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Clinical Sonography & Telecytology

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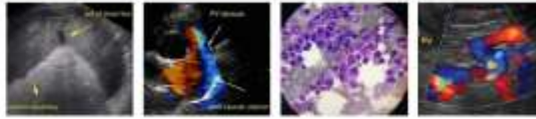


IMAGING PERFORMED BY

pawsonography@gmail.com 530-786-8340

PATIENT

Joseywales Dougherty

SPECIES

Canine

BREED

Goldendoodle

SEX

FS

AGE

10 years

WEIGHT

80

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT

HOSPITAL NAME

Pine Creek VC

REFERRING VET

Dr. Denny Nolet

INVOICE

12972

DATE

1/6/22

PRESENTING CLINICAL SIGNS

Appointment reason: Swollen neck and throat. -Last meal was 5pm last night. Pt has been swollen from the chin down the chest since yesterday morning (1/2/22). Eating and drinking well, no V/D. Pt is more lethargic per O and has a minor cough that comes and goes. MM=light pink, CRT=1. No punctures or wounds found, no sign of fluid build up under the skin. Appears to be soft tissue swelling with no pain attached. Per DN, sent out bloodwork to lab (Healthchek+
Abnormal PE/Chem/CBC/UA Results: RADS attached- LABS: albumin 2.5, Na/K ratio 25, potassounm 6, Cl 121, HCT 37.1, Hg 11.8,

ULTRASONOGRAPHIC EXAMINATION OF THE HEART & ABDOMEN

Cardiac Presentation

Brief echocardiogram in this patient demonstrated mild LA / LV enlargement with mild decreased LV systolic function. The right atrium and right ventricle were of normal size with potential for mild subjective hyperechoic thickening of the RV free wall and area of the right AV groove. Mild to moderate volume pericardial free fluid was present. No overt cardiac or heart base masses were evident. Concurrent moderate volume pleural free fluid was present with areas of suspected yet nonspecific, atypical lung. Fractional shortening measured 28.6%. Ejection fraction measured 59%. EPSS measured 0.5 cm. LA 2D measured 4.9 cm. LVIDD measured 4.9 cm.

A moderately sized, mildly nonhomogeneous mass occupying the subjective mid to caudal left thorax was present, measuring approximately 11 cm x 10 cm.

Urinary System

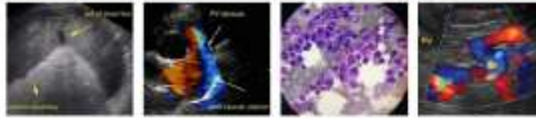
The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

The 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 8.5 cm in length. The right kidney measured 8.9 cm in length.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.65 cm width at the caudal pole and 0.58 cm width at the cranial pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.79 cm width at the caudal pole and 0.59 cm width at the cranial pole.



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Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted. No evidence of splenic neoplastic criteria was noted.

Liver/ Gallbladder

The liver exhibited subjective mild generalized 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. Potential signs of emerging hepatic vasculature congestion were noted, although not definitive. The gallbladder was non-distended in size with mild gallbladder debris. 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 pancreas base and right pancreatic limb exhibited mild prominent size with Isoechoic to heterogeneous parenchyma compared to the adjacent omentum. No overt evidence of pancreatic neoplastic criteria was noted.

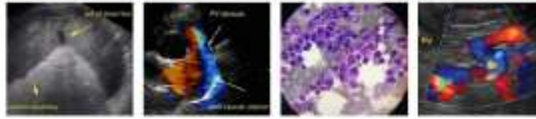
Free Abdomen

Potential for very scant pockets of ventrocaudal peritoneal free fluid is possible yet not definitive. No overt lymphadenopathy was noted. The omentum was of uniform echogenicity. No overt lymphadenopathy was noted.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Mid to caudal thoracic mass - subjective left thorax
- Suspect areas of atypical yet nonspecific lung - consolidation, neoplasia, or other
- Moderate volume pleural and pericardial effusion- potential emerging cardiac tamponade
- Subjective mild thickened to hyperechoic RV free wall and area of right AV groove
- Mild subnormal LV systolic function



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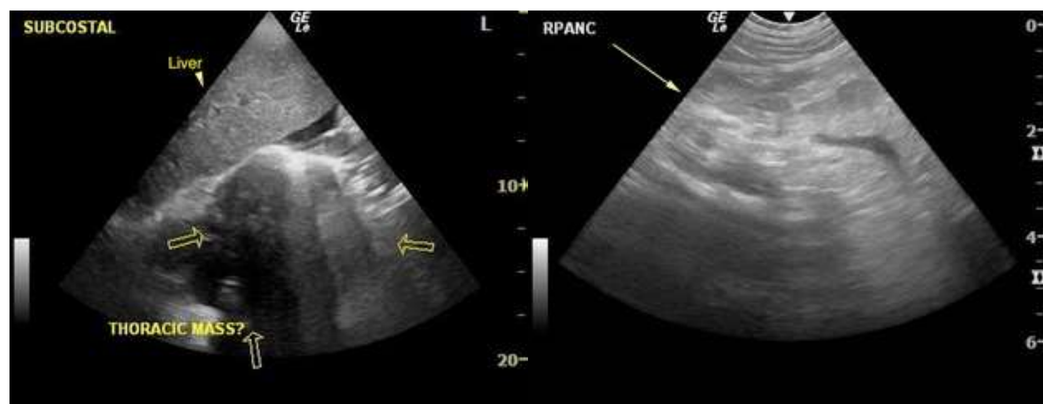
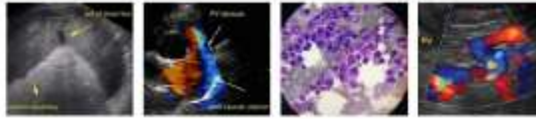
- Mild hepatomegaly - subjectively benign, vacuolar hepatic changes with potential for emerging congestive hepatopathy
- Mild chronic renal changes
- Heterogeneous to prominent pancreas base and right pancreatic limb - age-related changes, parenchymal remodeling owing to previous Inflammation or low-grade chronic pancreatitis possible

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Although evidence of mild LA / LV enlargement and mild decreased LV systolic function were present on subjective echocardiogram, the lack of significant LA / LV enlargement or significant LV systolic dysfunction indicates that the pleural effusion in this case is noncardiogenic in origin, likely secondary to primary thoracic or thoracopulmonary pathology. The possibility of a multifactorial component to the pleural and pericardial effusion cannot be definitively excluded, however. Potential for emerging right ventricle and right atrioventricular groove pathology such as metastatic disease of potential separate etiology, given the likelihood of noncardiogenic pericardial effusion, is warranted. Thoracocentesis +/- pericardiocentesis for effusion analysis, cytology +/- C/S if possible is recommended for further clarification. No overt evidence of primary intraabdominal neoplasia as a potential cause of thoracopulmonary or cardiac metastasis.

Although additional recommended diagnostics which may include ultrasound-guided FNA of the thoracic mass if accessible, thoracopulmonary neoplasia with potential for emerging cardiac neoplasia are favored In this case.





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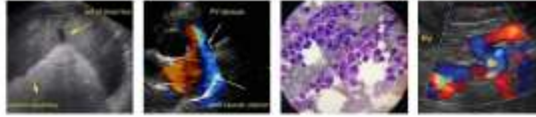

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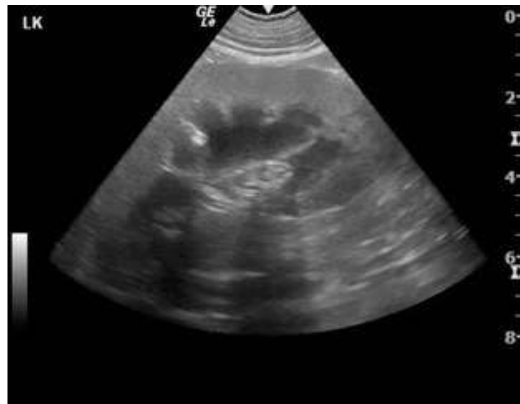

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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