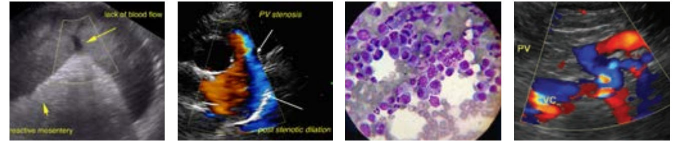
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Oggy Fedele

SPECIES
Canine

BREED
West Highland Terrier

SEX
Neutered Male

AGE
8 Years

WEIGHT
16.8 Pounds

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

IMAGING PERFORMED BY
Dr. Megan Bray

HOSPITAL NAME
Taylorsville VC

REFERRING VET
Dr. Melissa Earp

INVOICE
44965

DATE
2/8/23

PRESENTING CLINICAL SIGNS

P presented on 1/25/23 for routine exam with a Locum DVM. Grade 2/4 periodontal disease was noted, and COHAT scheduled. Pre-op bloodwork was submitted (attached) and hemoconcentration was noted. P presented for dental today, and PVC repeated and was 82% with total protein of 7 g/dL. Large, firm mass was appreciated in the cranial abdomen. Dental was put on hold, and ultrasound was performed. No sedation was given.

Abnormal PE/Chem/CBC/UA Results: Labs from 1/25/23- hemoconcentration (attached) 2/8/23: Large mass palpated in cranial abdomen, non-painful. PVC 82% TP 7 g/dL

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic 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 is large (8.46 cm) and irregular in shape with mildly reduced corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is a large, distinct, mixed echogenic, slightly hyperechoic mass effect arising off the caudal pole of the left kidney. This mass lesion measures 5.83 cm x 6.04 cm.

The right kidney has a normal shape and size (4.73 cm). Overall echogenicity is normal with mildly reduced 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 normal in size measuring 0.67 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 in size measuring 0.51 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.

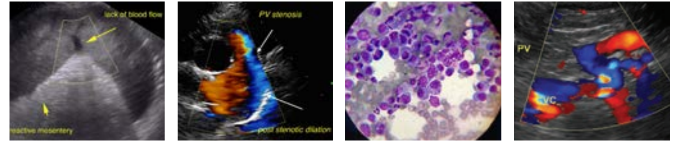
Spleen

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 large in size, and normal in echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

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.



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Gastrointestinal

The stomach contains minimal luminal contents. 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 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 measures 0.45 cm. Jejunum wall measures 0.31 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.

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.

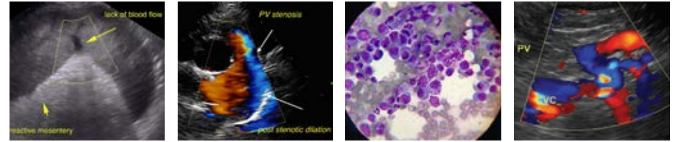
ULTRASONOGRAPHIC FINDINGS

- Large, mixed echogenic mass arising from the caudal pole of the left kidney – This could represent a benign or neoplastic mass effect. A primary renal tumor is suspected.
- Large, heterogeneous liver – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy.
- Decreased corticomedullary distinction in both kidneys – The bilateral renal findings are consistent with age-related change.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a large mass effect arising from the caudal pole of the left kidney. This is likely causing hypoxia and resultant release of erythropoietin, which is causing the hematocrit to rise and causing polycythemia. This level of polycythemia can be life threatening. Phlebotomy should be performed to stabilize the patient, and 3-view thoracic radiographs should be performed. If there is no evidence of metastasis, then consider referral to a veterinary surgeon for nephrectomy to help correct the paraneoplastic syndrome and to remove the tumor. There is some concern that there is decreased corticomedullary distinction in the right kidney, so function with one kidney could be questionable. The only other palliative therapy would be recurrent phlebotomies, which tend to be needed frequently and are poorly tolerated over time.

If there is no metastasis, and renal function is adequate with one kidney, then prognosis could be good for this individual with surgery. A fine needle aspirate could be considered of the kidney provided blood pressure is normal. Additionally, urinalysis and culture is recommended.



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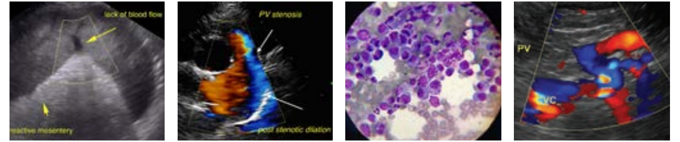

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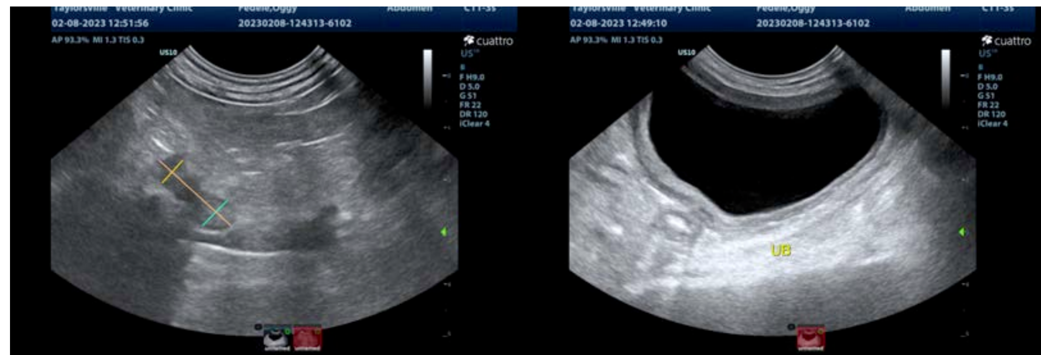

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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