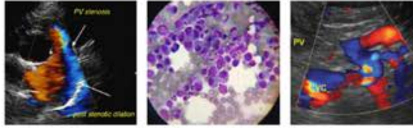
IMAGING PERFORMED BY
SVS Mobile Imaging MI 734 - 637 - 7711
svsimagingmi@gmail.com



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

PATIENT
Lucy Schlesinger

SPECIES
Canine

BREED
Yorkie X

SEX
Spayed Femle

AGE
15 Years

WEIGHT
10.8 Pounds

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

IMAGING PERFORMED BY
Amy Mayhew, LVT

HOSPITAL NAME
SVS Imaging MI

REFERRING VET
Briarwood VH

INVOICE
41059

DATE
9/6/22

PRESENTING CLINICAL SIGNS

Licking perirectal area. Vomiting on and off for a few weeks. Seems painful per owner.
Abnormal PE/Chem/CBC/UA Results: Increase RBC on urine sample. Xray showed no cause for increase RBC in urine.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly distended with anechoic urine. The Bladder wall is diffusely irregular and thickened with some focal polypoid type areas that are concerning for possible mass lesion. The area most significantly affected extends approximately 1.4 cm with a height of 0.37 cm. The area of the trigone, ureteral papillae and proximal urethra appear clear of any focal mass lesions or calculi.

The left kidney has a normal shape and size (3.48 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 (3.88 cm) with small cortical cysts. 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 normal in size measuring 0.48 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 region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. No evidence of a mass effect.

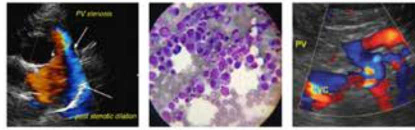
Spleen

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 hyperechoic nodule visualized within the parenchyma measuring 0.41 cm. This does not deviate the splenic capsule.

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. There is a somewhat ill-defined hyperechoic nodule visualized measuring 1.17 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 moderate amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.



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Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of 0.23 cm 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 uniform diameter with minimal fluid distension. Wall appears subjectively, mildly increased. Bowel loops follow a typical curvilinear path with distinct wall layering. Duodenum wall measures 0.48 cm. Jejunum wall measures 0.37 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 pancreas is 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

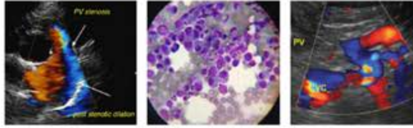
Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

PRIMARY FINDINGS

- Focal pedunculated, polypoid-like irregularities associated with the urinary bladder wall – most concerning for a possible transitional cell carcinoma, but diffuse severe cystitis is possible.
- Small, hyperechoic splenic nodule – The appearance of this nodule trends towards a benign lesion. Recommend continued monitoring +/- fine needle aspirate.
- Prominent, mottled pancreas – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.
- Heterogeneous liver with hyperechoic 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. The hyperechoic nodule has the appearance of a benign lesion. Recommend continued monitoring.
- 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.
- Subjectively thickened small intestine – The mild small intestinal wall changes may be a normal variant in this patient or could be consistent with an inflammatory process (e.g., inflammatory bowel disease).

SECONDARY FINDINGS

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



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The urinary bladder wall is diffusely irregular, but there are focal mass-like projections that are concerning for possible transitional cell carcinoma.

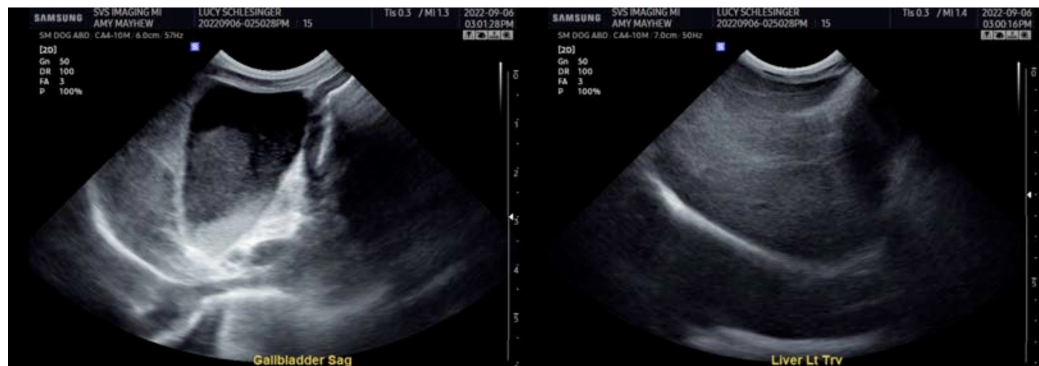
- Consider traumatic catheterization to obtain representative cells for cytology, or biopsy sampling via either cystoscopy (if a female) or surgery.
- If a cytologic sample is not available consider urine evaluation for BRAF mutation seen in patients with transitional cell carcinomas. A positive test is consistent with a TCC, a negative test is inconclusive and will need further diagnostics.
- Patients with bladder pathology should always have urinalysis and culture performed. Ideally cystocentesis should be avoided in patients with suspected bladder masses to try and prevent tracking of tumor cells along the needle path.
- If TCC is confirmed consider referral to/consultation with a board certified. Veterinary oncologist for recommendations regarding treatment options and prognosis.

There is a small, hyperechoic nodule visualized in both the spleen and liver. These are likely incidental, but continued monitoring is warranted.

Subjectively, the small intestine appears somewhat thickened and prominent. Given the history of chronic vomiting, this could be consistent with gastrointestinal disease. Additionally, the pancreas is somewhat prominent.

- Consider a novel protein/hydrolyzed protein prescription diet.
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc.. to further evaluate for pancreatic/small intestinal disease.
- Recommend chronic probiotic therapy.
- If vomiting persist, you could consider obtaining GI biopsies.

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



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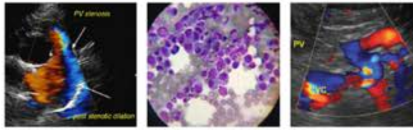

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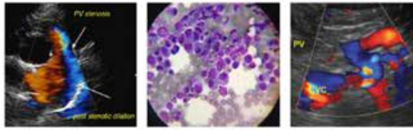

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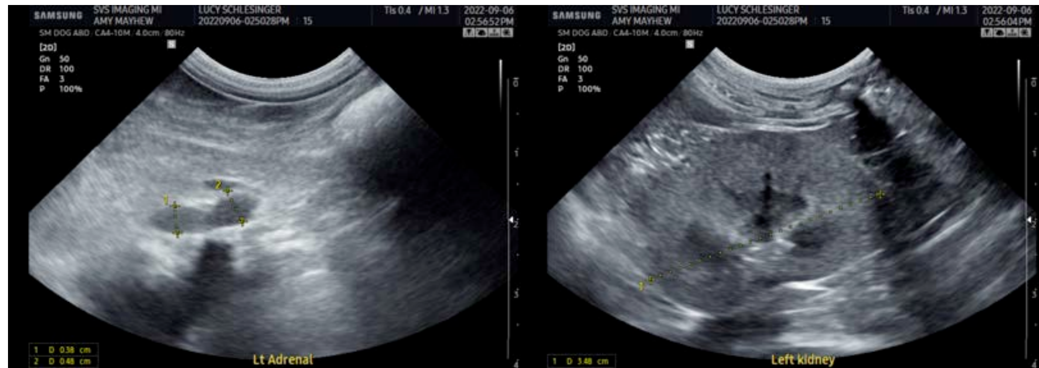

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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