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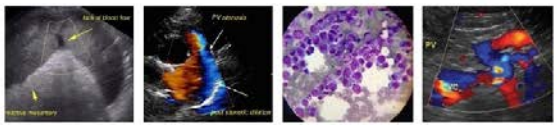


THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

**PATIENT**

Maggie McCurlie

**SPECIES**

Canine

**BREED**

Maltese X

**SEX**

Spayed Female

**AGE**

15 Years

**WEIGHT**

13 Pounds

**INTERPRETED BY**

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

**IMAGING PERFORMED BY**

Kelly Reschny

**HOSPITAL NAME**

Southside Pet Hospital

**REFERRING VET**

Dr. Velez

**INVOICE**

34164

**DATE**

1/12/22

## PRESENTING CLINICAL SIGNS

Maggie came in today for a PE after O noticed Maggie started having another episode of hematuria First episode happened last December 24th - dysuria , pollakiuria , hematuria of acute onset - sent out Clavaseptin x 10 days - per O clinical signs resolved within 24 hours. Maggie started having the same clinical signs today in the morning - O has been giving her Meloxicam to control discomfort PE II/VI LEFT SIDED HEART MURMUR NON PAINFUL BUT SUSPECTED HEPATOMEGALY MODERATE AMOUNT OF FRANK BLOOD NOTED AROUND THE VULVA currently on: Clavaseptin / Meloxicam Abnormal PE/Chem/CBC/UA Results: U/A:Gross hematuria but unable to read sediment due high concentration of RBC

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder is moderately distended with anechoic urine. The Bladder wall is diffusely thickened and irregular, measuring 0.65 cm in width. The area of the trigone, ureteral papillae and proximal urethra (to a depth of 2cm) appear free of any focal masses or calculi. Findings are most consistent with diffuse cystitis. Recommend urinalysis and culture.

The right kidney has a normal shape and size (4.45 cm) with pinpoint non-obstructive nephroliths. Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The left kidney has a normal shape and size (4.25 cm) with pinpoint non-obstructive nephroliths. Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

### *Adrenal Glands*

The left adrenal gland is normal in size measuring 0.59 cm. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

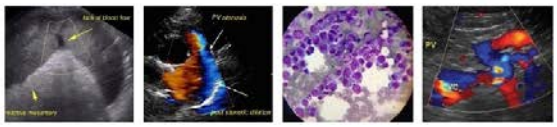
The right adrenal gland is normal in size measuring 0.55 cm. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

### *Spleen*

The spleen is subjectively normal in size. The spleen echotexture is heterogenous and mottled, the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. There is a 1.14 cm cavitated, irregular nodule visualized cranial to the left kidney. I suspect this is coming from the tip of the spleen, but cannot be 100% certain.

### *Liver*

The liver is subjectively normal in size and echogenicity, and is slightly irregular. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. On the left side of the liver, there is a distinct, irregular, hyperechoic mass effect measuring 4.1 cm in diameter.





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The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a moderate amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.

### *Gastrointestinal*

The stomach appears contains minimal luminal contents. It measures at a normal thickness of XX cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. Duodenum wall measured 0.42 cm. Jejunum wall measured 0.27 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

### *Pancreas*

The pancreas is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

## PRIMARY FINDINGS

- Diffusely thickened urinary bladder wall – most consistent with cystitis. Recommend urinalysis and culture.
- Irregular, cavitated nodule cranial to the left kidney – I suspect this is coming from the tip of the spleen. Alternately could be cavitated lymph node or omental nodule. Consider fine needle aspirate.
- Distinct hyperechoic solid mass effect in the liver - most consistent with a primary hepatic mass. This lesion could represent a benign or neoplastic process.

## SECONDARY FINDINGS

- Mild gallbladder sludge – The significance of the aggregated gallbladder sludge is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes to the urinary bladder are most consistent with diffuse cystitis.

- Urinalysis and culture are recommended.
- If symptoms persist/infection is not present, consider repeat imaging in 4-6 weeks to see if lesion is progressing.
- If persistent/progressive recommend urine evaluation for BRAF mutation seen in patients with transitional cell carcinomas

Due to the recurrent nature of these episodes, recommend culture and sensitivities prior to all antibiotic treatments.

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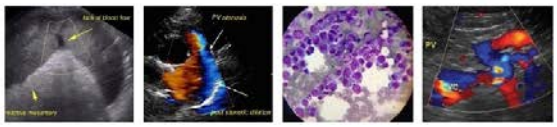

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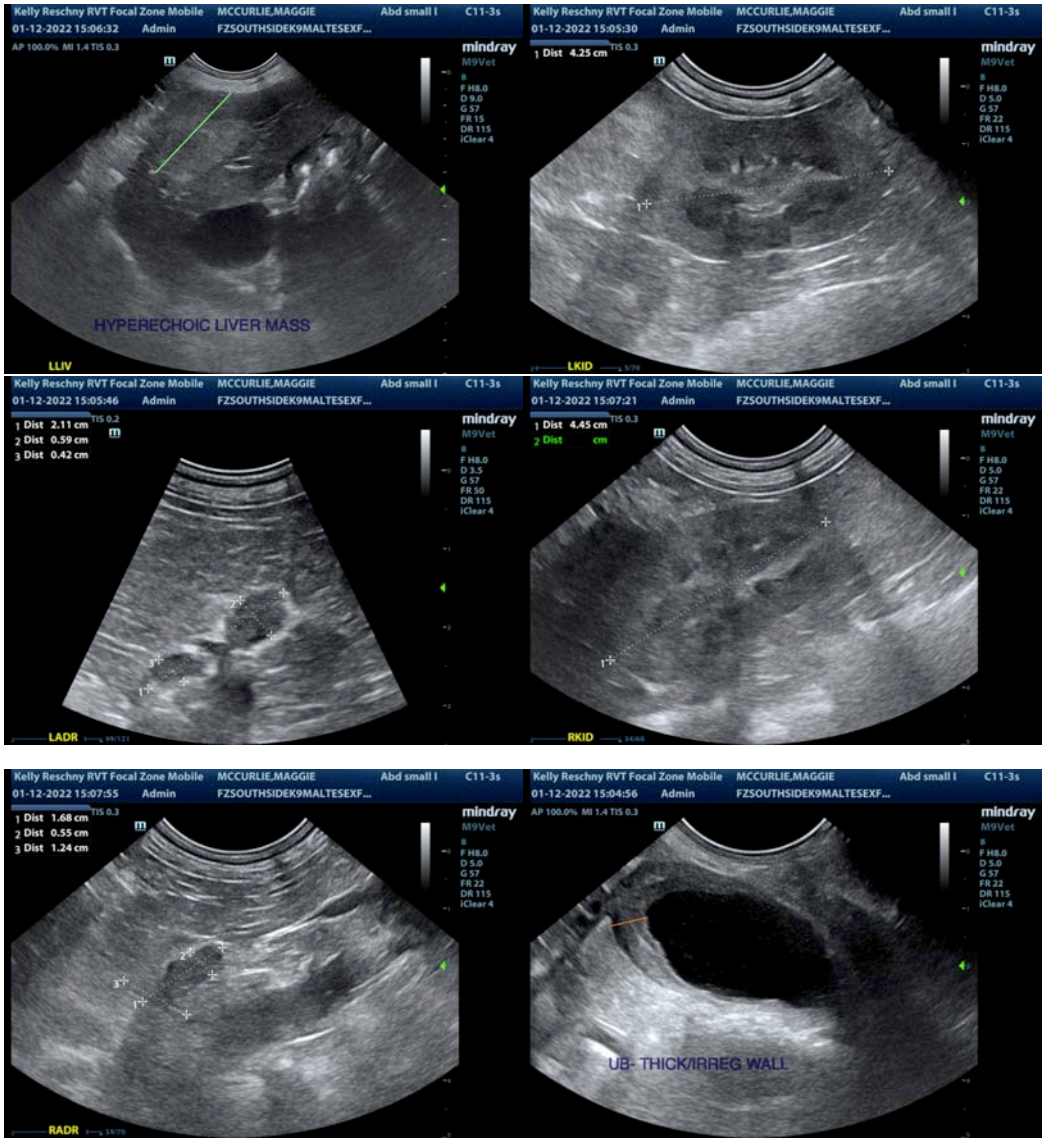
There is a nodule visualized cranial to the left kidney. I believe this is coming off of the tip of the spleen, and it appears somewhat pedunculated and cavitated. These findings are concerning. Consider fine needle aspirate with a very small gauge needle. This is a very superficial lesion.

There is a suspected large primary liver mass visualized. This could be related to the nodule visualized cranial to the left kidney, or could be an independent process. I suspect they're unrelated.

- Consider a fine needle aspirate of the hepatic mass -if possible
- Consider a CT scan to better delineate the extent of this mass lesion and for potential referral to a veterinary surgeon for removal. Many primary liver masses have a favorable prognosis if they can be surgically removed. Evaluation of the possible splenic nodule with CT could also be considered +/- splenectomy.
- Recommend 3-view thoracic radiographs to look for concurrent intrathoracic lesions.



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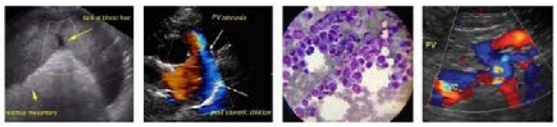

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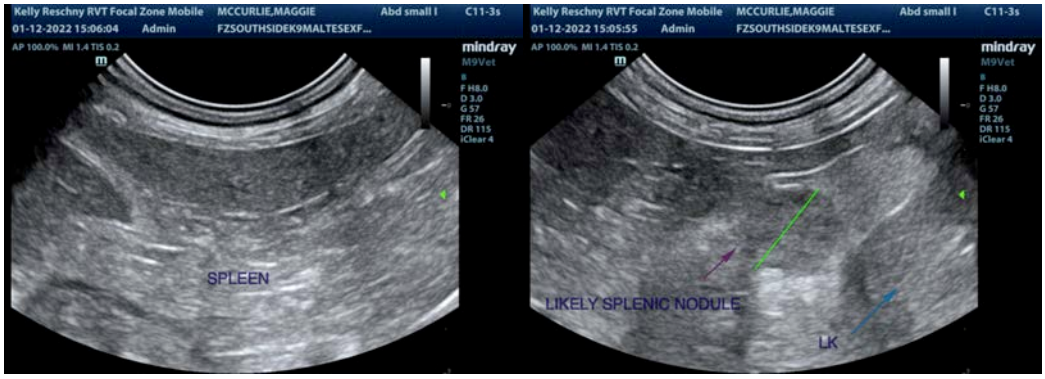


**The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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.

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)
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