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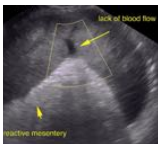
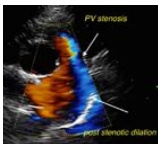
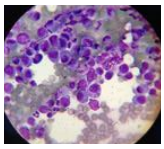
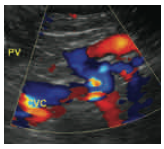
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Callie Perdue

SPECIES
Canine

BREED
Catahoula

SEX
Spayed Female

AGE
12 years

WEIGHT
90.6 lbs

INTERPRETED BY
Lisa Carioto, DVM, DVSc, Diplomate ACVIM

IMAGING PERFORMED BY
Dr. Beard

HOSPITAL NAME
West Prince AH

REFERRING VET
Dr. Beard

INVOICE
30456

DATE
5/17/22

PRESENTING CLINICAL SIGNS

History: On Metacam for painful back/legs (spondylosis). Owner reports PU/PD. They have another dog in the household with Cushing's, they are worried about this one.
ALKP 748, Lymphocytes 126, Monocytes 1,134. HW neg. UA pending.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is well distended with anechoic contents. The wall is smooth and regular. No abnormalities are present with the trigone or proximal urethra. A trivial amount of free floating sediment is present, however, there is no evidence of cystoliths, polyps or a mass.

Kidneys

The **left** kidney measures 7.31 cm. The capsule is very mildly irregular. The cortex is mildly hyperechoic and mildly thicker than usual. A mild loss of the normal definition of the cortico-medullary junction is present. Mineralizations and very small nephroliths of the diverticulae and pelvis are present, without evidence of pyelectasia. An accumulation of intrapelvic fat is noted. The surrounding mesentery is very mildly hyperechoic.

The **right** kidney measures 7.63 cm. Findings are similar to the left kidney, however, the mineralization of the pelvis is more severe in the right.

Aortic bifurcation/trifurcation

No abnormalities observed.

Adrenal Glands

The **left** adrenal gland measures 0.79 cm at the cranial pole, 0.58 cm at the caudal pole and 2.80 cm in length. The cranial pole is enlarged and “plump”, however, a mass or nodule is not visualized. No abnormalities are noted with the gland’s overall architecture, echogenicity or echotexture. The phrenico-abdominal vein and surrounding vasculature and mesentery are unremarkable.

Only a portion of the **right** adrenal gland is visualized. It measures 0.78 cm in diameter and is “plump”. A mass is not observed. No abnormalities are noted with the gland’s overall architecture, echogenicity or echotexture. The phrenico-abdominal vein and surrounding vasculature and mesentery are unremarkable.

Spleen

The spleen is within normal limits in size, architecture, echotexture, and echogenicity. It is folded on itself. The capsule is smooth. Two small hypoechoic nodules are present mid-body. They measure 5 mm x 5 mm. They do not affect the integrity of the capsule. No abnormalities are observed with its vasculature, i.e. congestion and thrombi are not identified.

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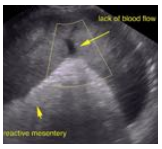
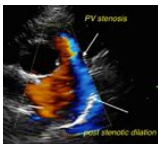
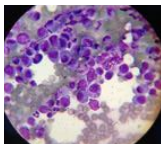
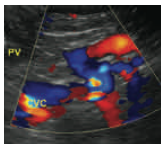

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A solid, round, mass with slightly irregular contours is observed. It originates from the spleen. Occasional hyperechoic nodules, some of which cast shadows, are noted. The large mass measures at least 6.3 cm in diameter x 7.6 cm in length. The largest hyperechoic nodule that shadows measures 5.3 mm in diameter x 8.0 mm in length. A few hypoechoic regions scattered haphazardly throughout the mass are noted, in addition to very thin anechoic lacunae. Hyperechoic tissue separates the mass from the spleen. The mass displaces the stomach caudally.

Liver

Hepatomegaly is present. The liver's borders are smooth, but rounded. A diffuse, mildly coarse or granular echotexture is observed, which may be due to a reactive hepatopathy. It is diffusely hyperechoic; i.e. it is hyper to the falciform fat. A hypo to almost isoechoic nodule is noted. It measures 1.2 cm in diameter x 1.6 cm in length. Target lesions are not observed. No obvious abnormalities are noted with the hepatic vessels.

The gallbladder wall is very mildly thicker (1.4 mm) and hyperechoic than normal. A small amount of echogenic material is present within the GB. The sludge is inspissated, forming nodules, which are adhered to the wall. The portions of the cystic and/or common bile ducts observed are not dilated or tortuous, i.e. there are no signs of an obstruction.

Gastrointestinal

Gas is present within the lumen of the stomach. The gastric wall is within normal limits in thickness and the wall layers are well defined. The submucosa is mildly thicker than usual. No obvious abnormalities are observed with its peristalsis.

The duodenum is within normal limits in thickness. The definition of wall layers is preserved. Gas, fluid and ingesta are noted within the lumen of the duodenum.

No abnormalities are observed with the small intestines. Very mild fogging of the mucosa is noted.

A large amount of gas is present within the transverse colon.

The colonic wall is not thickened and mural detail is considered normal.

Pancreas

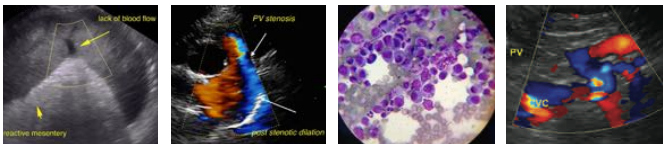
The **left limb** has a very mildly coarse echotexture, consistent with age related changes. Signs of active pancreatitis or neoplasia are not appreciated.

The right limb is heterogeneous with punctate, hyperechoic foci dispersed haphazardly throughout its parenchyma. Differential diagnoses include age-related changes, fibrosis due to previous episodes of pancreatitis, ischemia and/or amyloid deposition. Signs of active pancreatitis or neoplasia are not appreciated.

Other

Lymph nodes

No abnormalities are observed



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Abdominal effusion is not visualized.

ULTRASONOGRAPHIC FINDINGS

- Bilateral adrenomegaly, which is suggestive of adrenal hyperplasia secondary to pituitary dependent hyperadrenocorticism. Stress (chronic illness) may also be contributing to the adrenal changes noted.
- The splenic mass mid-body is not cavitary, i.e., its appearance is not consistent with hemangiosarcoma or a sarcoma. Extramedullary hematopoiesis or a hematoma that is becoming organized cannot be excluded.
- A splenic thrombus is noted in the splenic vein. Only a transverse view is available, therefore, it is not possible to determine the extent of it.
- Vacuolar and reactive hepatopathies suspected. Hyperadrenocorticism may be present. Other differential diagnoses for a diffusely hyperechoic liver, such as, hepatitis, cholestasis and cholangitis/cholangiohepatitis are considered less likely, but cannot be excluded with certainty.
- Nodular hyperplasia, a benign age related change, is also based on the appearance of the hypoechoic nodules. Target lesions are not noted in the liver, i.e. obvious signs of neoplasia are not noted.
- Gallbladder sludge; often clinically insignificant, however, gastroesophageal reflux disease (GERD), may occur in some patients. Obtaining a history regarding signs of GERD from the client is suggested. Cholecystitis, including a suppurative form, must be considered based on changes observed.
- Renal changes are suggestive of age-related degeneration. However, mineralization and small nephrolithiasis are present, which may be a nidus for infection. Glomerulonephritis or interstitial nephritis may also be contributing to some of the changes observed. Pyelonephritis cannot be excluded.
- Mild, subclinical inflammatory bowel disease cannot be excluded.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The following recommendations are suggested

- Fine needle aspirates of the splenic mass are suggested to obtain a definitive diagnosis.
- A urinalysis and urine culture and sensitivity are recommended to exclude pyelonephritis.
- If negative, a urine protein: creatinine ratio is suggested.
- Arterial blood pressure
- Obtaining a history regarding signs of GERD.
- An ACTH stimulation test or low-dose dexamethasone suppression test is suggested, based on the patient's clinical signs.

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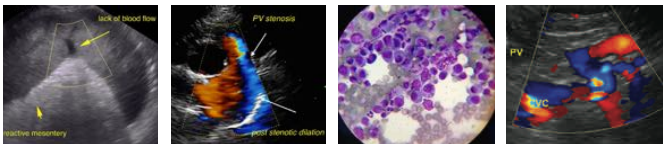

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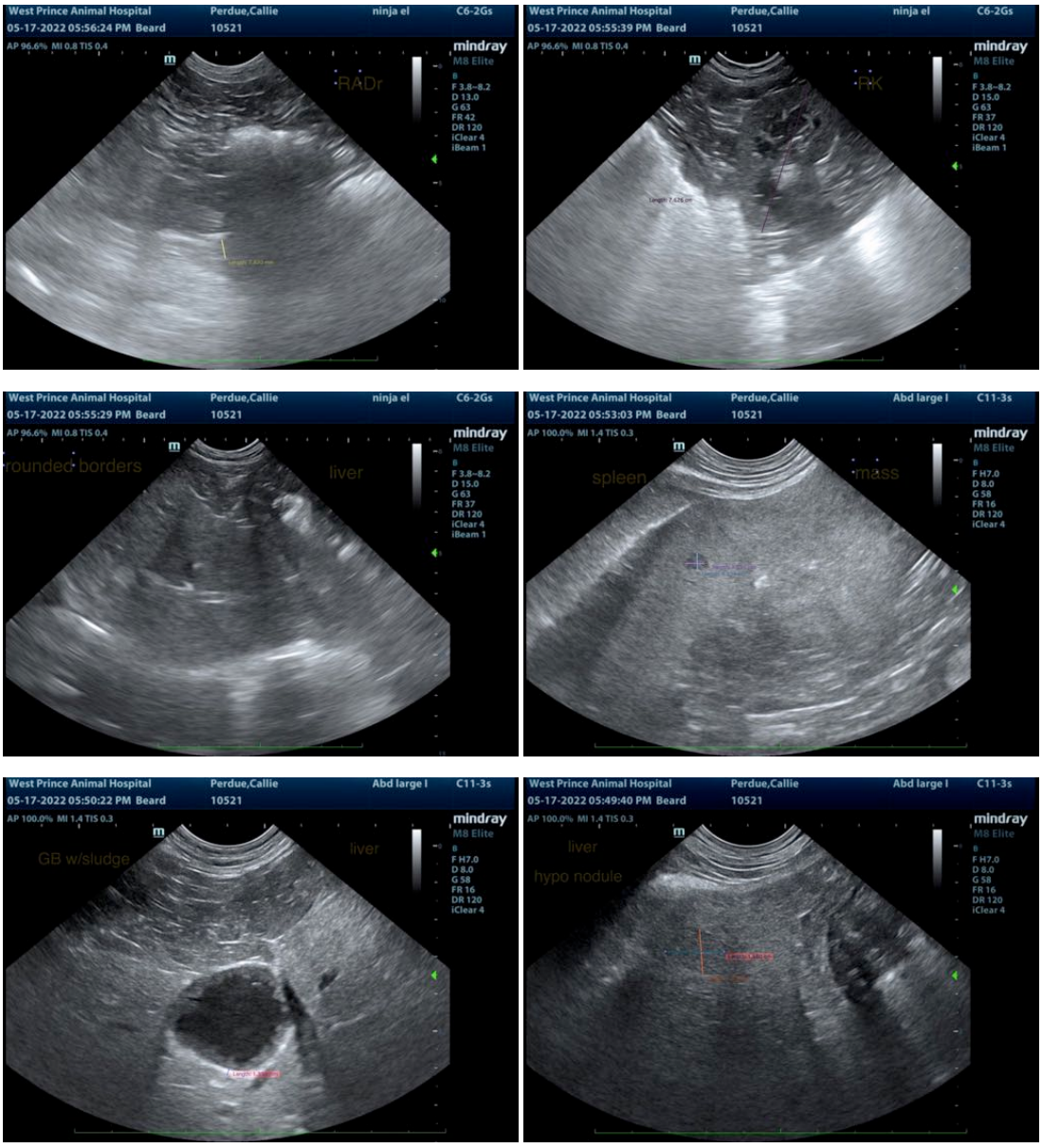
- clopidogrel is suggested to decrease the risk of further thromboemboli
- omega-3 fatty acids in addition to a diet for osteoarthritis are suggested
- supplements for OA, laser therapy, etc.



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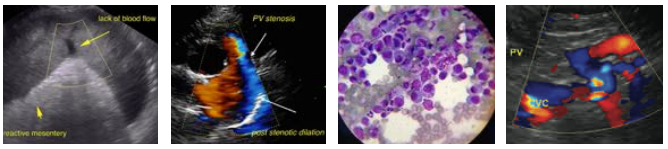

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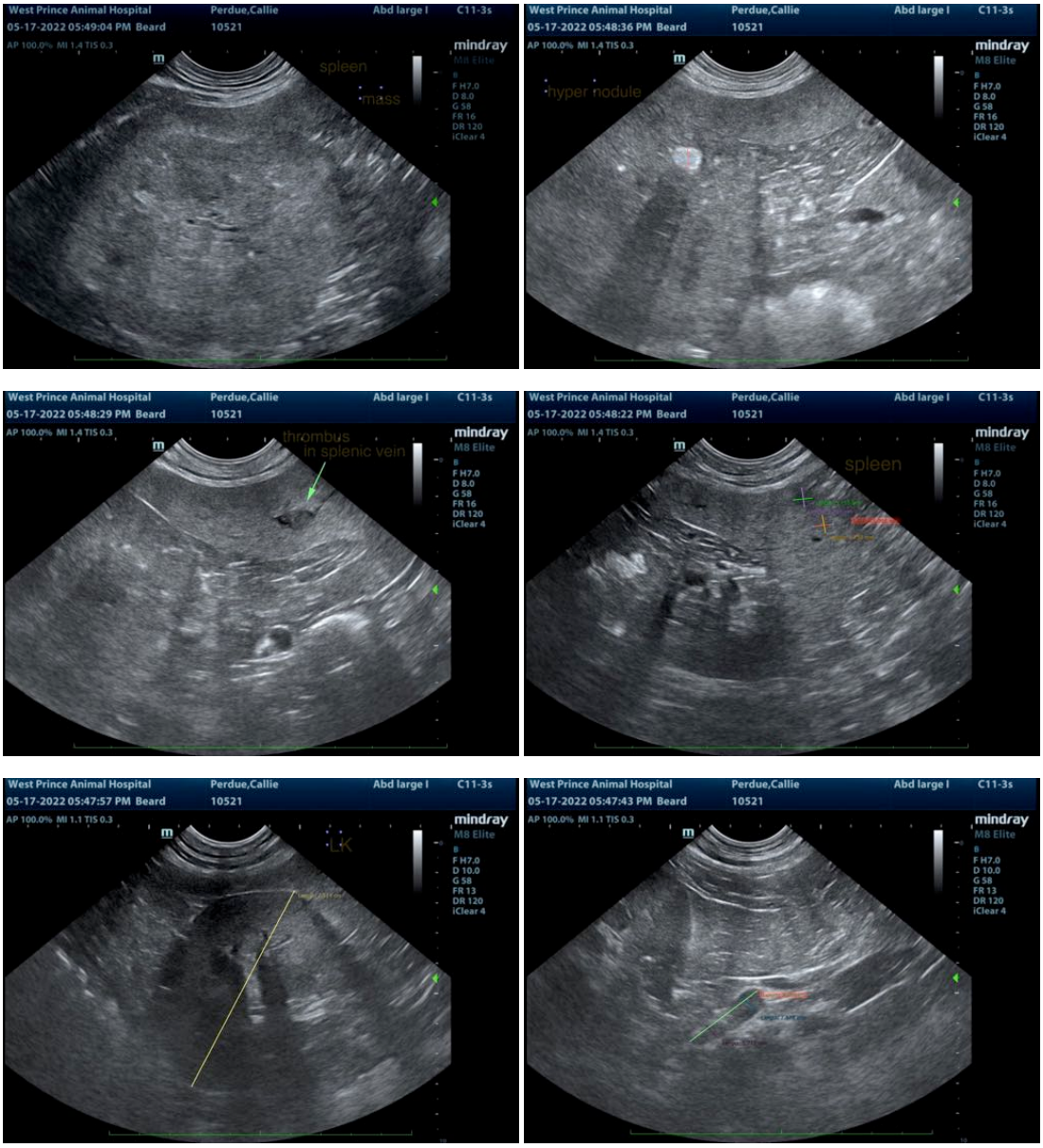

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Lisa Carioto, DVM, DVSc, Diplomate ACVIM

Lisa.Carioto@sonopath.com