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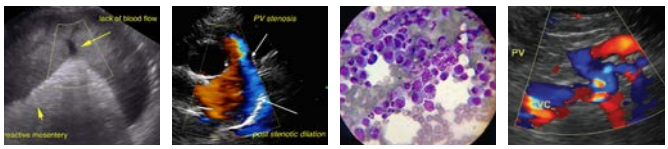

PATIENT

Phoenix Matys

SPECIES

Canine

BREED

Rottweiler

SEX

Neutered Male

AGE

8 Years

WEIGHT

148.8 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Shari Reffi, CVT

HOSPITAL NAME

North Warren AH

REFERRING VET

Dr. Corrado

INVOICE

46456

DATE

4/6/23

PRESENTING CLINICAL SIGNS

Concern for megaesophagus/lar. par/dis-motility issue. Increased thirst. Meds: Cyproheptadine 240mg/5ml

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly to moderately distended with anechoic urine. The Bladder wall is diffusely mildly thickened (1.13 cm), and the mucosa is mildly irregular. The trigone, ureteral papillae, and visible urethra (to a depth of 2cm) appear normal with no evidence of severe mucosal irregularities, masses or cystic calculi. Findings are most consistent with bacterial cystitis or lack of urine distension. Recommend urinalysis and culture.

The prostate is normal in size (2.1 cm) and shape for this neutered male dog. The parenchyma is homogenous and the external margins are smooth. The prostatic urethra appears normal with no evidence of irregularity, invasion, mass effect or calculi.

The left kidney has a normal shape and size (7.1 cm). Overall echogenicity is normal with adequate 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 (7.37 cm). Overall echogenicity is normal with adequate 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 large and slightly irregular, measuring 1.85 cm in the cranial pole, 2.6 cm at the caudal pole, and 5.3 cm in length. It is observed in its normal position cranial to the left renal artery. It is somewhat abnormal in appearance in that it is slightly heterogeneous and large. No significant evidence of vascular invasion is visualized.

The right adrenal gland is normal in size measuring 0.93 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 surgically absent, removed approximately two years ago. There is a mass lesion visualized in the region of the splenic fossa (see description under “other”).

Liver

The liver is subjectively normal in size, and 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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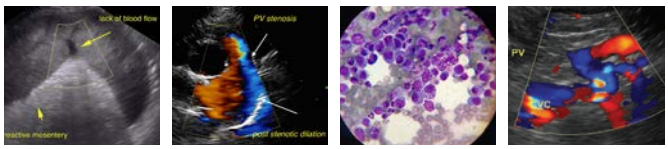

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Gastrointestinal

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. The duodenum measured as normal (between 0.3-0.5cm in wall thickness) and the jejunum measured as normal (between 0.2-0.47cm.) 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 area of 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. There is a solitary, large, hypoechoic mid abdominal lymph node visualized measuring 1.72 cm x 1.85 cm. The omentum is hyperechoic around the abdominal mass.

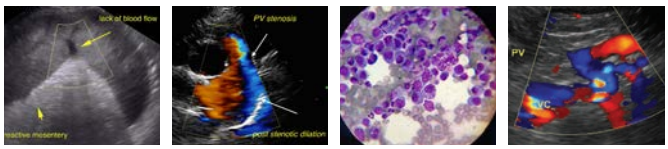
Other

There is a large, round mass effect visualized in the region of the left splenic fossa measuring 5.67 cm x 6.82 cm. This lesion has a thick hypoechoic rim with a more hyperechoic center and some hyperechoic shadowing material, possibly consistent with gas(?). An association with other abdominal structures is not visualized.

The right auricle and pericardium were visualized and were unremarkable. No obvious pathology is visualized. If cardiac function evaluation is desired a full echocardiogram is warranted.

ULTRASONOGRAPHIC FINDINGS

- Thickened, slightly irregular urinary bladder wall – The bladder mucosal changes could be consistent with cystitis or artifactual due to lack of adequate luminal distension. Bladder neoplasia cannot be ruled out but is considered unlikely in this patient.
- Large, irregular left adrenal gland – Findings are most consistent with a left adrenal mass. Adrenomegaly could be consistent with neoplasia (e.g., adenoma, carcinoma, pheochromocytoma), hyperplasia, inflammation, other.
- Large, hypoechoic, complex mass effect in the region of the splenic fossa – This could represent a lymph node, a necrotic tumor, abscess, recurrence of a neoplastic process, etc. Recommend a fine needle aspirate.
- Heterogeneous liver – The hepatic changes are consistent with age-related parenchymal remodeling and are not considered clinically significant at this time.



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- Large, hypoechoic mid abdominal lymph node – This lymph node is concerning for a metastatic lesion, although a reactive lymph node is possible.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a large, hypoechoic, almost cavitated appearing mass effect in the region of the splenic fossa. It has some ill-defined shadowing in the center of the lesion, which could possibly be consistent with gas/a necrotic lesion/abscess, etc. Recommend a fine needle aspirate of this lesion. Additionally, if there is a window to reach the enlarged mesenteric lymph node, consider a fine needle aspirate.

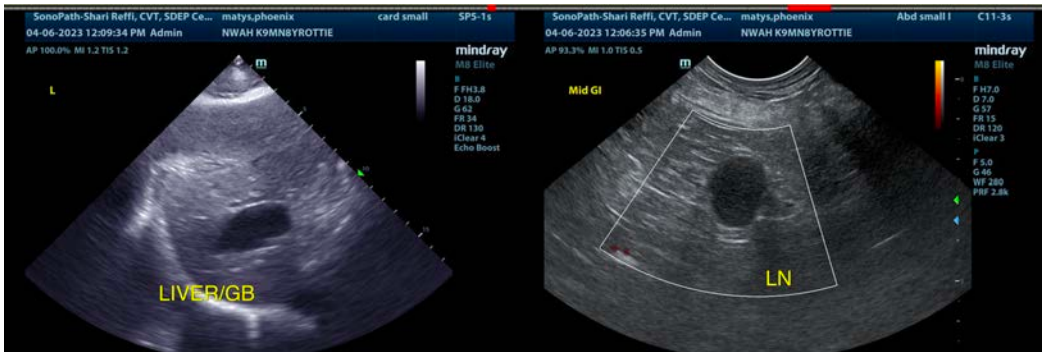
The enlarged left adrenal gland is most consistent with an adrenal mass lesion. This could be benign or malignant and could be secreting hormone or be non-active.

- If symptoms of Cushing's are present, you could consider adrenal function testing. I do not recommend this currently, as there is significant non-adrenal illness present, and interpretation would be challenging.
- Recommend blood pressure evaluation. If the patient is hypertensive, consider measuring catecholamine levels, looking for pheochromocytoma.
- If surgical removal would be considered, then consider a contrast CT scan to evaluate for possible vascular invasion, metastasis, etc.
- If surgical intervention is not desired, then recommend continued monitoring with ultrasound, as these lesions can sometimes be aggressive and grow quickly.

It would be a possibility to consider a contrast CT scan of the abdomen to evaluate both the mass effect and the left adrenal. If possible, recommend aspirating the mesenteric lymph node, looking for evidence of possible metastasis.

There is questionable scant pericardial effusion visualized. Consider an echocardiogram.

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



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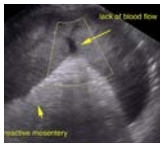
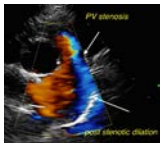
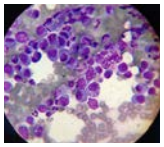
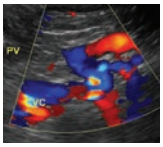

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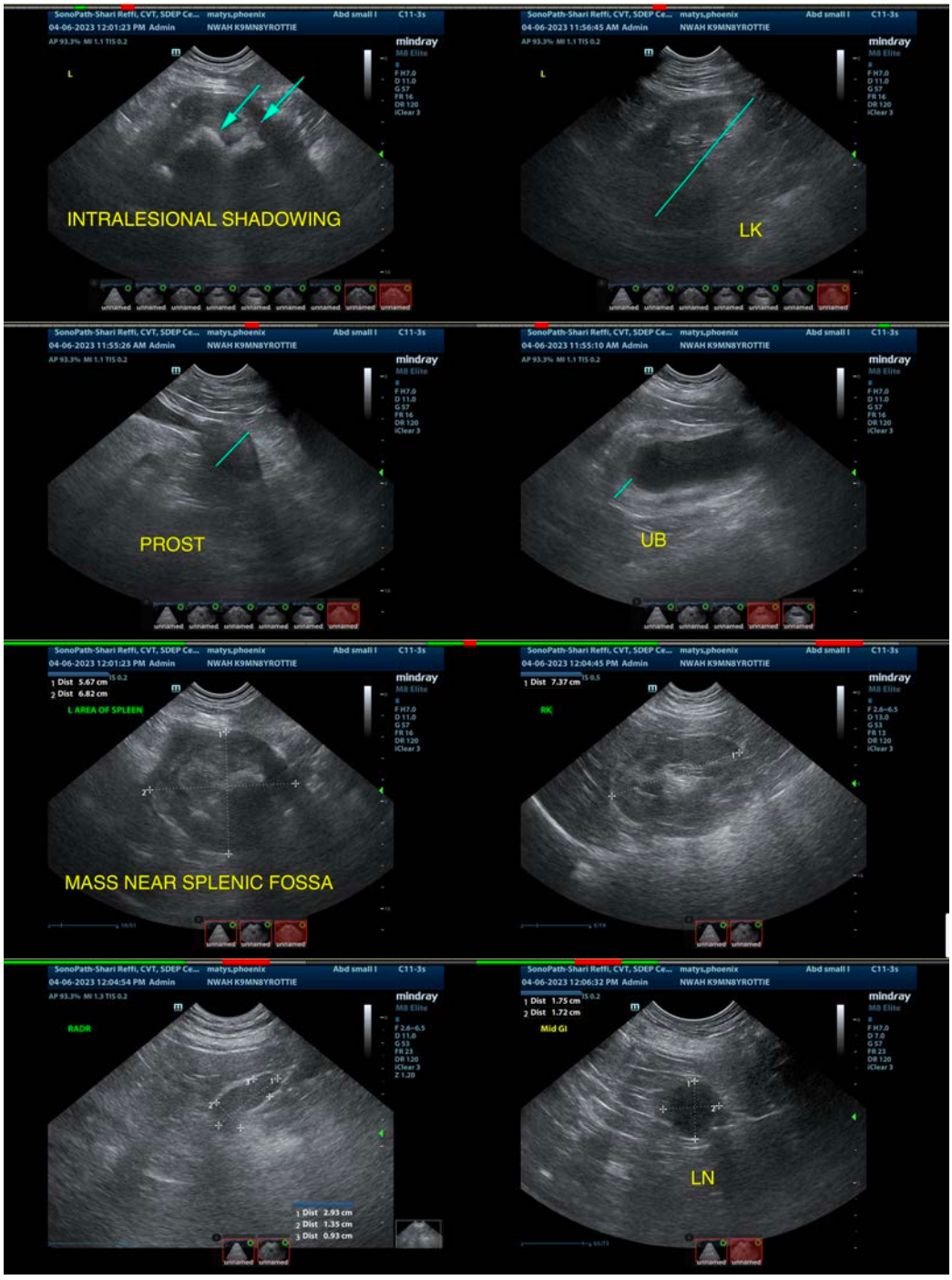

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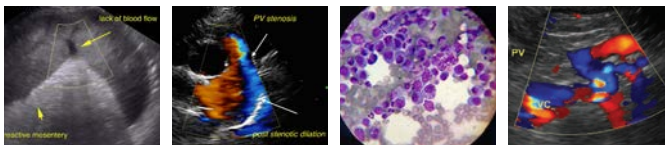

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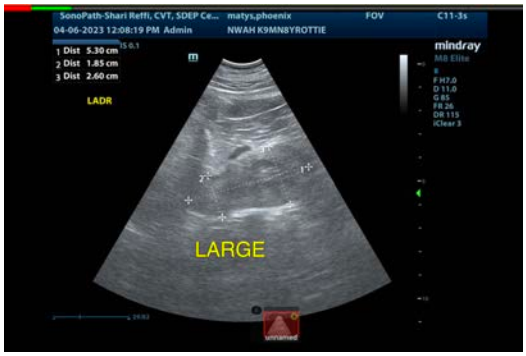

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

kathleen.sennello@sonopath.com