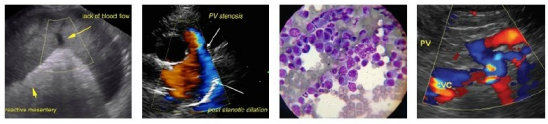

PATIENT

Walter Andrews

SPECIES

Canine

BREED

Poodle

SEX

Neutered Male

AGE

13 Years

WEIGHT

6.4 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

Sierra Pet Clinic

REFERRING VET

Dr. Mark Fagundes

INVOICE

44735

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8/17/23

PRESENTING CLINICAL SIGNS

TEMPERATURE: 99.1 PULSE: 140 RESPIRATIONS: 25 HISTORY: P has been vomiting (especially after eating). condition has been intermittent but worse the last couple of days -AR SUBJECTIVE: BAR OBJECTIVE: mm pink, crt <2 sec, heart and lungs auscultate wnl, m/s wnl, eent wnl, neuro wnl, integument wnl ASSESSMENT: vomiting PLAN: X-rays of abdomen and thorax - see below rad reportfrom 8/12/2023. SQ LRS 100 mls, cerenia 0.4mls sq rx cerenia and famotidine

Abnormal PE/Chem/CBC/UA Results: Three whole body radiographs of a geriatric, small breed canine were submitted for evaluation. Thoracic radiographs reveal mild cardiomegaly with left-atrial dilation indicated by loss of a definable caudal cardiac waist on the lateral views. This indicates degenerative mitral valve disease with insufficiency. The carina and caudal brainstem bronchi are also mildly elevated due to left atrial dilation. This could potentially result in coughing. Otherwise the trachea has a normal diameter with a patent appearing lumen. The lungs exhibit age-appropriate broncho- interstitial markings and normal pulmonary vascular structures with no sign of cardiogenic pulmonary edema or other abnormal pulmonary opacities. The pleural space and mediastinum are within normal limits. In the abdomen, there is a roughly 4 cm diameter, round soft tissue opacity mass in the left cranial dorsal abdomen. It appears to be cranial to the left kidney and may represent a markedly enlarged left adrenal gland. However other possibilities including a mass on the head of the spleen cannot be ruled out. This mass contacts the fundus of the stomach and seems to be mildly compressing it in a cranial direction. This may account for the patient's vomiting. The liver, spleen, kidneys and urinary bladder are within normal limits to the extent visible. The stomach is contracted and empty. Small bowel loops have normal diameters and normal opacity. The large intestine is moderately to fully distended containing primarily stool. Gas is present in the cecum. Collapsed intervertebral disk spaces are noted at L1-2, L2-3, L4-5 and L5-6, consistent with degenerative disk disease and possible disk herniation. Mild to moderate spondylosis is also noted at these locations but is not felt to be clinically significant. There is also an impression of degenerative disk disease involving all of the cervical intervertebral junctions between C2 and C7. However, positioning of the cervical spine is not sufficient to make a full and confident evaluation. Conclusion radiologist report Mild cardiomegaly with left atrial dilation is noted consistent with degenerative mitral valve disease and insufficiency. There was no impression of left-sided congestive heart failure. A 4 cm diameter soft tissue opacity mass cranial to the left kidney in the left cranial dorsal abdomen may represent left adrenal neoplasia or possibly a mass like lesion involving the head of the spleen. The structure appears to be compressing the fundus of the stomach and may be responsible for the patient's vomiting. Degenerative disk disease is noted at several locations in the lumbar spine and possibly also involving all intervertebral disk spaces in the cervical spine.

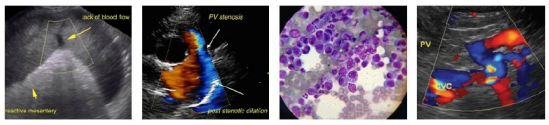
ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly distended with anechoic urine. The Bladder wall appears mildly diffusely thickened and irregular, measuring at 0.40 cm. The area of the trigone, ureteral papillae and visible urethra appear normal with no significant mass lesions, mucosal irregularities, or calculi.

The prostatic urethra appears somewhat prominent and dilated. The external measurement in the sagittal view of the prostate and dilated urethra is 1.28 cm with no focal parenchyma or urethral lesions visualized.

The left kidney has a normal shape and size (3.45 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal



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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 (3.41 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 0.34 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 0.34 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 large and irregular. The blood flow through the hilus and splenic parenchyma appears normal. There is a large, mixed echogenic, solid mass effect visualized towards the caudal aspect of the spleen measuring 3.57 cm x 3.57 cm. Additionally, there is a hypoechoic nodule towards the cranial aspect of the spleen, measuring 1.31 cm x 0.69 cm.

Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. The visible portions of the vasculature and biliary tract appear normal. There is a hypoechoic nodule measuring 0.70 cm in diameter near the gallbladder.

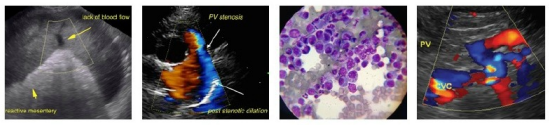
The gall bladder lumen is significantly distended. Some areas of the wall appear mildly thickened with adherent debris. There is a large amount of primarily non-organized echogenic debris. There is no evidence of bile duct dilation.

Gastrointestinal

The stomach contains minimal luminal contents. The wall appears slightly prominent, measuring at 0.80 cm in thickness. 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 0.46 cm. Jejunum wall measures 0.36 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.



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Pancreas

The right limb of the pancreas is prominent and hypoechoic as 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. The sublumbar lymph nodes are slightly prominent, measuring 0.55 cm on the left and 0.34 cm on the right. The mesentery is hyperechoic around the splenic mass.

Other

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.

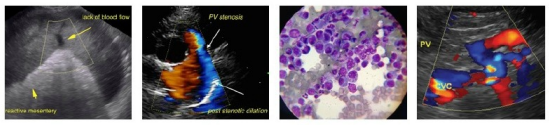
A left-sided perineal swelling is imaged, revealing subcutaneous small bowel with hyper to normal motility, consistent with a perineal hernia.

PRIMARY FINDINGS

- Large, mixed echogenic mass effect towards the caudal aspect of the spleen and hypoechoic mass at the cranial aspect – Solid mixed echogenicity masses are visualized associated with the spleen. The masses distort the splenic capsule. Differentials include: benign lesions (lymphoid hyperplasia, hemangioma etc..) or cancerous lesions (hemangiosarcoma, lymphoma, histiocytic sarcoma etc..)
- Small, hypoechoic nodule visualized within the hepatic parenchyma – The significance of this nodule is unclear. The general appearance trends towards a benign process, although a metastatic lesion cannot be ruled out.
- Large, distended gallbladder with a large amount of intraluminal debris – A large amount of debris is evident in the gall bladder with no evidence of a mucocele or associated inflammation at this time. This could represent an early mucocele or cholestasis, with minimal evidence of associated inflammation at this time. Continued monitoring of labwork and ultrasound are warranted for progression of this lesion. Ursodiol therapy could be considered.
- Subjectively prominent/thickened gastric wall – The stomach wall thickening could be consistent with inflammation, edema, infiltrative neoplasia, imaging artifact due to rugal folds, other.
- Prominent sublumbar lymph nodes – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- Perineal hernia containing small bowel – An obvious obstruction is not noted. Entrapped bowel appears to have normal to increased motility.

SECONDARY FINDINGS

- Subjectively mildly thickened/irregular bladder wall – The bladder mucosal changes could be consistent with cystitis or artifactual due to lack of adequate luminal distension. Bladder



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neoplasia cannot be ruled out but is considered unlikely in this patient.

- Distended urethra at the level of the prostate – The significance of this is unclear. Recommend continued monitoring.
- Prominent, hypoechoic 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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

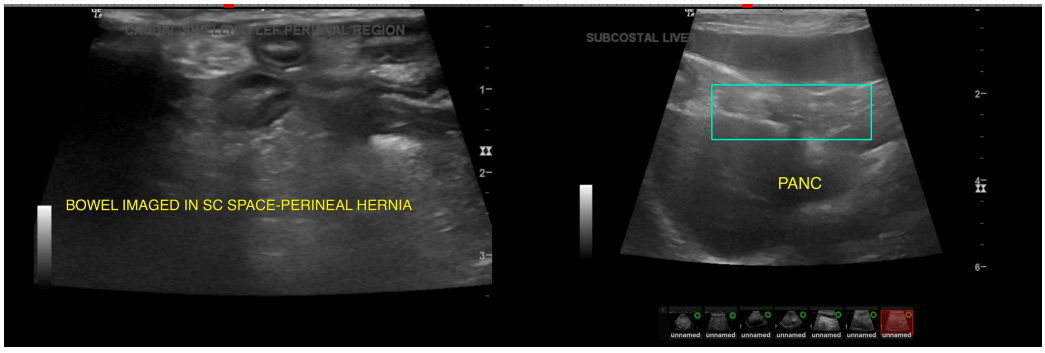
There is a large caudal splenic mass evident along with a more cranial nodule. These lesions could represent a benign or neoplastic process. Options moving forward would include a splenectomy for both diagnostic and therapeutic purposes or a fine needle aspirate of both lesions.

There is a large amount of debris visualized within the gallbladder with minimal surrounding inflammation. Recommend chronic Ursodiol therapy and continued monitoring of the gallbladder for possible progression of this lesion.

The left-sided perineal hernia is imaged, and there appears to be bowel contained within the hernia. The bowel appears relatively healthy with intact wall layering and hyper- to normal motility. Nonetheless, there is the risk for entrapment and strangulation, and the hernia could be contributing to the vomiting. Recommend surgical correction. Most perineal hernia are found with intact male dogs, particularly with enlarged prostates. The prostate in this individual is not overtly enlarged, but there is a significantly distended urethra, which is of questionable significance and should be monitored.

If abdominal surgery is performed, consider evaluation of the stomach. If the gastric wall appears thickened, recommend a biopsy. This could be artifactual due to edema, association with the local mass lesions, etc., but a mild primary gastric mass lesion cannot be ruled out.

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



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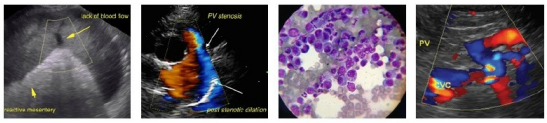

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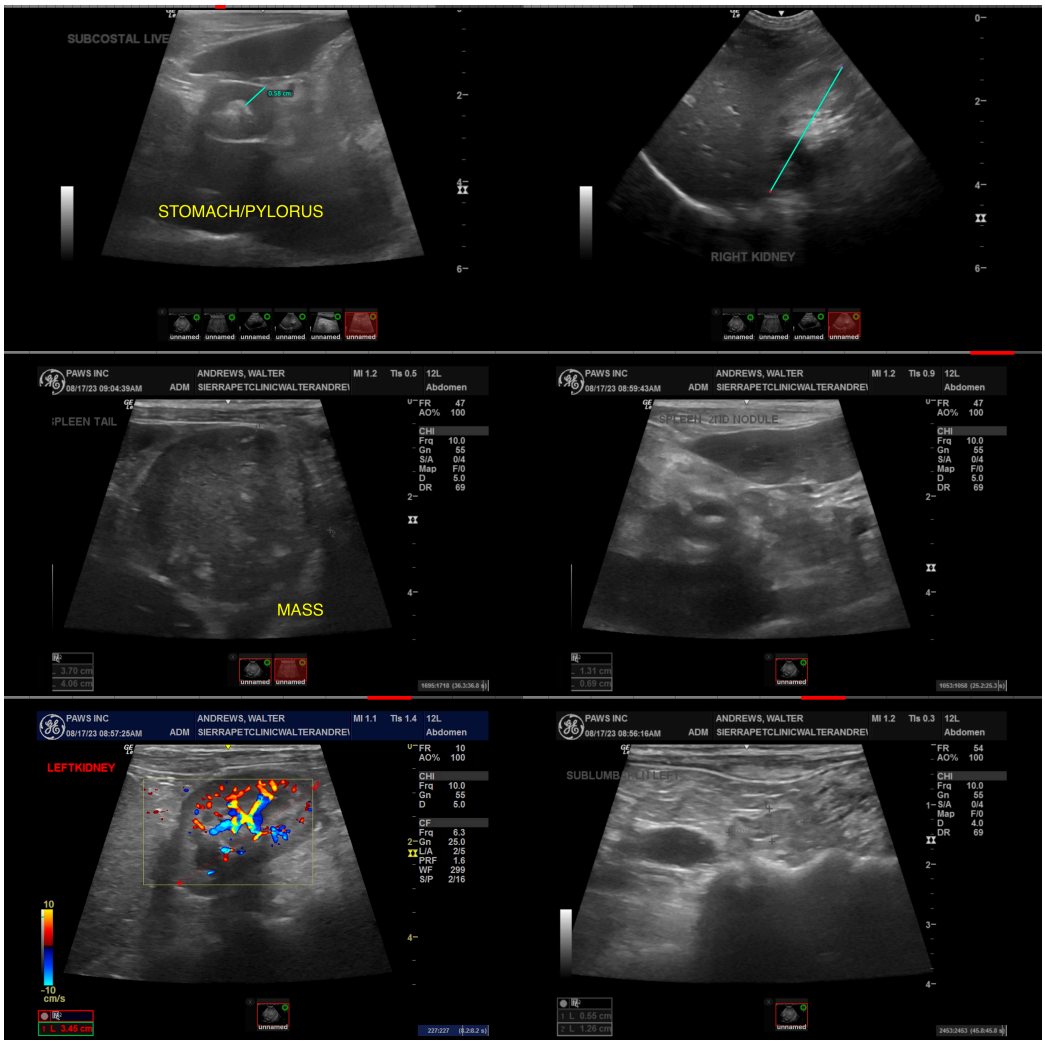

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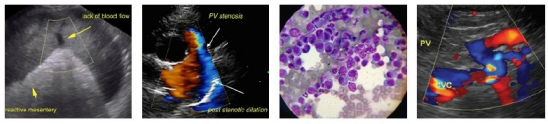

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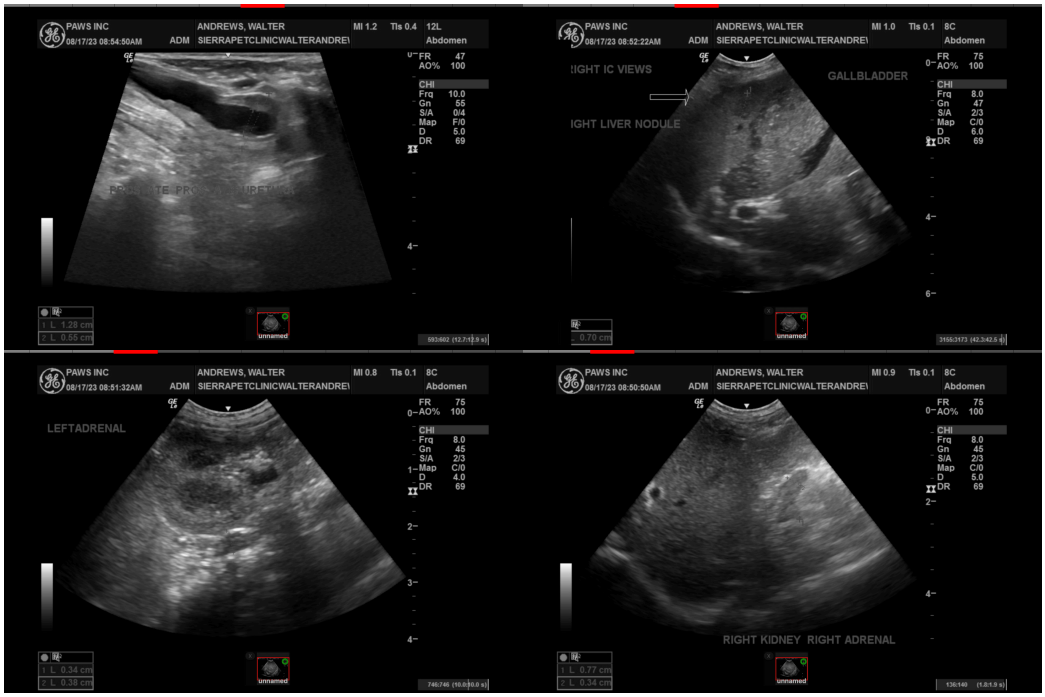

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@sonopath.com