



PATIENT

Dingo Stidle

SPECIES

Canine

BREED

Australian Cattle
Dog

SEX

Intact male

AGE

4 years 7 months

WEIGHT

37.10 lbs.

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

Dr. Rivera

HOSPITAL NAME

DPC VH

REFERRING VET

Dr. Rivera

INVOICE

DATE

1/28/22

PRESENTING CLINICAL SIGNS

Rechecking: LETHARGY History: P IS A 4Y7M OLD INTACT MALE AUSTRALIAN CATTLE DOG PRESENTING TODAY FOR RECHECK LETHARGY. O STATES LETHARGY COMES AND GOES. P HAS NOT BEEN EATING WELL ON AND OFF. TODAY NOT DOING GREAT NOT PLAYING JUST LAYING. OVERNIGHT P HAD EPISODE OF VOMIT AND DIARRHEA. O STATES P DOES NOT NORMALLY EAT CANNED FOOD BUT FED CANNED FOOD THINKS THATS WHAT CAUSING DIARRHEA
Abnormal PE/Chem/CBC/UA Results: Exam Notes: BAR; hydrated; soft suspect painful on GI palpation.

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.

The prostate was mildly enlarged in size with intact, symmetrical capsule contour. The margins of the gland were intact and able to be differentiated from the surrounding tissue. The prostatic parenchyma was mildly echogenic to heteroechoic without parenchymal mineralization. The prostate measured 2.3 cm diameter.

The area of the aortic trifurcation was free of pathology.

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 5.5 cm in length. The right kidney measured 5.8 cm in length.

Adrenal Glands

The left and right adrenal glands were not definitively visualized.

Spleen

A large, primarily spherical mass involving the spleen with secondary capsule expansion and disruption was present and measured 9.0-10.0 cm in diameter. The mass exhibited nonhomogeneously hypoechoic parenchyma without areas of cavitation. The splenic parenchyma not involved with the mass exhibited generalized heterogeneity. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis.

Liver/ Gallbladder

The liver exhibited potential mild enlargement. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination.



PATIENT	The hepatic and portal vasculature were normal in appearance without signs of congestion. No overt hepatic masses or nodules were noted. The gallbladder was non-distended in size with primarily anechoic luminal content. The cystic and common bile ducts were normal.
Dingo Stidle	
SPECIES	<i>Gastrointestinal</i>
Canine	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.
BREED	
Australian Cattle Dog	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.
SEX	
Intact male	Normal visible colon wall layers were present with apparent formed feces in lumen.
AGE	<i>Pancreas</i>
4 years 7 months	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.
WEIGHT	<i>Free Abdomen</i>
37.10 lbs.	Regional perisplenic to generalized reactive mesentery was present. Moderate volume peritoneal free fluid was noted. No overt lymphadenopathy was present.
INTERPRETED BY	ULTRASONOGRAPHIC FINDINGS
R. McKenzie Daniel, DVM, DABVP (Canine and Feline)	<i>Primary Findings</i>
IMAGING PERFORMED BY	<ul style="list-style-type: none"> • Large, nonhomogeneously hypoechoic splenic mass • Concurrent to moderate volume peritoneal free fluid and generalized primarily perisplenic reactive mesentery • Subjective mild vacuolar hepatopathy pattern • Bilateral mild chronic renal changes • Benign prostatic hyperplasia • Subjective mild gastroenteritis
Dr. Rivera	
HOSPITAL NAME	<u>INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS</u>
DPC VH	Although histopathology is required for definitive diagnosis, the splenic mass is most suggestive of neoplasia such as sarcoma or other. Benign pathologies are possible, yet considered less likely. Potential for omental adhesions to the splenic mass, given the perisplenic reactive mesentery, is possible although not definitive. Overt evidence of intraabdominal metastasis was not definitively evident, yet the possibility of non-visualized metastasis or micrometastasis cannot be definitively excluded in these cases.
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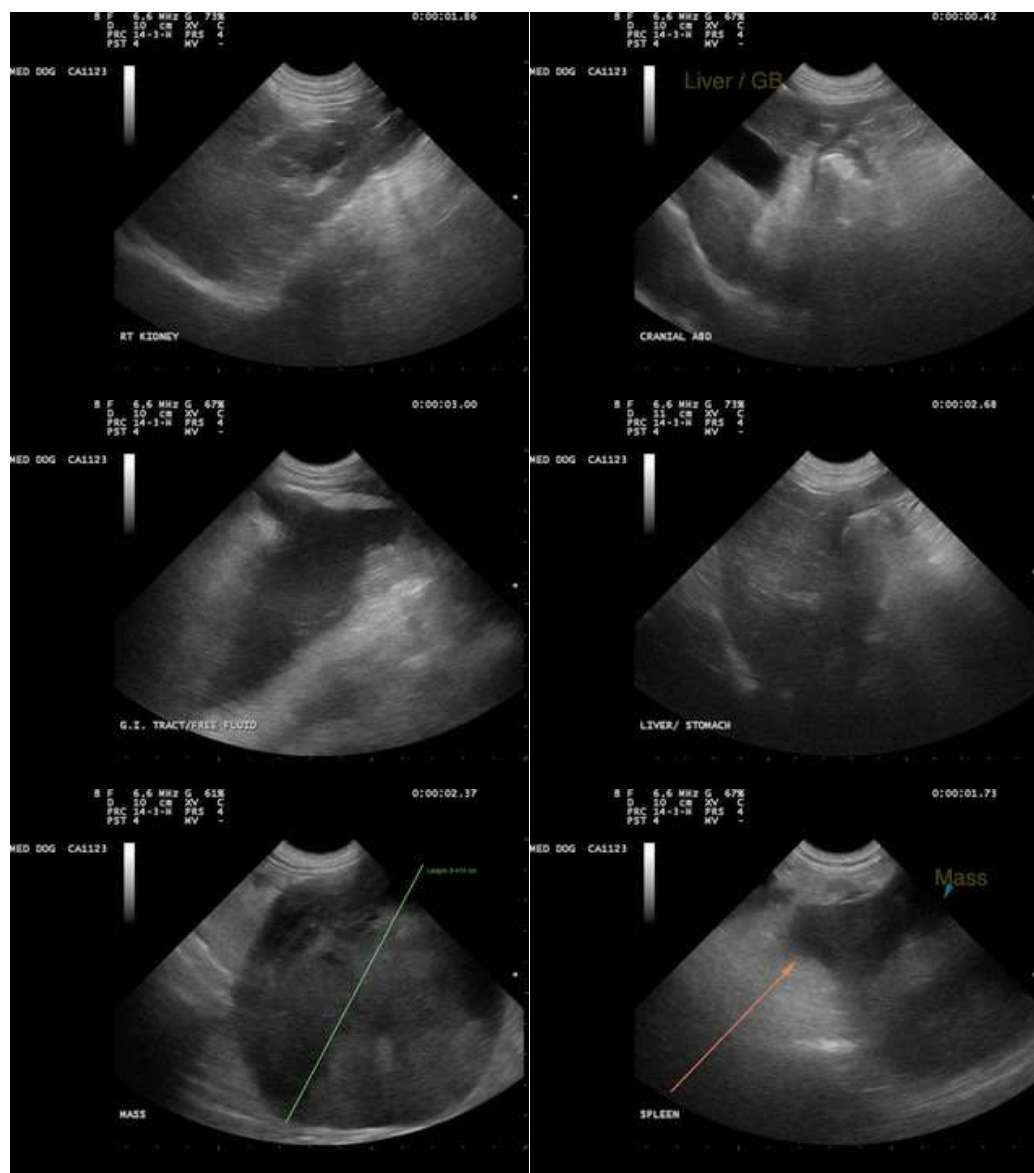
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Abdominocentesis for further assessment of the peritoneal effusion (hemoabdomen or other) is recommended, as well as correlation with full lab work. Three view chest radiographs to assess for evidence of thoracic pathology, as well as assessment of cardiopulmonary status, is recommended. Ideally, a brief sonographic assessment of the heart to assess for evidence of pericardial effusion or metastasis is recommended. Pending additional diagnostics and assuming no evidence of additional metastatic disease, laparotomy with expectation towards splenectomy, gross inspection of the perisplenic omentum, and liver may be considered. A guarded prognosis is warranted.





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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)
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