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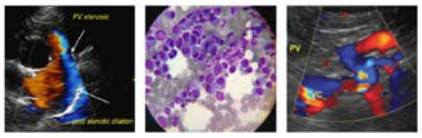

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PATIENT

Katie Hoffman

SPECIES

Canine

BREED

Labrador

SEX

Spayed Female

AGE

12 Years

WEIGHT

54 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Rachel Runnells, RVT

HOSPITAL NAME

SVS Imaging KC

REFERRING VET

Dr. Oetting

INVOICE

41173

DATE

9/8/22

PRESENTING CLINICAL SIGNS

8/23/22 presented for recurrent urinary issues and 6# weight loss. On Lasix and Enalapril for heart failure, Gaba and Amantadine for OA, Proin started 8/23 for incontinence, and CBD oil. CBC, chem, UA on 8/23/22 uneventful. Hyporexia yesterday; ate a hamburger patty but vomited it shortly thereafter. Anorexia rest of yesterday and today. Was fed 2 hot dogs a couple days ago. Hospitalized on fluids right now.

Abnormal PE/Chem/CBC/UA Results: Possibly able to palpate a central abdominal mass. Rads: Globoid heart, decreased detail Rt cranial quadrant of abdomen on VD, thick appearance to empty bladder. Abnormal cPL; discussed that CPL does not distinguish between pancreatic cancer and pancreatitis.

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. **See other for description of possible intrapelvic mass.

The left kidney has a normal shape and size (6.69 cm). Overall echogenicity is normal with mildly reduced corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (6.54 cm). Overall echogenicity is normal with mildly reduced corticomedullary distinction and a typical 1:3 cortex:medulla ratio. 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 0.73 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 0.50 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 spleen echotexture is heterogenous and mottled. There is a solid mixed echogenicity mass effect visualized in the cranial third of the spleen measuring 2.79 cm x 2.91 cm. Additionally, there is some irregularity and an isoechoic mass effect towards the tail of the spleen measuring 1.0 cm in diameter.

Liver

The liver is large 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 are numerous small cystic regions. One measures 1.46 cm. Additionally, there are also ill-defined hypoechoic nodules. There is a larger isoechoic rounded area towards the caudal aspect of the liver measuring 1.39 cm x 3.21 cm. An example of a hypoechoic lesion measures 1.39 cm.

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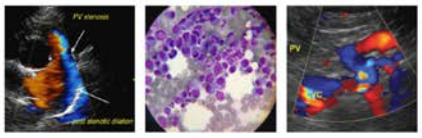

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The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and primarily anechoic. The cystic and common bile ducts are normal/not visible.

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 0.50 cm. Jejunum wall measures 0.33 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 large and hypoechoic to surrounding mesentery. There is no evidence of discrete nodules or cystic lesions. There is evidence of regional mesenteric inflammation. Consistent with mild pancreatitis.

Free Abdomen

There is a large amount of mildly echogenic free fluid. No lymphadenopathy is noted. The omentum appears generally increased in echogenicity.

Other

There is the suspicion of an intrapelvic mass effect that appears to be located near the urinary bladder, possibly in the intrapelvic region, measuring approximately 2.2 cm x 2.98 cm. In another view, it is visualized somewhat lateral to the urinary bladder, measuring 2.29 cm x 1.54 cm. It is difficult to distinguish this from free fluid. This could possibly be a cervical mass or a lymph node. Consider power doppler evaluation of this area.

ULTRASONOGRAPHIC FINDINGS

- Mottled, irregular spleen with a large isoechoic mass effect and smaller nodules near the tail of the spleen – The diffuse splenic changes are non-specific and could be consistent with lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis. The focal lesions visualized could represent a benign or neoplastic process.

- Irregular, prominent, hypoechoic and mottled pancreas – The pancreatic changes are most consistent with mild pancreatitis/pancreatic inflammation. Recommend fPLI testing and continued monitoring for improvement or possible development of a pancreatic abscess. Consider fine needle aspirate if not improving. Some areas of the pancreas appear very irregular. This could be consistent with remodeling or nodular change.

- Large, irregular, heterogeneous liver with ill-defined hypoechoic nodules and cystic lesions – 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

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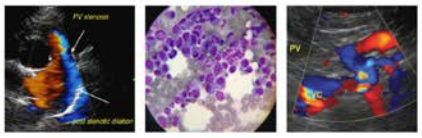

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likely) or other hepatopathy. The nodules observed trend toward a more benign process but underlying neoplasia cannot be ruled out.

- Large volume free abdominal fluid
- Suspect hypoechoic intrapelvic mass/lymph node – Correlate with digital rectal exam and consider power doppler of the area.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a large amount of mildly echogenic free fluid in the abdomen, which makes evaluation of some of the abdominal structures challenging. There is the suspicion of a mass lesion in the intrapelvic region. This could correlate with the urinary issues described- possibly cervical in origin/or lymph node? Recommend a digital rectal exam to palpate for an anal gland mass or any urethral irregularities. This lesion is very hypoechoic and difficult to differentiate from fluid. Consider power doppler in the area and a fine needle aspirate. Contrast CT scan would likely be necessary to further delineate the area.

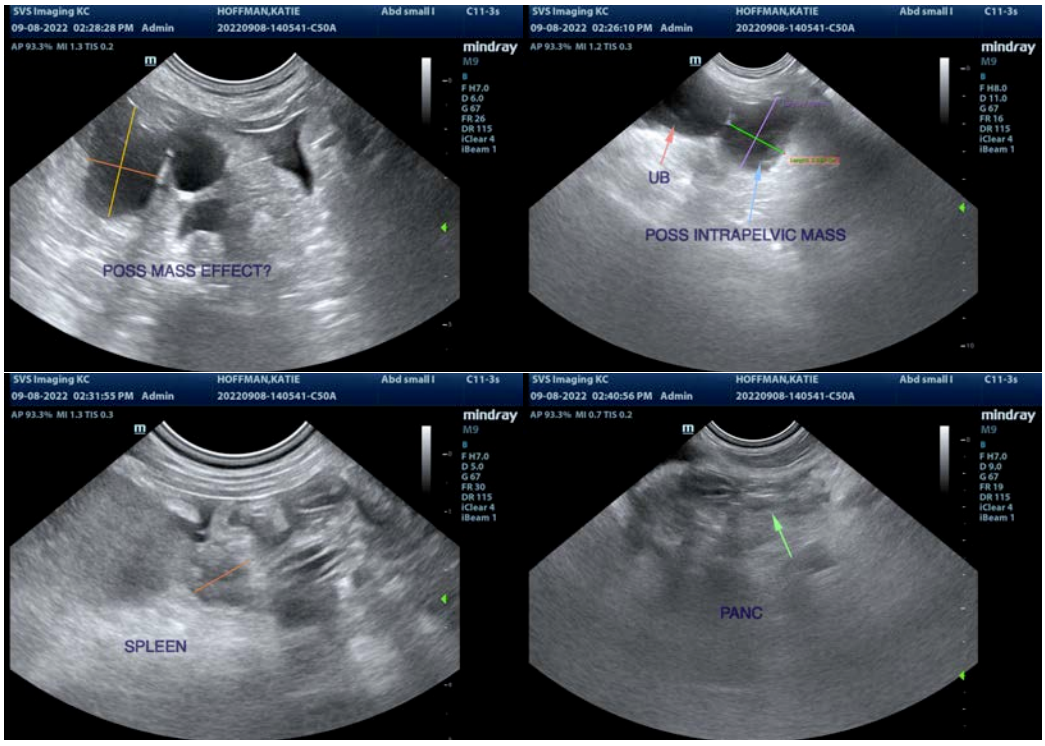
There is a mass effect and some less well-defined nodules and irregularities in the spleen. Options moving forward would include fine needle aspirates or splenectomy with histopathology.

Recommend fluid analysis and cytology on a sample of the fluid present in the abdomen.

The pancreas is irregular and mottled. It appears inflamed in some areas and almost nodular in some other regions. The significance of this is unclear.

If cytologic evaluation of the spleen, and abdominal fluid is not diagnostic, then consider further evaluation of the intrapelvic mass lesion and/or contrast CT to get a better idea of the scope of the lesions with better detail and less fluid interference.

Additionally, I would recommend 3-view thoracic radiographs and a cardiac ultrasound to try and determine if there could be heart disease contributing to the ascites/clinical picture present.



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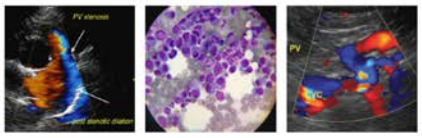

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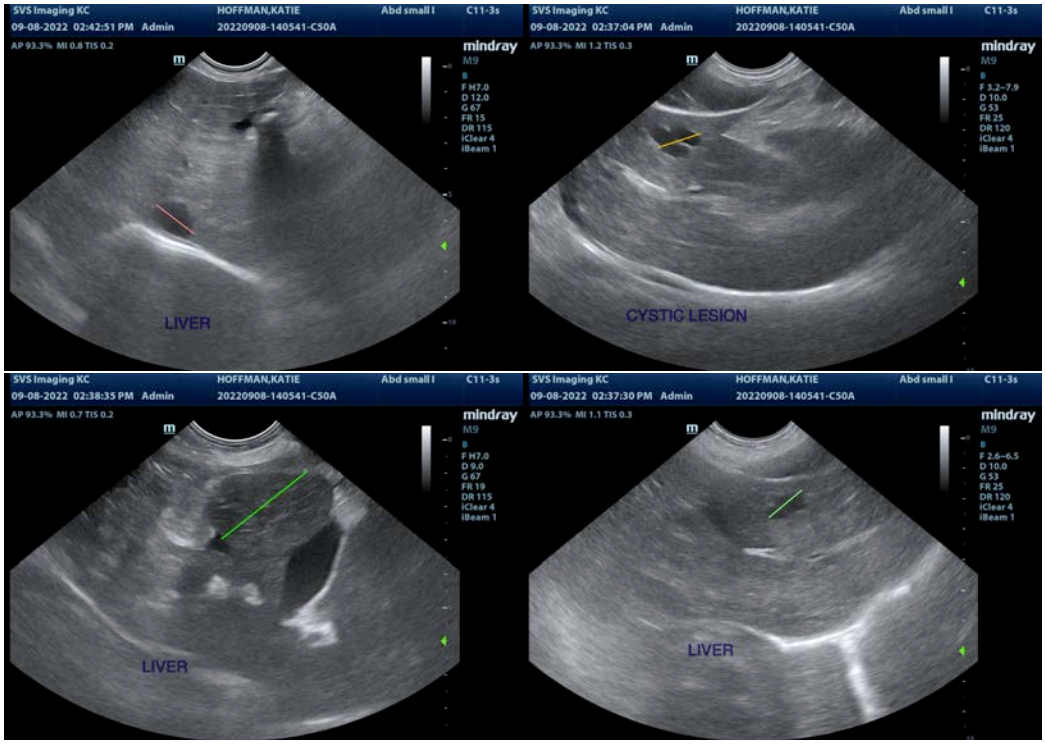

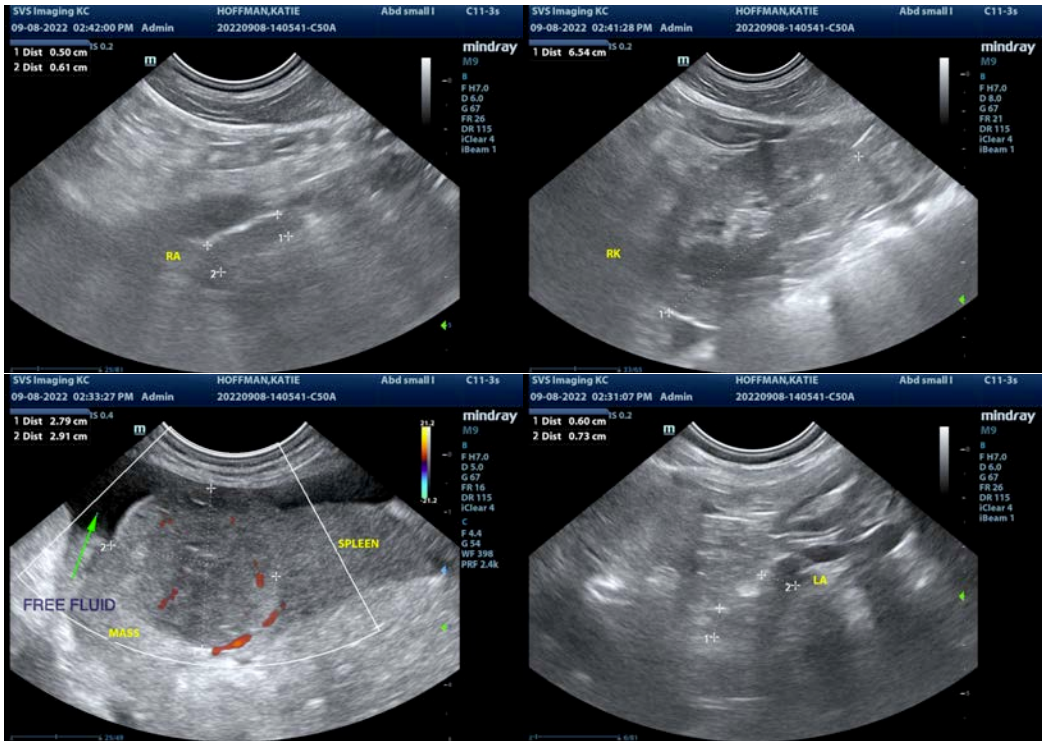

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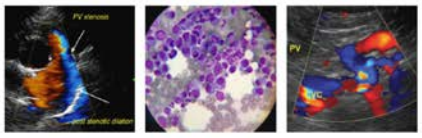

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

kathleen.sennello@sonopath.com