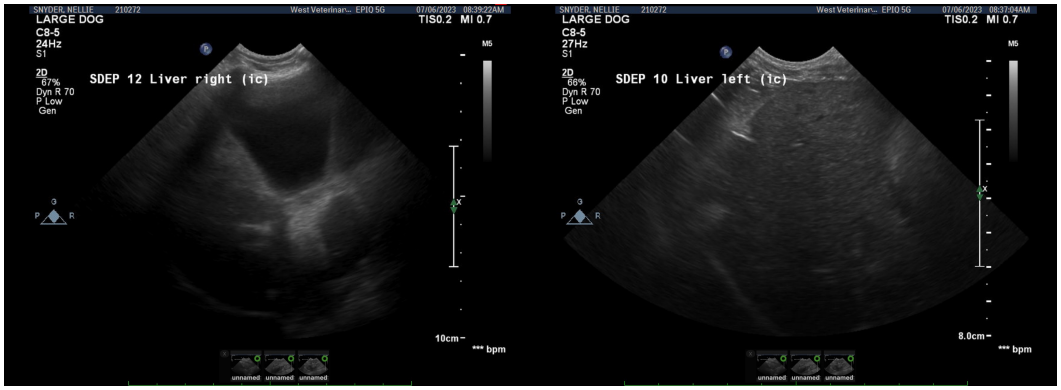

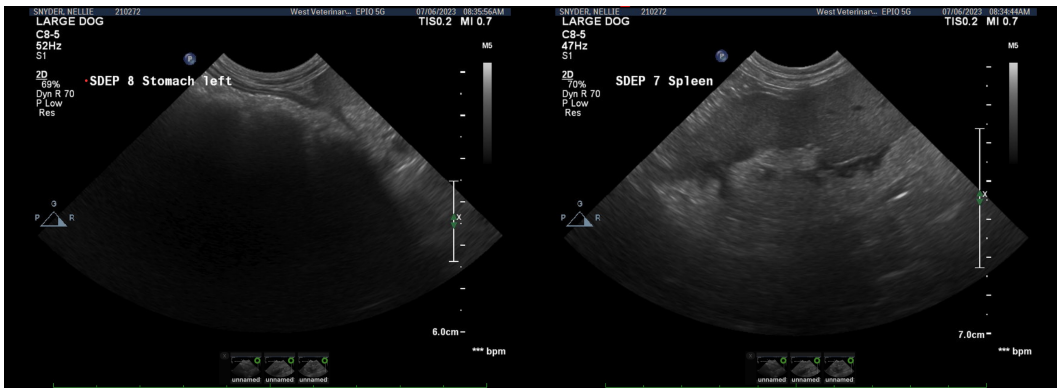

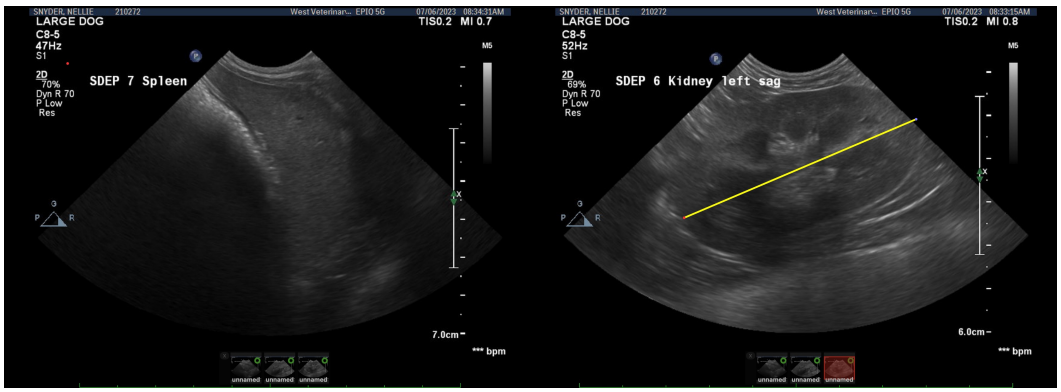

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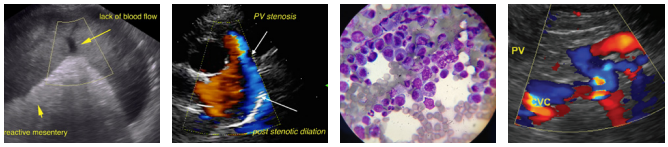

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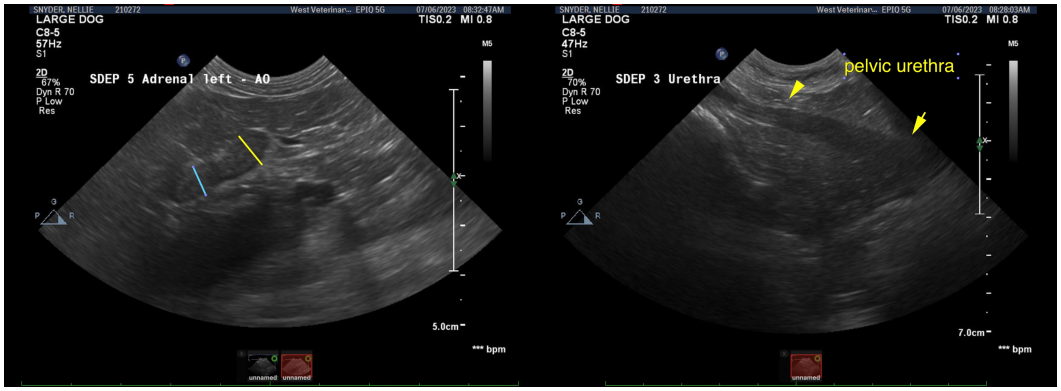

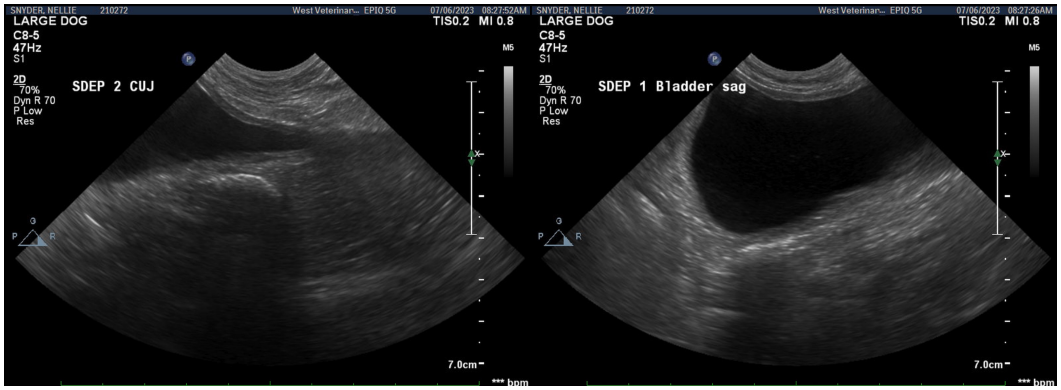

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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