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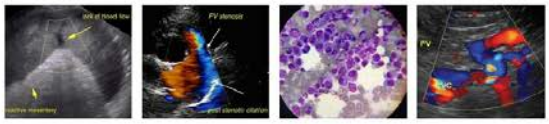

IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Finn Pailing

SPECIES

Canine

BREED

Cavalier King Charles Spaniel

SEX

Neutered Male

AGE

9 Years 9 Months

WEIGHT

20 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

MountRose AH

REFERRING VET

Dr. Katie Weldon

INVOICE

43832

DATE

7/6/23

PRESENTING CLINICAL SIGNS

Follow up echo (CS)-prev report attached-History * Degenerative Valve Disease; ACVIM B2, mod MR, borderline mild LVEH, normal systolic function, mod LAE, trace TR, 8/28/20. Static, 5/20/22. Pulmonary hypertension (PHT), mild (38 mmHg), 5/20/22 Had echo through PAWS on 5/20/22 and above Dx. P doing well otherwise at home. Today is a yearly scan He has had a recent elevation in ALP that has gone up again in 2 months. Owner would like to do an abdominal scan as well. Not clinical for Cushing's. No overt changes at home. No toxin or toxic plant exposure. P is overtly normal at home. Working diagnosis Degenerative Valve Disease; ACVIM B2, mod MR, borderline mild LVEH, normal systolic function, mod LAE, trace TR, 8/28/20. Static, 5/20/22. Pulmonary hypertension (PHT), mild (38 mmHg), 5/20/22; Possible hepatopathy, vs mass etc.

Abnormal PE/Chem/CBC/UA Results: No sedation-Elevated ALP was 243 on 4/5/23 now 433 on 7/5/23; otherwise normal. Non-symptomatic at home, grade 5/6 systolic murmur noted, lungs clear. BP-136 systolic

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 (0.53 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 (4.64 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 (4.7 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 normal in size measuring 0.59 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.

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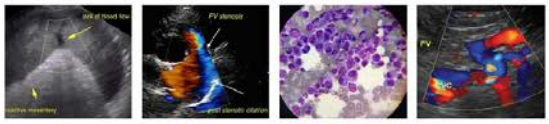

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Spleen

The spleen is normal in size but irregular in shape. The blood flow through the hilus and splenic parenchyma appears normal. There is a cystic nodule visualized arising from the cranial aspect of the spleen measuring 1.25 cm x 1.24 cm.

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 gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a moderate 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. Duodenum wall measures 0.34 cm. Jejunum wall measures 0.32 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

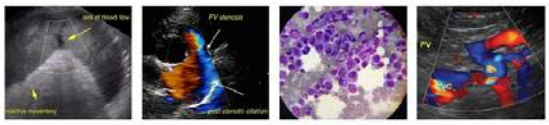
The right limb of the pancreas is mildly prominent and mottled compared to the surrounding isoechoic mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

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.

ULTRASONOGRAPHIC FINDINGS

- Cystic hypoechoic nodule visualized arising from the cranial aspect of the spleen – There is a non-cavitated, hypoechoic splenic nodule visualized. Differentials include lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis. The cystic/cavitated nature of this lesion and its peripheral location increase concerns about possible malignancy or rupture.



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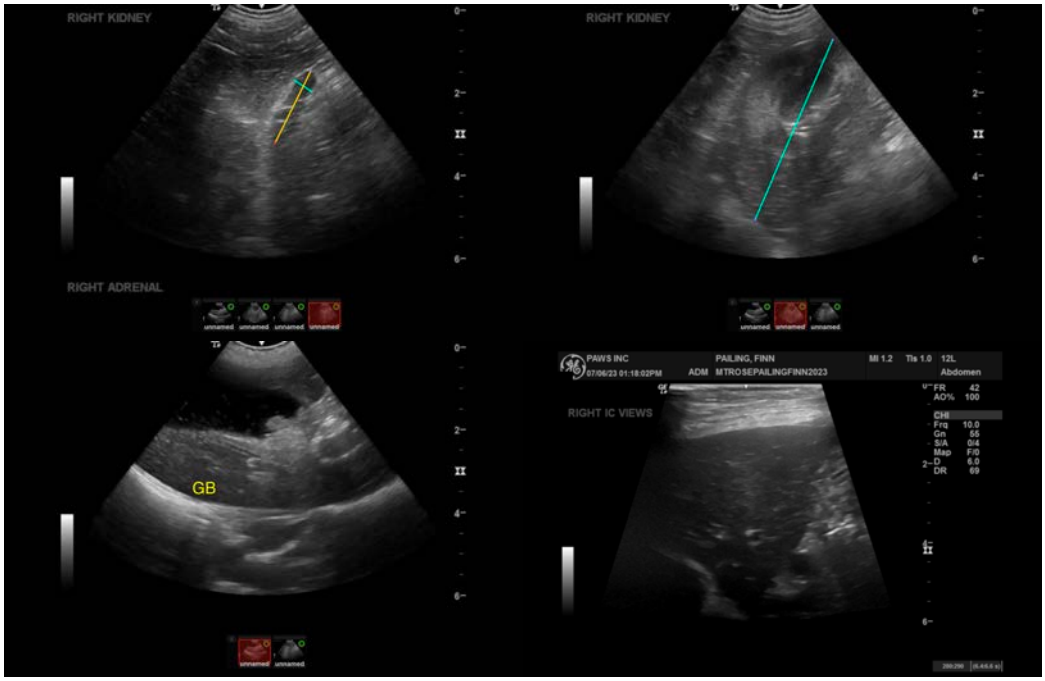
- Mildly prominent/mottled right limb of the pancreas – The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Heterogeneous liver – The diffuse hepatic changes are non-specific 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.
- Moderate gallbladder debris – The significance of the aggregated gallbladder debris is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting but seems unlikely to be causing a current issue. Recommend continued monitoring.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes observed associated with the liver are non-specific. No focal lesions are visualized to explain the elevation in ALP reported. At this time, options would include a liver function test and a fine needle aspirate or continued monitoring with ultrasound and lab work +/- Denamarin. There is a moderate amount of gallbladder debris present but no evidence of inflammation, wall thickening, etc., so continued monitoring is likely appropriate.

There is a somewhat irregular cystic/cavitated nodule arising from the cranial aspect of the spleen. This could represent a benign or neoplastic process. Based on its cavitated nature and its peripheral location (bulging from the splenic capsule), concern would be slightly increased as to the possibility of malignancy or rupture. Options moving forward could include a fine needle aspirate, continued monitoring with ultrasound, or a splenectomy for histopathology.

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



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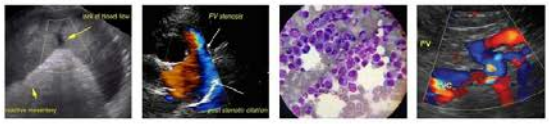

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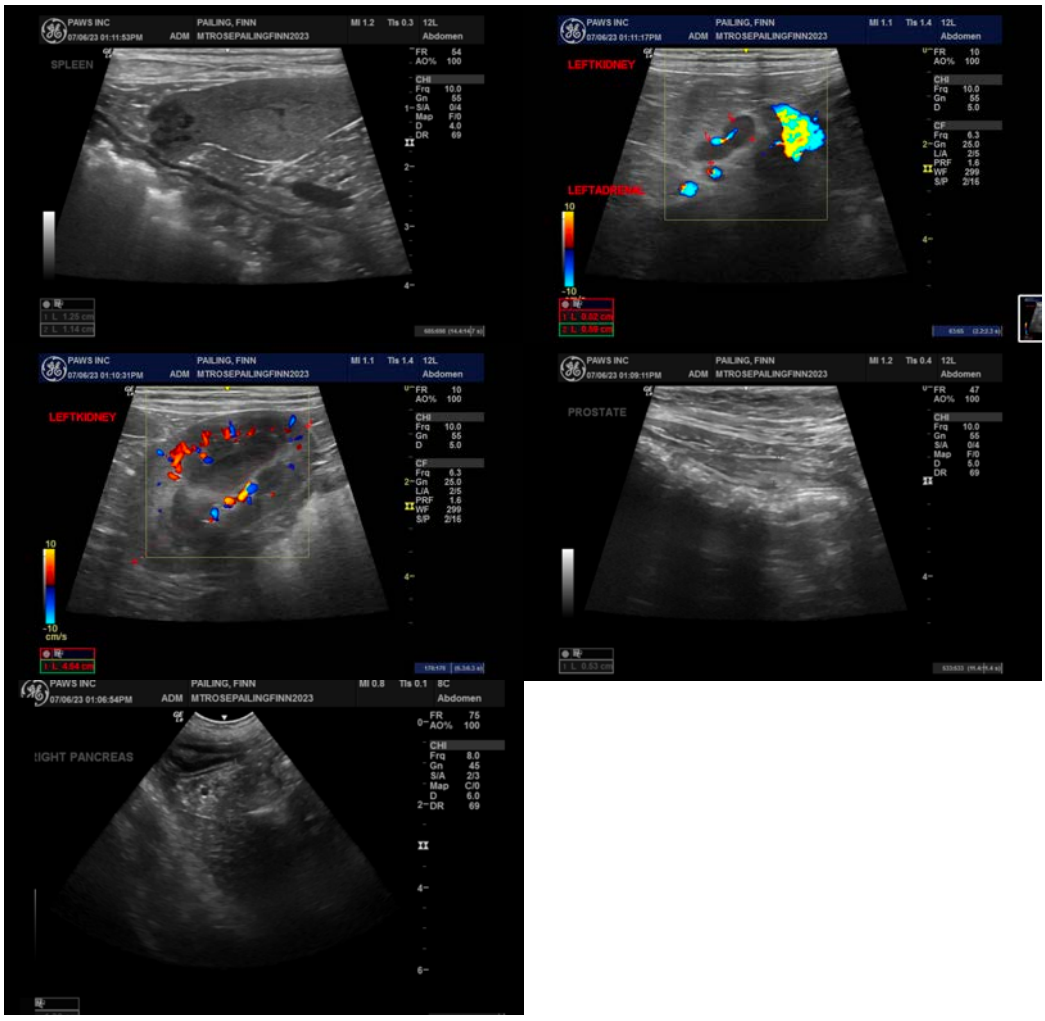

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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