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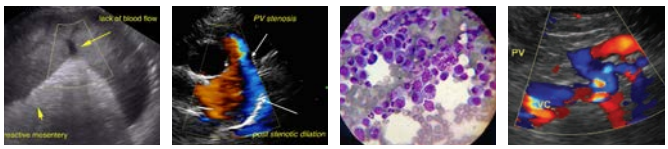

PATIENT

Baby Moses

SPECIES

Canine

BREED

Malti-Poo

SEX

Spayed Female

AGE

10 Years

WEIGHT

20 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Meghan Myers

HOSPITAL NAME

Hershire AH

REFERRING VET

Dr. Meghan Myers

INVOICE

41467

DATE

9/21/22

PRESENTING CLINICAL SIGNS

vomited 1x yesterday, anorexic today, acutely distended abdomen; PE T 102.5, BW--ALT 334, ALP 518, elevated amylase but cPL normal; very painful and tense on abdominal palp; radiographs--incidental cystic calculi; decreased serosal detail esp cranially and questionable mineralization near GB and unclear if fat vs mass effect ventral to liver. Pet was very painful for ultrasound even with 0.3mg/kg torb IV - unable to attempt visualization of adrenals, more sedation would be needed which owners declined. Abnormal PE/Chem/CBC/UA Results: LT 334, ALP 518, elevated amylase but cPL normal; t.bili normal

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with echogenic urine. The Bladder is irregular and has numerous finger-like polypid projections that are somewhat difficult to clearly see. Three of these are measured at 1.27 cm x 0.72 cm, 0.57 cm x 0.82 cm, and 0.57 cm x 0.74 cm. Additionally, there is a hyperechoic calculus in the dependent portion of the urinary bladder measuring 0.97 cm x 0.82 cm. The remainder of the urinary bladder, trigone, and proximal urethra appear free of any mass lesions or calculi.

The left kidney has a normal shape and size (4.0 cm). Overall echogenicity is slightly hyperechoic with poor 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 (3.7 cm). Overall echogenicity is slightly hyperechoic with poor 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 not clearly seen due to patient discomfort.

The right adrenal gland is not clearly seen due to patient discomfort.

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.

Liver

The liver is large in size, and normal in 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. There is a very large, hyperechoic, thick-walled mass effect visualized in the liver, measuring 5.3 cm x 4.86 cm. This is surrounded by inflammation and echogenic fluid and is most likely a mass effect or abscess.

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.

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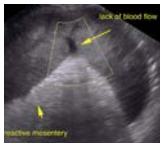
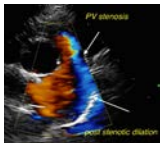
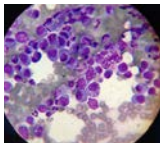
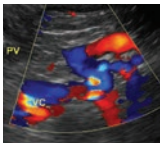

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Gastrointestinal

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 pancreas is prominent and hypoechoic (primarily in the left limb) 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

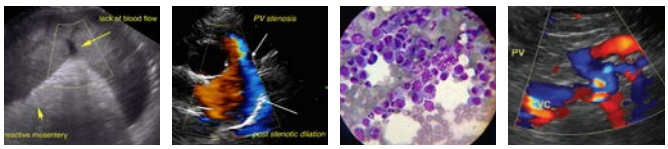
There is a large volume of free echogenic fluid. No lymphadenopathy is noted, but there is diffusely inflamed mesentery consistent with peritonitis.

PRIMARY FINDINGS

- Large, inflamed, hyperechoic mass effect within the liver – findings are suspicious for either an inflamed tumor or an abscess.
- Polypoid like projections visualized within the urinary bladder – most consistent with benign polyps, but an underlying neoplastic process cannot be ruled out.
- Hyperechoic shadowing stone in the urinary bladder – recommend urinalysis and culture. This could be the source of irritation for the development of the polyps.
- 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.
- Large volume echogenic free fluid and diffuse mesenteric inflammation – consistent with peritonitis (sterile or infectious).

SECONDARY FINDINGS

- Decreased corticomedullary distinction in both kidneys – The bilateral renal findings are consistent with age-related change.
- Hypoechoic, prominent left limb of the pancreas – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.



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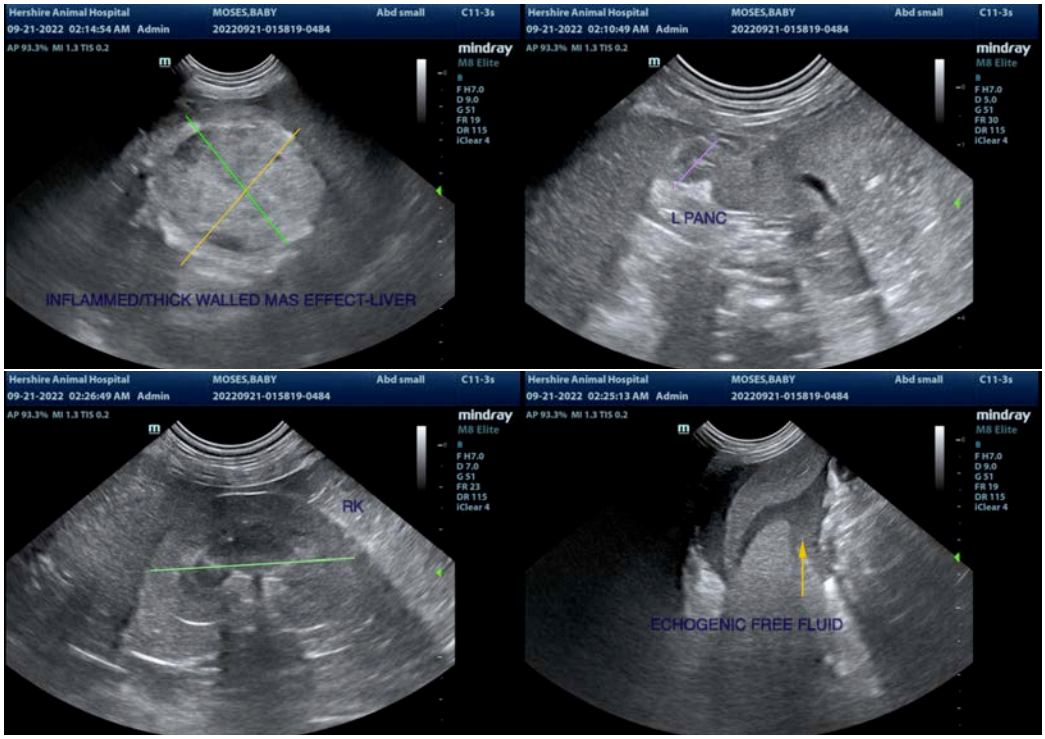
- Large, heterogeneous liver – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The large volume of echogenic free fluid and diffuse inflammation are consistent with peritonitis. Recommend sampling of the abdominal fluid for cytology evaluation and an aerobic and anaerobic culture. The likely source of this inflammation is the lesion in the liver. This could represent a mass effect, an abscess, or a necrotic abscessed mass. Removal is recommended. Ideally a pre-operative contrast CT scan would be performed to surgically plan, but if this is a septic effusion, emergency surgery is recommended (ideally evaluate cytology in-hospital to look for evidence of intracellular bacteria). Additionally, a fine needle aspirate of the mass lesion could be performed, but I suspect that regardless of diagnosis, removal would be recommended.

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

There is a stone in the dependent portion of the urinary bladder and numerous mass lesions projecting from the urinary bladder wall. I suspect these are inflammatory polyps, but underlying neoplasia cannot be excluded. Recommend a urinalysis and culture and removal of the bladder stone (ideally) for analysis. Alternately, if an infection is present, you could consider treatment of the infection and attempting dissolution of the stone with the hopes that the polyps will resolve, but prolonged antibiotic therapy and continued monitoring would be closely recommended. If there is no evidence of a urinary tract infection, recommend a traumatic catheterization to try and obtain a cytologic sample. Alternately, cystotomy would be a good option.



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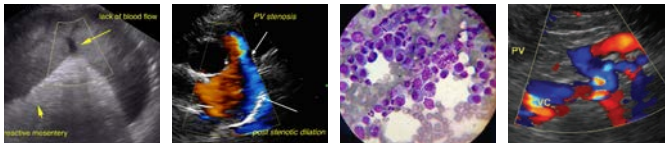

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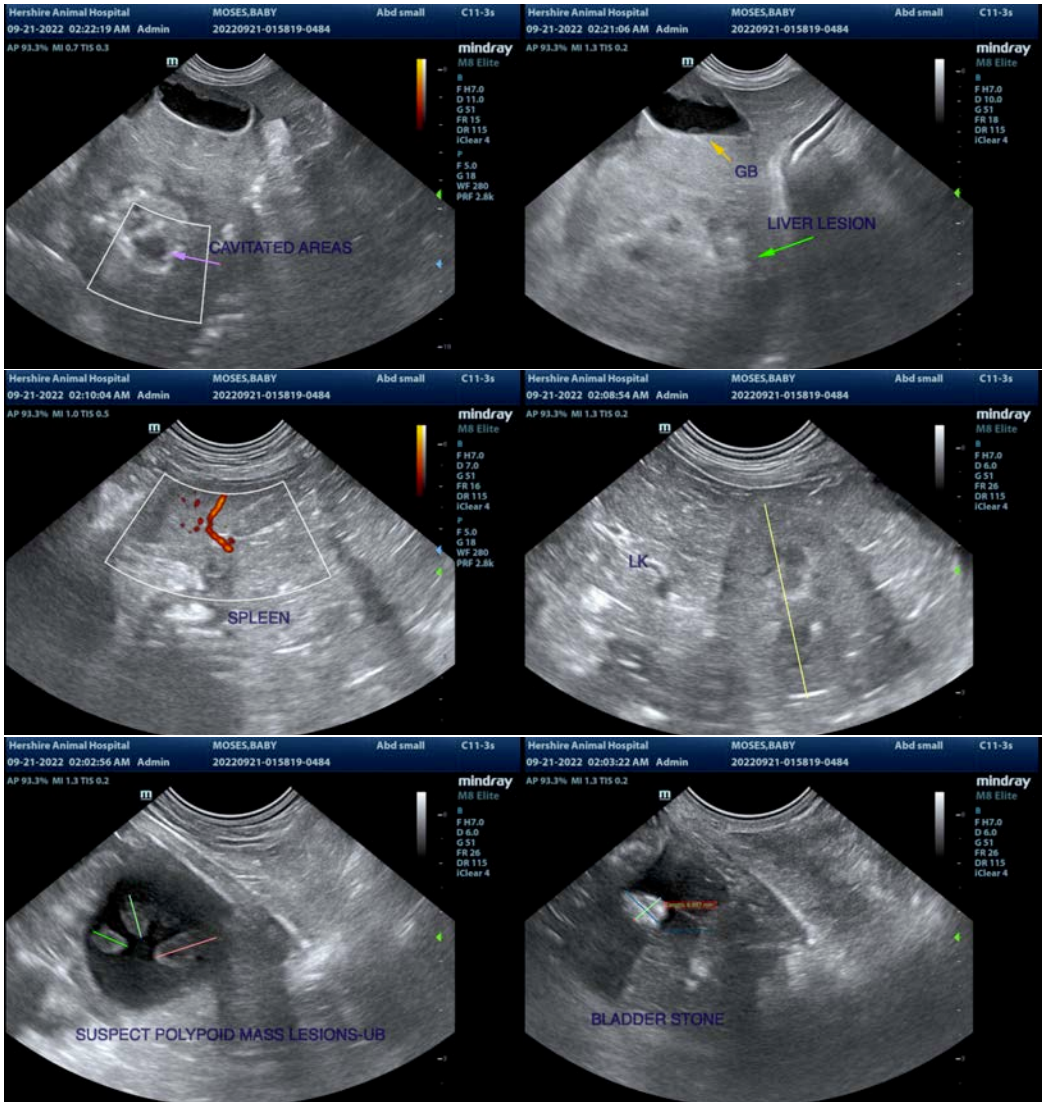

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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