PATIENT

Angus Beam

SPECIES

Canine

BREED

German Shepherd

SEX

Neutered Male

AGE

9 Years 6 Months

WEIGHT

103.4 lbs

INTERPRETED BY

Greg Kuhlman, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY

Kathleen Byrnes

HOSPITAL NAME

Animal Hospital of Boone

REFERRING VET

Dr. Watson

INVOICE

74298

DATE

4/8/26

PRESENTING CLINICAL SIGNS

P presented for US due to chronic anorexia, poor appetite and occasional vomiting. Chest rads revealed diffuse nodules concerning for fungal dz vs mets. Fungal test sent out and positive for coccidiomycosis, but lab concerned it is a false positive.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder is moderately distended with anechoic urine. No uroliths are seen. The bladder wall is normal in appearance and thickness. No masses are seen.

The prostate is normal in size at 8.8 mm in width. It is symmetrical with uniform echogenicity.

The right kidney presents normal size (8.1 cm) with normal shape and architecture. Normal corticomedullary distinction. No pyelectasia, ureteral dilation or nephrolithiasis.

The left kidney presents normal size (7.3 cm) with normal shape and architecture. Normal corticomedullary distinction. No pyelectasia, ureteral dilation or nephrolithiasis.

Adjacent to the caudal pole of the left kidney there is a hypoechoic, irregularly shaped lesion present that measures 1.8 cm x 1.1 cm. This lesion does not appear to be specifically attached to or within the left kidney.

Adrenal Glands

The right adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The cranial pole measures 7.3 mm and the caudal pole measures 5.5 mm.

The left adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The cranial pole measures 6.2 mm and the caudal pole measures 6.6 mm.

Spleen

Within the body of the spleen near the hilus there is a 3.8 cm in diameter, capsule displacing, mildly cavitated, heterochoic mass lesion present. Throughout the body of the rest of the spleen there are multiple other multifocal hypoechoic lesions present. A representative lesion measures 7.8 mm in diameter.

Liver

The liver presents normal size and shape with smooth lobar margins. The parenchyma has normal echogenicity with normal echotexture. No focal lesions are seen. Intrahepatic bile ducts are normal. Normal vascular pattern. No evidence of obvious metastatic disease seen within the liver.

The gallbladder presents normal size with anechoic contents. Normal gallbladder wall. No evidence of bile duct distention or obstruction.

Gastrointestinal

The stomach and intestines have normal wall layering and thickness. Colon contains normal contents with normal wall thickness.

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Pancreas

The visible pancreas is normal in size with normal echogenic parenchyma and surrounded by normal peri-pancreatic mesentery.

Free Abdomen

Mild mesenteric lymphadenopathy is present, a representative node measures 8.7 mm x 15.2 mm, appears reactive.

There is a scant pocket of free fluid present near the caudal pole of the left kidney.

ULTRASONOGRAPHIC FINDINGS

- Splenic mass lesion - This lesion is concerning for malignant neoplasia such as hemangiosarcoma or other malignant neoplasia. Less likely this lesion is due to a benign etiology such as a hemangioma or granuloma. Other differentials include round cell neoplasia such as lymphoma versus mast cell disease.
- Other hypoechoic splenic lesions – May represent benign extramedullary hematopoiesis, possibly metastatic neoplasia from the primary larger lesion seen near the hilus, or possibly also due to round cell neoplasia such as lymphoma, mast cell disease, or histiocytic sarcoma.
- Mild mesenteric lymphadenopathy – most likely reactive due to a neoplastic cause, or may be enlarged due to infectious etiology.
- Hypoechoic, irregular lesion adjacent to the caudal pole of the left kidney – Likely a lymph node.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Consider fine needle aspirate of an enlarged abdominal lymph node with submission for cytology to help determine cause for mild lymphadenopathy.

Recommend ultrasound guided fine needle aspirate of the lesion adjacent to the caudal pole of the left kidney with submission for cytology to help further clarify the tissue of origin and etiology.

If possible, obtain ultrasound guided fine needle aspirate sample of the free fluid near the caudal pole of the left kidney and submit for fluid analysis and cytology. If only a small amount of fluid is obtained, recommend just submitting for cytology.

Recommend aspiration of the larger splenic lesion if possible for cytology and one or several of the smaller hypoechoic lesions found throughout the spleen to try to determine etiology of these lesions. If aspirate samples are inconclusive, then recommended considering splenectomy if clinically warranted and submitting spleen for histopathology.

It was discussed in the submission that the patient is positive for coccidiomycosis (also known as Valley Fever). It is unclear, given that the patient is currently living in the east coast, why this disease was tested for. If patient does have a travel history to areas where coccidiomycosis is endemic, such as out west (specifically Arizona or Colorado), then consider that the positive test may be true. If the patient has no significant travel history, retesting for this disease may be warranted, given that the lab is concerned it may be a false positive. It is not included in the history which test was submitted for

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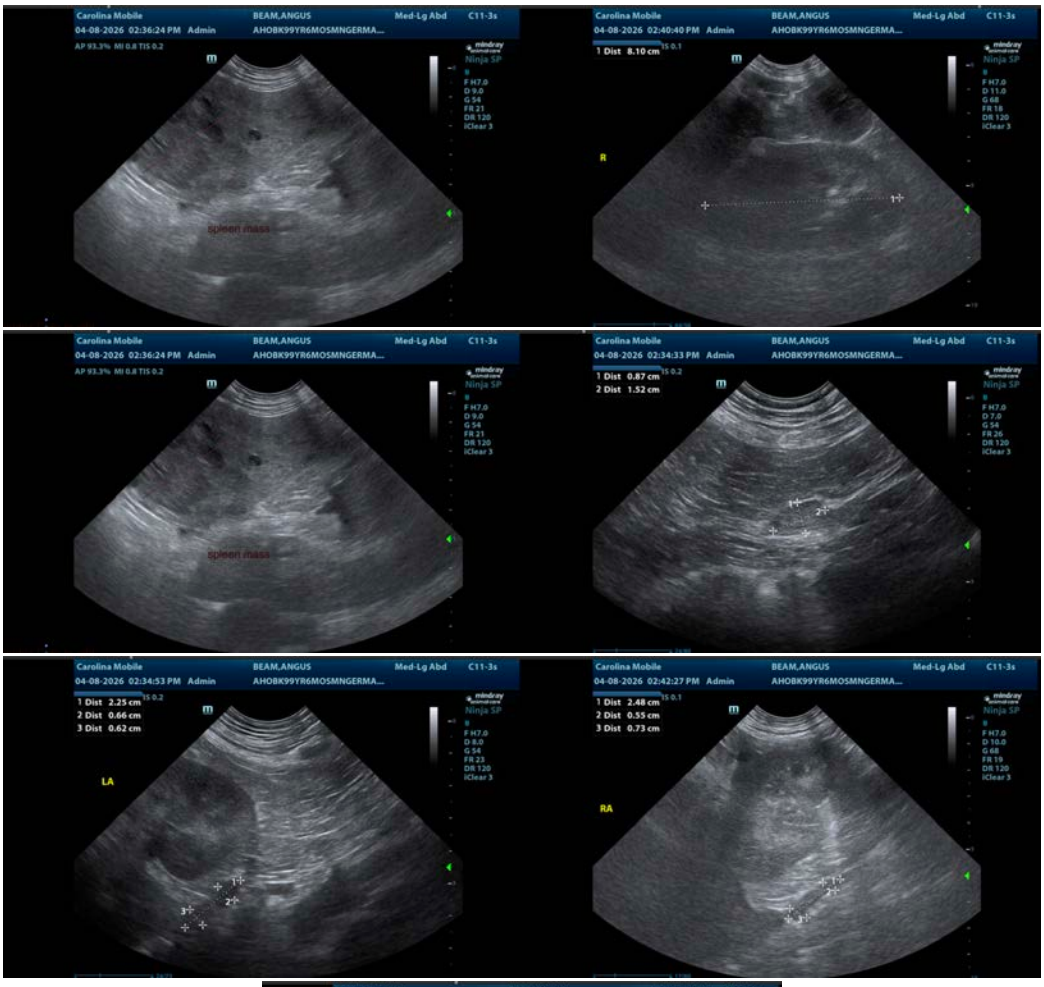
coccidiomycosis. If not submitted to Mira Vista Labs in Indiana, considering submitting a sample there as a confirmatory test to rule in/out coccidiomycosis.

The changes in the spleen are unlikely to be due to fungal disease. If aspirate sample of the splenic lesion show pyogranulomatous inflammation, then potentially fungal disease is a cause of the patient's splenic and pulmonary lesions. At this time it seems more likely that the patient has primary splenic neoplasia that has most likely metastasized to the lungs.



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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.

Greg Kuhlman, DVM, DACVIM (SAIM)

Veterinary Internal Medicine Specialist
info@SonoPath.com