

**DATE PRESENTING CLINICAL SIGNS**

5/18/22

Decreased exercise tolerance, eating slower than normal and sometimes not finishing meals. Increased thirst that has gradually increased over last 1-2 years. Increased panting at unexpected times. Large mid abdominal mass noted on abdominal palpation, suspect splenic

PATIENT

Achmed Hurwitz

Current Medications: Gabapentin 300mg BID (3-4years), Dasuquin.
 Lab Results: 4+ proteinuria, USG 1.018.

SPECIES

Canine

Date of Previous IntraPet Ultrasound: No previous.
 Sedation: Dexdomitor/Torbugesic prior to sonographer arrival.
 Stat Report: Declined.

BREED

American Bulldog

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**SEX**

Neutered Male

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.

AGE

2/28/11

The prostate is normal in size (1.27 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.

WEIGHT

64 Pounds

The left kidney has a normal shape and size (6.89 cm). 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, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

INTERPRETED BY

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

The right kidney has a normal shape and size (7.26 cm). 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, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

IMAGING PERFORMED BY

Stephanie Pearce
 RDCS, RVT

Adrenal Glands

The left adrenal gland is normal in size measuring 0.91 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.

HOSPITAL NAME

Stevenson Village Vet

The right adrenal gland is normal in size measuring 0.74 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.

REFERRING VET

Dr. Vinson

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. The spleen is displaced caudally due to the cranial abdominal mass.

INVOICE

37735

Liver

The liver is large in size, and normal in echogenicity with an irregular shape. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. There is a very large mixed echogenic, partially cystic mass effect that appears to be coming from the liver. This lesion measures >13.27 cm x 10.02 cm.

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 mild amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.

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 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.

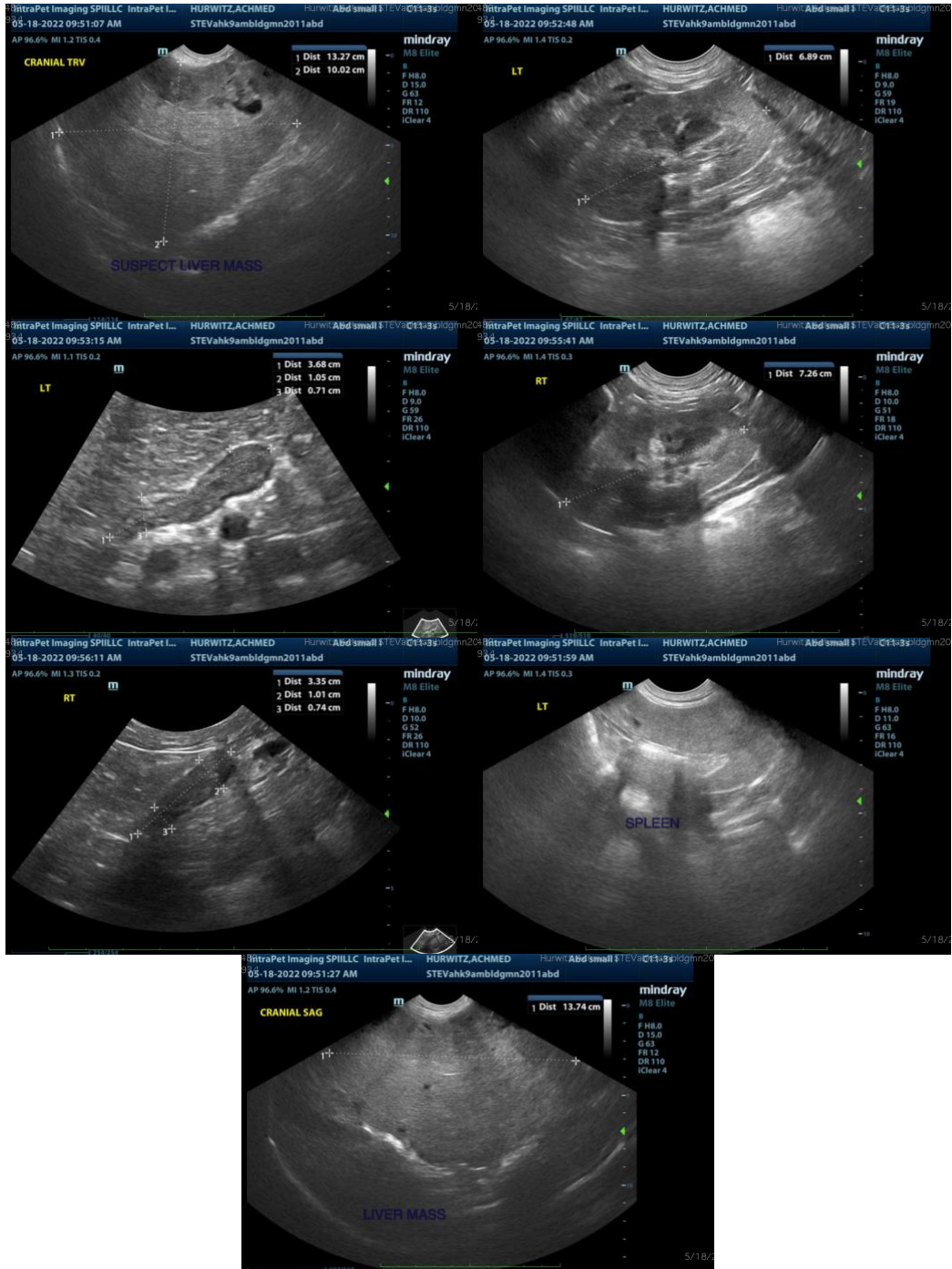
ULTRASONOGRAPHIC FINDINGS

- Large, irregular, heterogeneous and partially cystic cranial abdominal mass that appears to be arising from the liver – Findings are most consistent with a primary hepatic mass.
- Mild gallbladder debris – 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

There is a very large cranial abdominal mass. The mass appears to be arising from the liver and is most consistent with a large primary hepatic mass (adenoma or adenocarcinoma). Consider a contrast CT scan for further evaluation of the margins of this lesion and the possibility for surgical removal. If able to be surgically removed, some very large hepatic masses are relatively benign in activity, and can have a good outcome with surgical excision.

Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.



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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