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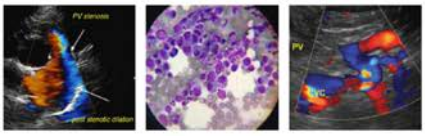

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PATIENT

Bubba Gibson

SPECIES

Canine

BREED

Boston Terrier

SEX

Neutered Male

AGE

13.5 Years

WEIGHT

30.6 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Amy Mayhew, LVT

HOSPITAL NAME

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REFERRING VET

Family Pet Practice

INVOICE

39044

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6/23/22

PRESENTING CLINICAL SIGNS

Current Medications: Not on any chronic medications beyond Simparica Trio Gave Trazodone 100mg once 3 hours prior to scan Patient History: Primary concern is PU/PD, worsening over the past month. Plan to submit urine +culture today. IH ACTH stim performed today, normal findings, does not rule out cushings Recently treated for suspect pancreatitis after ingesting large amt of spicy sausage. Both dogs in home have hx of waxing/waning diarrhea over the past year (rule out dietary indiscretion vs other) Has moderate heart murmur for awhile- O has declined workup Hx of apocrine carcinoma removed from RS in 2017, liposarcoma from L thorax in 2017 Fed Royal Canin Urinary SO Mod Cal since 2016 - hx of chronic UTIs with crystalluria, O has prev declined imaging to monitor for uroliths, masses. Hx of corneal abrasions over the years.
Abnormal PE/Chem/CBC/UA Results: Can be aggressive, hx of being very guarded around abdomen- rule out pain vs behavioral Immature cataracts OU, OU central opaque corneal deposit, Brown corneal deposits OD (likely ruptured uveal cyst). Eyes very hyperemic, suspect behavioral Grade II-III/VI heart murmur - O has prev declined cardiac workup Firm fluctuant mass 1.5cm x 1.5 cm mass cranial ventral sternum- has not been tested PU/PD per O- sometimes can hold it overnight, sometimes can not. Hx of urinary issues/crystals, but has not always been on exlusive diet Most recent UA (earlier this month) had USG of 1.010, no infection or crystals seen. Rec culture today Please see attached labs Culture pending

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 prostate is normal in size (1.1 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 (5.46 cm). Overall echogenicity is slightly hyperechoic with poor 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.

The right kidney has a normal shape and size (5.01 cm). Overall echogenicity is slightly hyperechoic with poor 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.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.74 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 0.52 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. There is a hypoechoic expansile solid mass effecet visualized within the parenchyma, measuring 3.08 cm x 3.7 cm.

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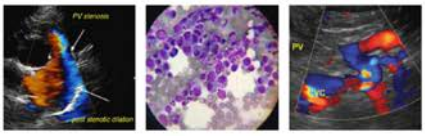

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Liver

The liver is large in size and irregular. 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 hypoechoic nodule visualized within the parenchyma measuring 0.93 cm.

The gall bladder lumen is significantly distended. Some areas of the wall appear mildly thickened with adherent debris. There is a large amount of primarily non-organized echogenic debris. There is no evidence of bile duct dilation. These changes can be consistent with an early gall bladder mucocele.

Gastrointestinal

The stomach is dilated with a large amount of 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 uniform diameter with minimal fluid distension. Wall appears subjectively, mildly increased. Bowel loops follow a typical curvilinear path with distinct wall layering. Duodenum wall measured 0.57 cm. Jejunum wall measured 0.42 cm. Mucosal speckling is visualized in the duodenum. 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 hypoechoic in the right limb. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

There is scant free abdominal fluid. No lymphadenopathy. The omentum appears of normal echogenicity.

PRIMARY FINDINGS

- Hypoechoic, solid splenic mass – A focal, solid, hypoechoic mass is present within the splenic parenchyma. This mass distorts the splenic capsule. Differentials include benign lesions such as lymphoid hyperplasia, hemangioma, etc., or neoplastic lesions such as hemangiosarcoma, lymphoma, histiocytic sarcoma, etc.
- Large, heterogeneous, irregular liver with hypoechoic nodule – 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.
- Large gallbladder debris – There is a significant amount of debris in the gallbladder, which is starting to adhere to gallbladder wall. There is no surrounding significant inflammation. Recommend medical management and continued monitoring.
- Shadowing ingesta within the gastric lumen – Correlate with feedings history and abdominal radiographs. If adequately fasted then consider such differentials as delayed gastric emptying or a partial outflow tract obstruction (none visualized).

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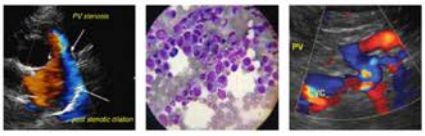

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- Subjectively thickened small intestine with mucosal speckling – Bright mucosal speckling has been proposed to represent dilated lacteals or focal accumulation of mucus, cellular debris etc.. in the mucosal crypts of the small intestine.

SECONDARY FINDINGS

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

- Hypoechoic, prominent 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

Numerous irregularities were visualized on today's scan, many of which can "normal" for an older pet. An obvious cause for the PU/PD reported is not readily visualized.

There is a hypoechoic splenic mass lesion visualized. This not cavitated, but does deform the splenic margins, and could represent a benign or neoplastic process. Options moving forward include either splenectomy for both diagnostic and therapeutic purposes, or a fine needle aspirate of the splenic mass.

The liver is large, irregular and heterogeneous, and has an ill-defined hypoechoic nodule. The appearance of this nodule trends towards a more benign appearance, but a neoplastic process cannot be ruled out. Fine needle aspirate of the liver could be considered. Additionally, this appearance could be due to a vacuolar/steroid hepatopathy if this patient has Cushing's disease.

The adrenal glands do not appear significantly enlarged. This does not exclude the possibility of Cushing's disease, but makes it less likely.

The gallbladder has a large amount of debris. Some of this debris is adhering to the gallbladder wall. Consider long-term Ursodiol therapy and continued monitoring for possible progression of this lesion.

There is shadowing material visualized within the gastric lumen. Correlate with abdominal radiographs and feeding history. If the patient is adequately fasted, this could represent ingested foreign material, delayed gastric emptying, or even a partial outflow tract obstruction (none observed).

The small intestine subjectively appears generally thickened, and there is some evidence of mucosal speckling in the small intestine. Given the history of off and on GI signs, this could represent underlying gastrointestinal disease.

- Consider a novel protein/hydrolyzed protein prescription diet.
- Consider chronic probiotic therapy.
- Recommend a GI panel to Texas A&M for a qualitative PLI, TLI, cobalamin and folate to further evaluate the pancreas and small intestine.
- If GI signs persist, consider obtaining GI biopsies.

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

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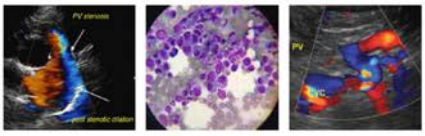

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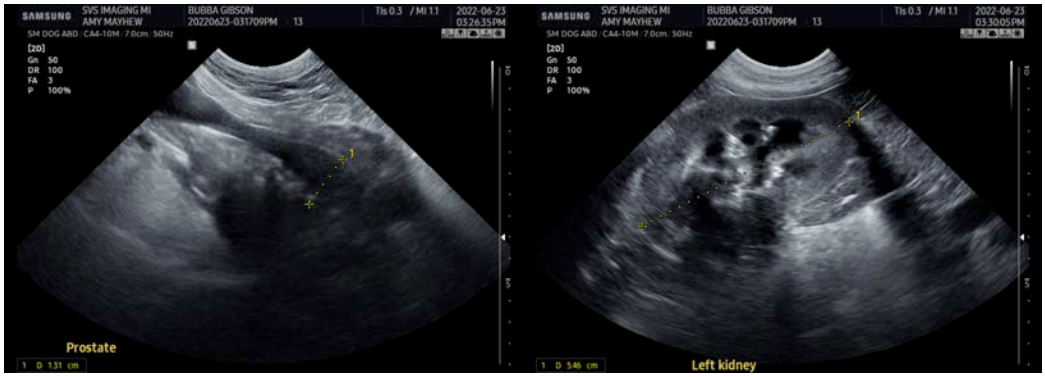

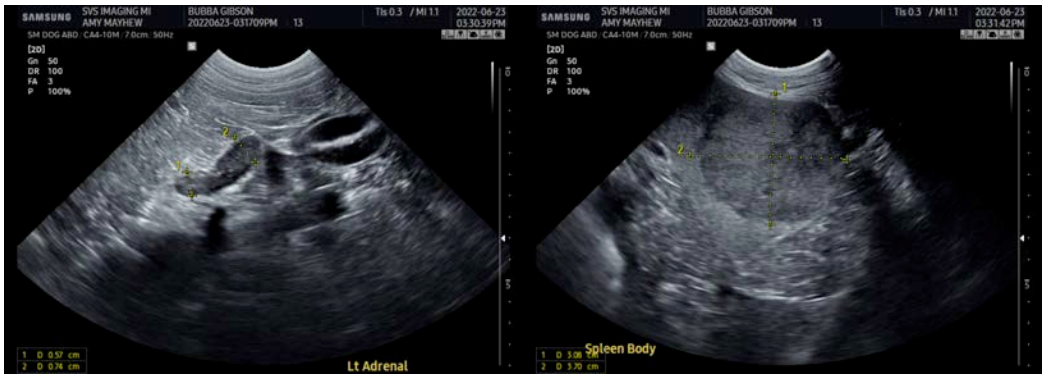

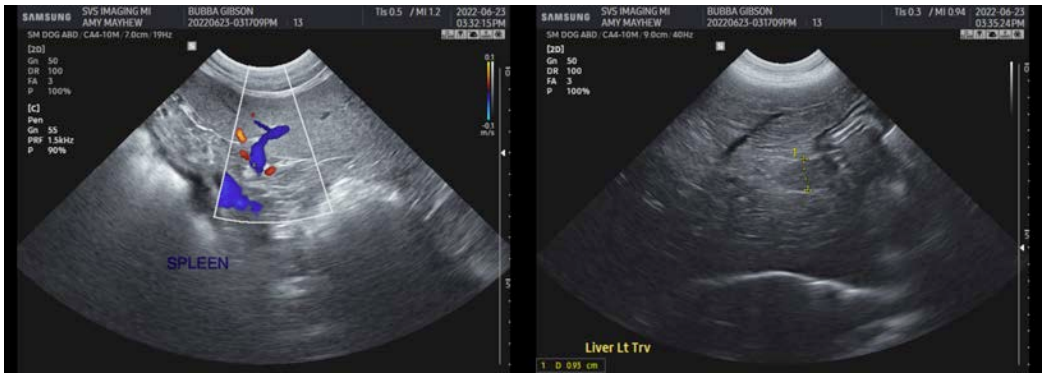

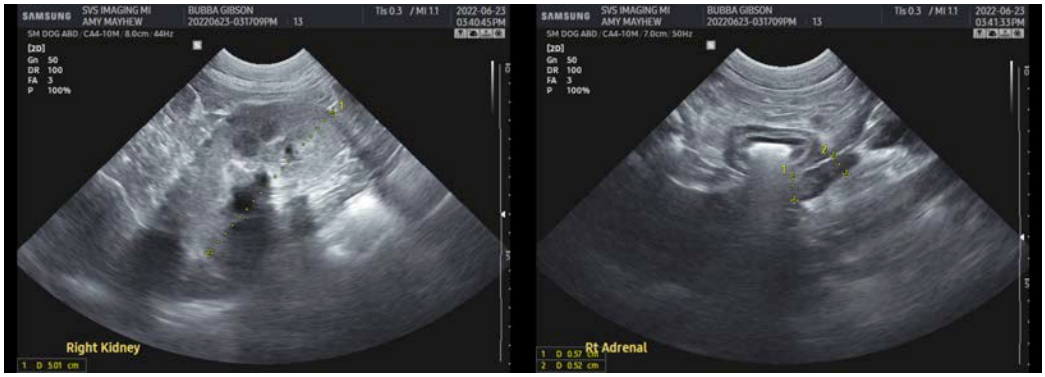

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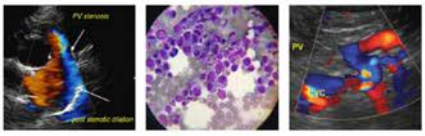

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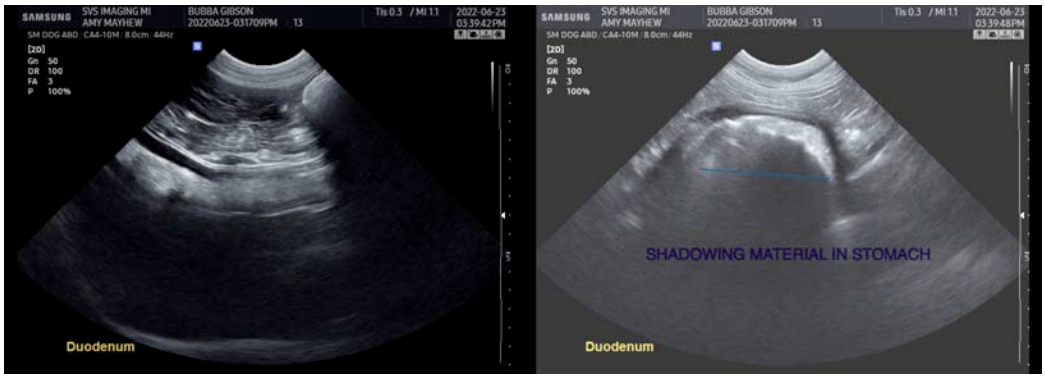

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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