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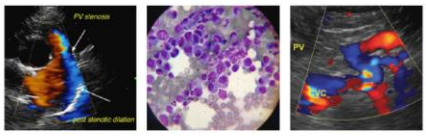

SonoPath
Clinical Sonography & Telecytology
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PATIENT
Kale Cochrane

SPECIES
Canine

BREED
Rottweiler Mix

SEX
FS

AGE
11 years

WEIGHT
57.6 lbs.

INTERPRETED BY
R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY
Amy Mayhew LVT

HOSPITAL NAME
SVS Imaging MI

REFERRING VET
Family Pet Practice- Dr. Richards

INVOICE
15781

DATE
1/10/23

PRESENTING CLINICAL SIGNS

Current Medications: Ursodiol 250 mg: 1 tab po q 24 hr Denamarin Adv Lrg: 1 tab po SID Quadruple 7.5 ml: between toes q 12 hr x 14 days

Patient History: AUS and chest rads on 1/10/23 for met check. Hx of mass on right rear foot, pea sized between 3rd and 4th digit. ANT Cytology performed 12/30/22- suggestive of MCT. Hx of low grade MCT removed Dec 2021. Plan to proceed with Stelfonta injection if met check is clear (will need to be on course of pred, diphenhydramine, famotidine) ANT CHP BW performed 11/18/22 -elevated liver values noted, have improved with meds Compare to prior IH AUS performed Nov 2021- mildly enlarged and diffusely heterogenous liver noted then. Has been doing well with denamarin and ursodiol

Abnormal PE/Chem/CBC/UA Results: Exam performed 12/29/22: Presented to followup on foot on Right hind, recently saw P and P more anxious 8. licking at right hind- skin overall no longer erythematous, no discharge, no pododermatitis present. No longer bothering area, infection appears significantly improvement. Still present: There is a raised, hairless, soft lesion above/between 4th+ 5th digit (feels soft/fluid filled). Small pea sized pustule developing between 3rd and 4th digit. Rest of feet look normal. Nonpainful at site, no lameness noted. Rest of coat ok- monitoring small mass on left front shoulder, no changes (smaller than a pea) -FNA confirmed MCT, consider Stelfonta injection

ALP 363, ALT 215, GGT 33, TBil 0.3, Unremarkable renal parameters, TG 526, Normal CBC, SG 1.044

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

No evidence of medial Iliac or sublumbar lymphadenopathy/masses.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 6.3 cm in length. The right kidney measured 7.4 cm in length.

Adrenal Glands

The bilateral adrenal glands were normal in size. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. No adrenal tumors are noted. The left adrenal gland measured 0.52 cm width in the cranial pole and 0.57 cm width in the caudal pole. The right adrenal gland measured 0.66 cm width in the caudal pole.

Spleen

The spleen was normal in size and contour with generalized mild parenchyma heterogeneity. No masses or nodules were noted. Normal splenic vascularity was present.

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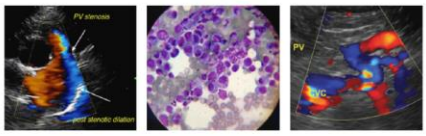

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Liver/ Gallbladder

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to benign parenchymal remodeling. A discrete, right, nondisruptive, intraparenchymal nodule measuring 2.3 cm in diameter was present. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size containing primarily anechoic content with mild, echogenic gallbladder debris. No evidence of gallbladder or peripheral gallbladder inflammatory criteria was noted. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction, or foreign material.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction, or foreign material.

Normal visible colon wall layers were present with apparent formed feces in lumen.

Pancreas

The parenchyma of the left limb, body, and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease were evident.

Free Abdomen

No omental masses, lymphadenopathy, or evidence of peritoneal free fluid were noted.

ULTRASONOGRAPHIC FINDINGS

- Hepatopathy exhibiting mild heterogeneous / remodeled parenchyma with focal / intermittent discrete intraparenchymal nodule - nonspecific, vacuolar hepatopathy, inflammatory / immune-mediated disease, nonobstructive cholestasis, hyperplasia, hematopoiesis, early fibrosis, or other hepatopathy possible, potential for early neoplastic / metastatic hepatopathy is thought less likely yet cannot be definitively excluded
- Mild heterogeneous spleen - subjectively benign
- Mild gallbladder debris - non-mucocele
- Mild age-related kidneys

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No obvious evidence of intraabdominal neoplastic / metastatic criteria with primarily nonspecific hepatic parenchymal changes present. Assuming normal clotting status, screening hepatosplenic FNA cytology using a 25-gauge needle is recommended, given the confirmed cutaneous mast cell tumor and for further assessment. Sonographic monitoring of the spleen and liver based on oncology recommendations would be a more conservative approach. Hepatosupportive medications including Denamarin and Ursodiol may prove beneficial. Three-view chest radiographs are suggested to rule out occult thoracic pathology.

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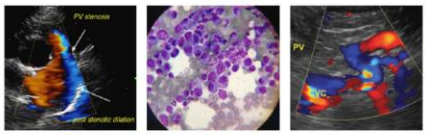

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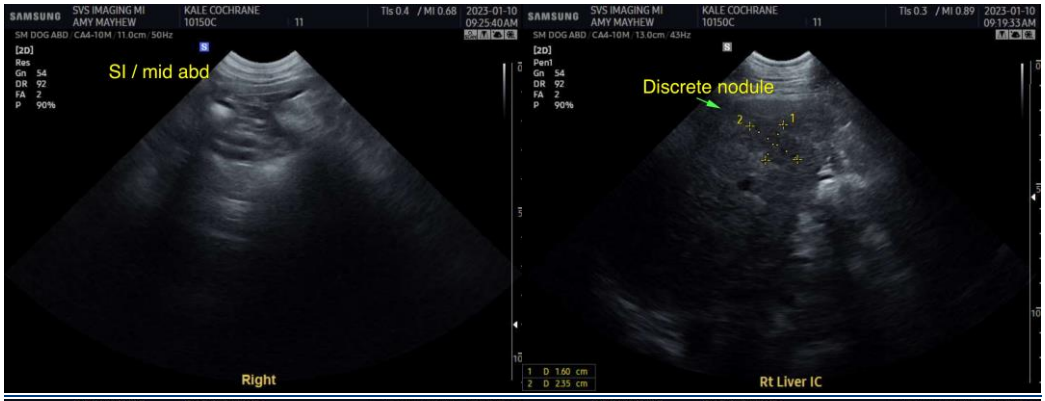

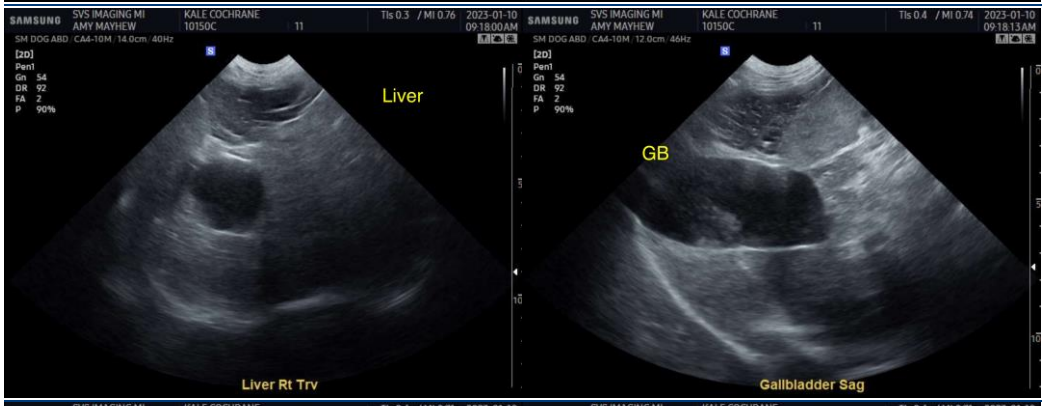

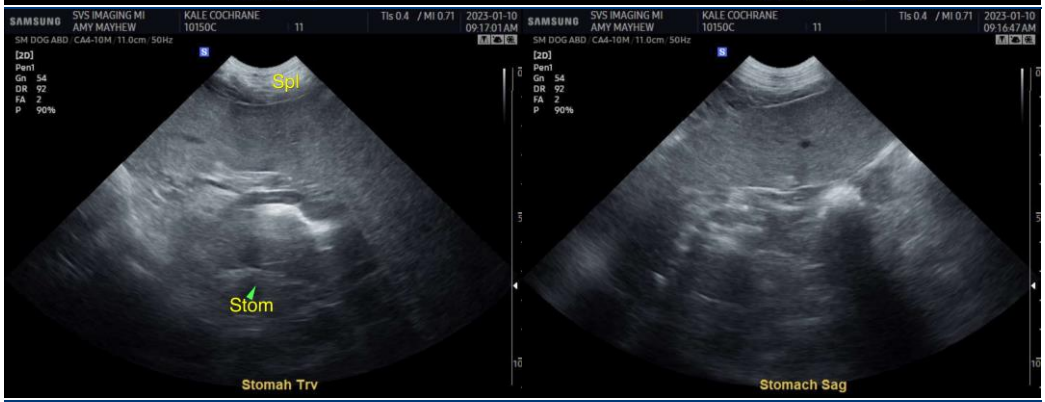

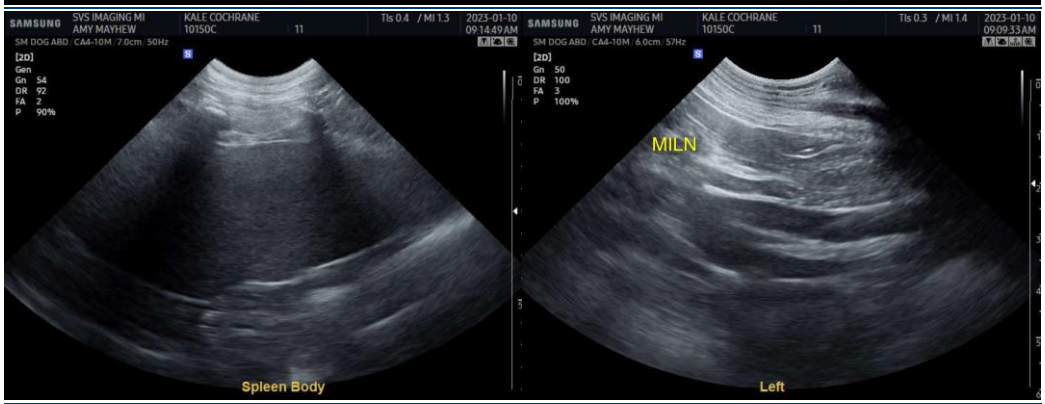

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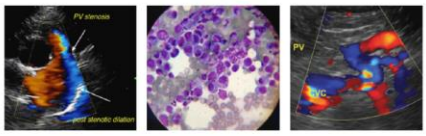

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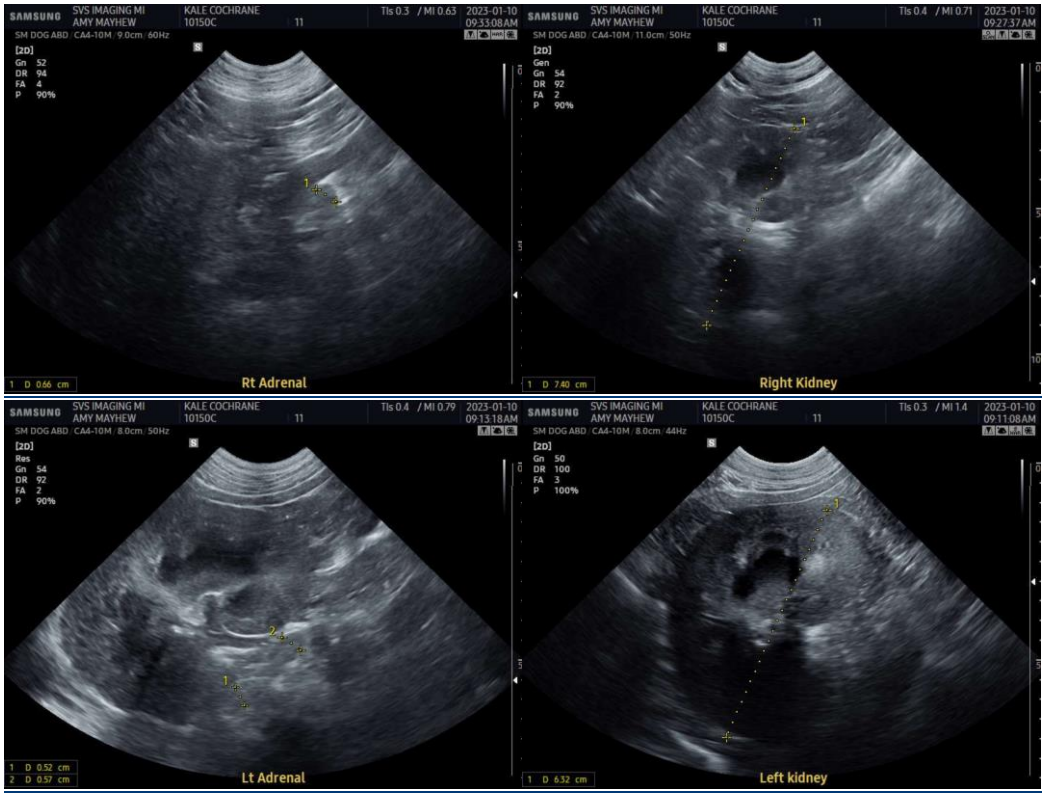

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)
info@SonoPath.com