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Clinical Sonography & Telecytology
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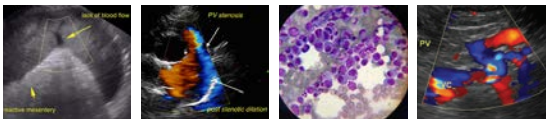

imagine SOUND LLC.
IMAGING PERFORMED BY
dbimaginesound@gmail.com 917-647-4318

PATIENT
Nana Soto

SPECIES
Canine

BREED
Pekingese

SEX
Spayed Female

AGE
10 Years

WEIGHT
9.5 Pounds

INTERPRETED BY
Eric Lindquist, DMV DABVP, Cert IVUSS

IMAGING PERFORMED BY
Denise Bruno, LVT, RDMS

HOSPITAL NAME
Ideal Pet Vet Clinic

REFERRING VET
Dr. Kolta

INVOICE
41185

DATE
9/8/22

PRESENTING CLINICAL SIGNS

Increased ALT 563; ^ Alk 3966; ^K 5.9; ^Cholesterol 509; Decreased CL 101. Labs attached

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. Minor amount of sand present measuring 0.87 cm. No evidence of inflammatory or neoplastic changes were noted. Ureteral papillae were normal.

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 his age patient. Medullary structure differed distinctly from that of the cortex. Pelvic dilation noted in the right kidney. The right kidney measured 4.17 cm. The distal right ureter revealed a calculus measuring 0.76 cm with ureteral dilation of 5.0 mm. The left kidney measured 3.54 cm.

Adrenal Glands

The **adrenal glands** appeared slightly enlarged and swollen. No evidence of focal capsular expansion or invasion into the phrenic veins were noted. No overt suspicion of neoplasia was noted. This is considered likely a hyperplastic change associated with stress or adrenal endocrinopathy (PDH). If isosthenuria is persistently present and the patient morphologically suggests Cushing's disease then ACTH testing would be indicated. The left adrenal gland measured 1.96 cm x 0.85 cm at the cranial pole and 0.78 cm at the caudal pole. The left adrenal gland measured 2.38 cmx 0.80 cm at the cranial pole and 0.67 cm at the caudal pole.

Spleen

The **spleen** revealed a hypoechoic nodule measuring 1.06 cm. The remainder of the spleen was slightly heterogeneous.

Liver

The **liver** presented coarse architecture and minor swelling. Minor excessive gallbladder debris noted. A hyperechoic nodule was noted in the left cranial liver measuring 1.0 cm, and a separate iso- to hyperechoic mass measuring 4.0 cm.

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.

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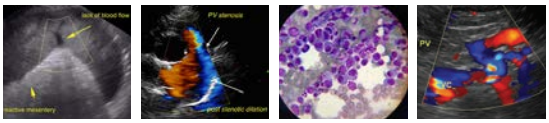

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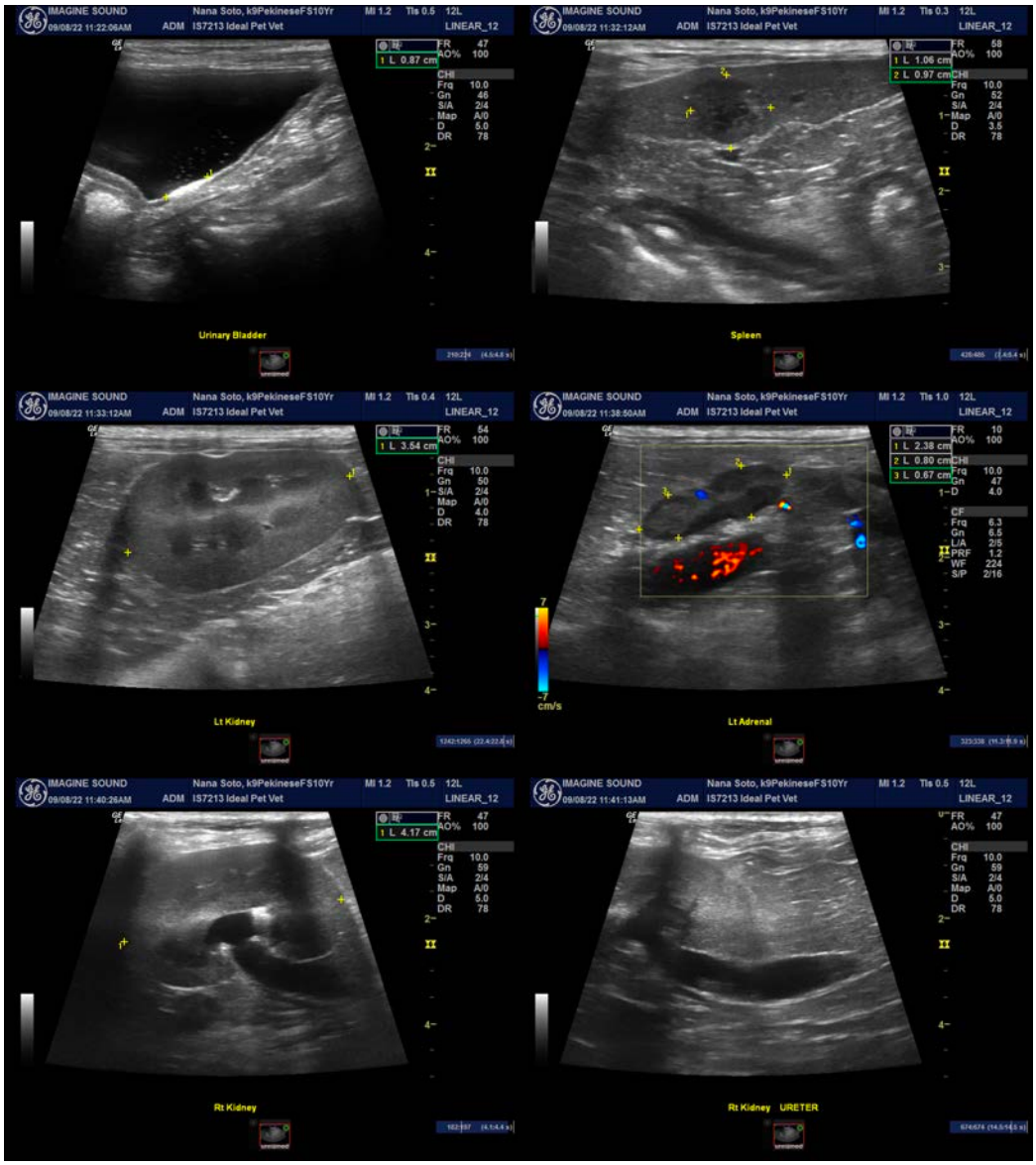
ULTRASONOGRAPHIC FINDINGS

- Hepatic mass and nodule
- Splenic nodule
- Obstructed right ureter owing to 0.76 cm calculus
- Bladder sand
- Mild degenerative renal changes with calculi and right renal pyelectasia

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The hepatic mass may be histopathologically benign or low-grade. Surgical intervention is necessary for the right ureteral obstruction as well as liberation of the bladder sand. CT evaluation of the liver mass could be considered to assess if possibly resectable, yet it extends medially, rendering resection possibly difficult. Splenectomy also indicated, given the splenic nodule that is expansive and disruptive. FNA of the splenic nodule and hepatic mass could be considered from a screening standpoint. Workup for pituitary dependent hyperadrenocorticism necessary once the immediate issues have resolved.



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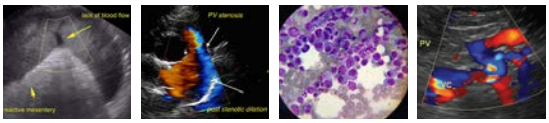

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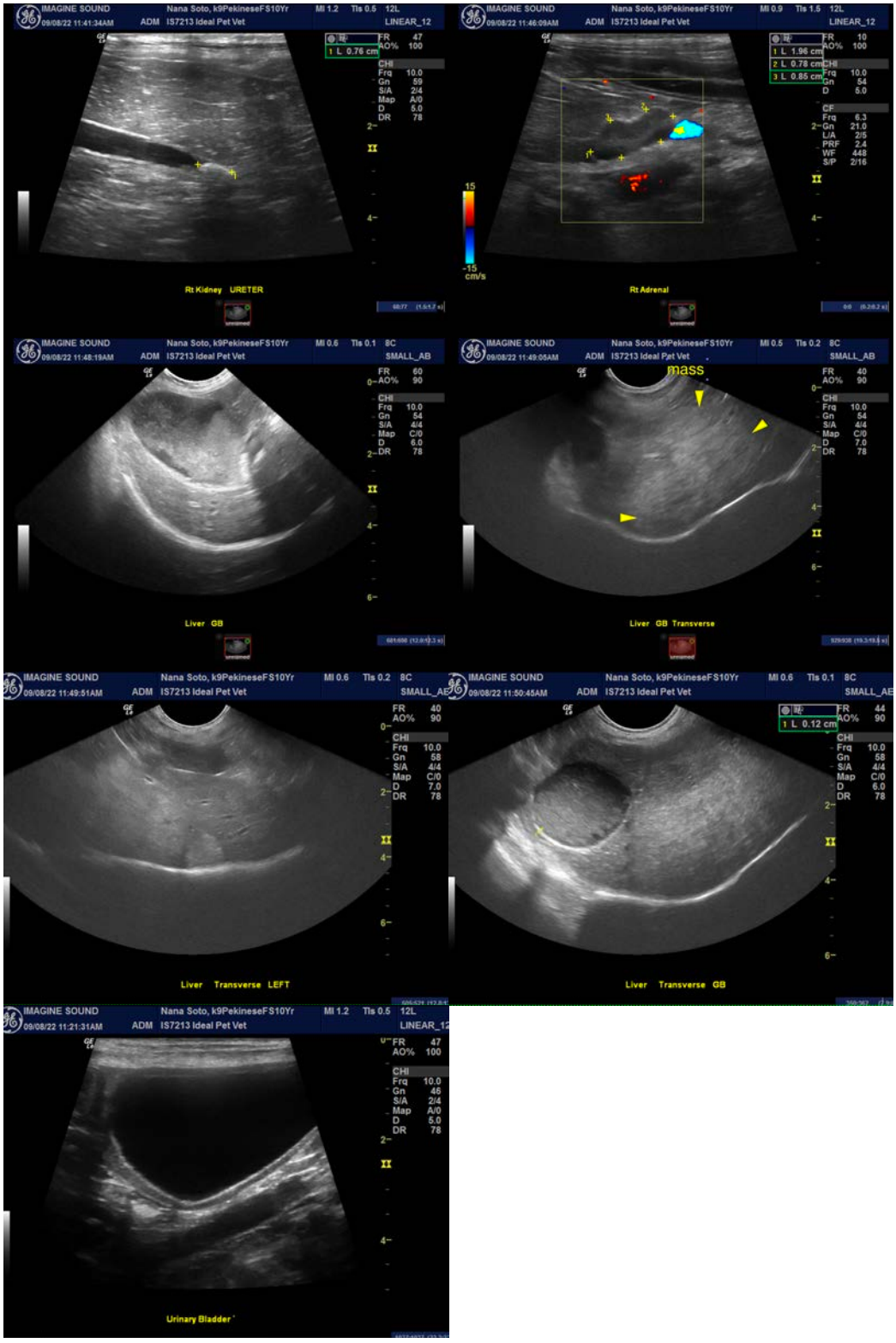

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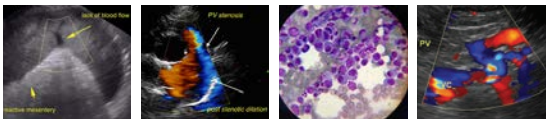

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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