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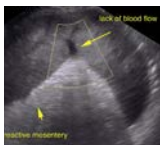
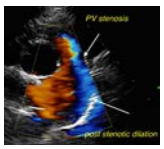
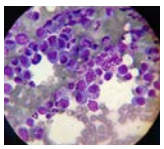
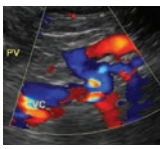
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

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

PATIENT

Harley Perna

SPECIES

Canine

BREED

Yorkshire Terrier

SEX

Neutered Male

AGE

12 Years

WEIGHT

8 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Scott

HOSPITAL NAME

Ho Ho Kus VH

REFERRING VET

Dr. Scott

INVOICE

44461

DATE

1/24/23

PRESENTING CLINICAL SIGNS

Hx of PLN and pancreatitis. Currently on telmisartan and clopidogrel. Bilious Vomiting twice in the last week - went to get urine sample to recheck UPC and saw strange thing in the bladder wall

Abnormal PE/Chem/CBC/UA Results: slight weight loss prev CBC/CHEm WNL and UPC 0.9 last time

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly to moderately distended with anechoic urine. The Bladder wall appears mildly diffusely thickened and irregular, measuring at 0.56 cm. In the mid ventral region of the urinary bladder, there appears to a focal hypoechoic nodule/mass lesion that is submucosal/intramural, measuring approximately 0.66 cm x 0.52 cm. The area of the trigone, proximal urethra, and urethral papillae appear free of any mass lesions or calculi.

The visualized areas of prostate and surrounding tissue appear normal. Unfortunately, the prostate is not fully visualized likely due to its intrapelvic location. Correlate with rectal exam findings.

The left kidney has a normal shape and size (3.79 cm) with numerous cortical cysts. Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.81 cm) with numerous cortical cysts. Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is borderline large in size measuring 0.76 cm at the caudal pole. 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.

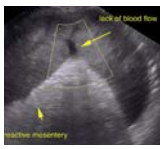
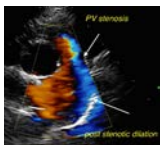
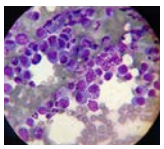
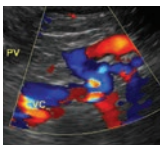
The right adrenal gland is normal/borderline large in size measuring 0.83 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size, echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

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The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and primarily anechoic. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach is moderately dilated with fluid and irregular shadowing material most consistent with normal ingesta and gas. It measures at a normal thickness of <0.7cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layering 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 measures 0.30 cm. Jejunum wall measures 0.29 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 prominent and mottled compared to the surrounding isoechoic mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

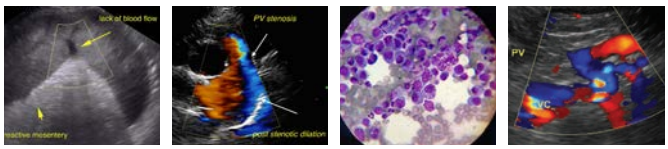
Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

PRIMARY FINDINGS

- Focal intramural hypoechoic nodule/mass effect and irregular bladder wall mucosa – findings are most consistent with cystitis and a focal lesion, which could represent round cell neoplasia, leiomyoma, leiomyosarcoma, or other intramural pathology.
- Moderate shadowing ingesta – Correlate with the feeding history and abdominal radiographs. If the patient was adequately fasted consider such differentials as delayed gastric emptying, a partial outflow tract obstruction (none seen) or ingested foreign material.
- Borderline bilateral adrenomegaly – The bilateral adrenomegaly could be consistent with bilateral hyperplasia (e.g., secondary to pituitary-dependent hyperadrenocorticism), bilateral infiltrative neoplasia, inflammatory adrenal disease, other. Correlation with clinical findings is recommended.

SECONDARY FINDINGS

- Decreased corticomedullary distinction in both kidneys – The bilateral renal findings are consistent with age-related change.



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- Prominent, mottled pancreas – The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

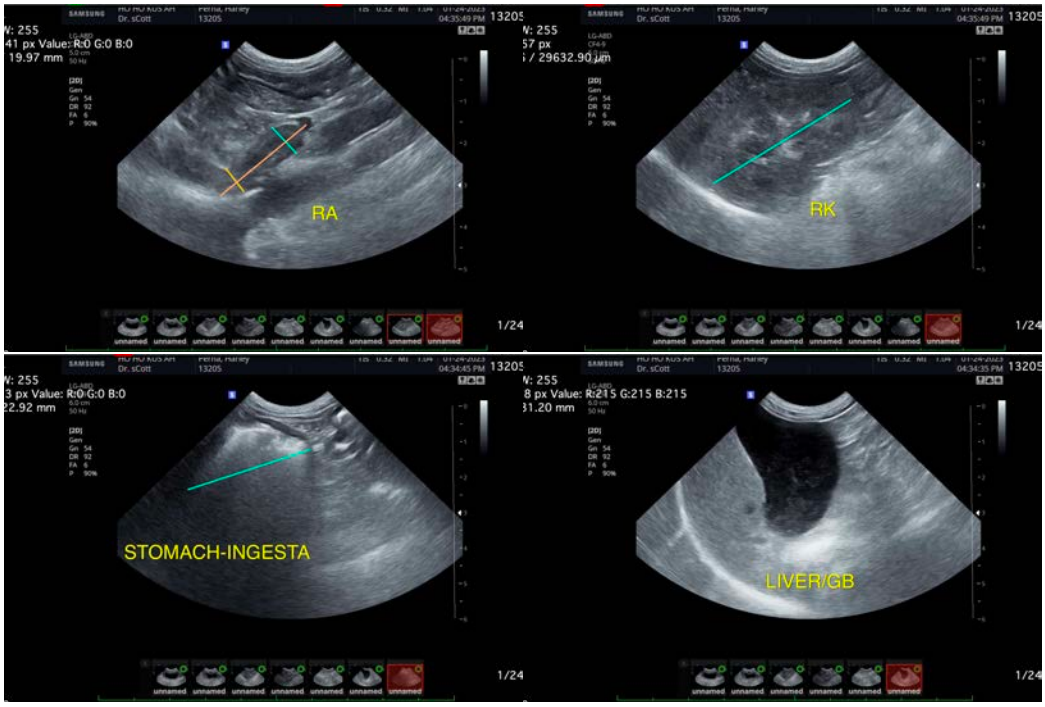
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The appearance of the bladder wall and the slightly irregular mucosa are most consistent with cystitis. Correlate with a urinalysis and culture. Additionally, there is a focal hypoechoic intramural lesion, which could be consistent with a benign or neoplastic lesion affecting the muscularis layer, such as round cell neoplasia, a leiomyoma, leiomyosarcoma, etc. Other differentials are possible. Consider a fine needle aspirate. If a diagnosis cannot be obtained based on a fine needle aspirate and the lesion is persistent, then consider surgical removal/biopsy.

The adrenals appear somewhat prominent for a small dog. Correlate this with clinical signs, bloodwork, etc., as this could be consistent with early Cushing's disease.

The changes observed in the kidneys are consistent with chronic age related renal disease as described in the history. If not already done, recommend blood pressure, urinalysis and culture as a baseline.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.



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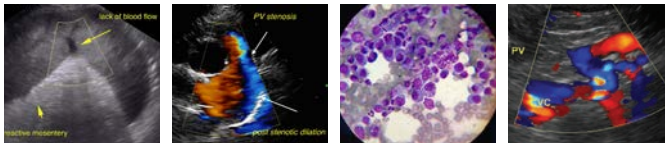

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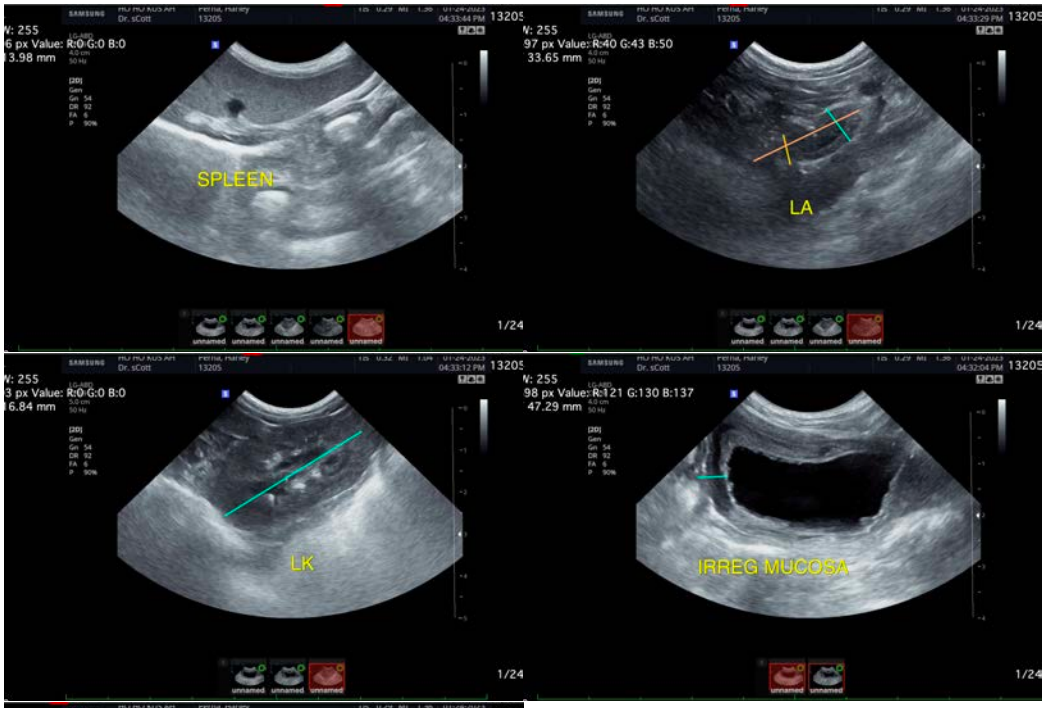

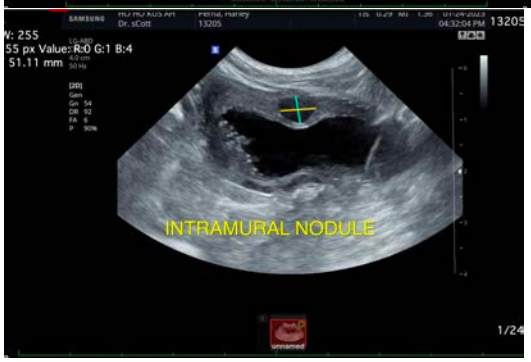

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

kathleen.sennello@sonopath.com