



PATIENT

Jenda Virella

SPECIES

Canine

BREED

Australian Shepherd

SEX

SF

AGE

10 years 7 months

WEIGHT

62.3 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

12625

DATE

11/16/21

PRESENTING CLINICAL SIGNS

Date: 11/13/2021 Reason for Visit: ANNUAL History: P IS A 10Y7M OLD F/S AUSTRALIAN SHEPHERD PRESENTING TODAY FOR ANNUAL VISIT. O STATES P BEEN DOING WELL HAD A LITTLE SOFT STOOL THIS AM POSS ATE SOMETHING SHE SHOULDN'T HAVE AND LAST WEEK WAS LETHARGIC FOR ONE DAY OTHERWISE NO PROBLEMS/CONCERNS. NEEDS REFILL TRIFEXIS. C/S/V/D: SOFT STOOL THIS AM Abnormal PE/Chem/CBC/UA Results: Hydration: Appropriately hydrated Mentation: BAR EENT: No nasal discharge; clear no discharge OU, ~2 mm mass on lower eyelid margin OS; clean no exudate AU; No cough on tracheal palpation. Oral Cavity: moderate to heavy dental tartar present Lymph Nodes: Symmetrical, no changes in size, shape, consistency Skin: Good hair coat, no signs of ectoparasites. No lesions noted. CV/Respiratory: No murmur/arrhythmia or crackles/wheezing auscultated. Synchronous pulses, normal rate. Normal bronchovesicular sounds. Abd/GI: Soft non painful abdomen, no organomegaly, no abnormalities on abdominal palpation Uro/Perineum: N Musculoskeletal: Normal ambulation, no lameness noted. BCS 7/9 Neurological: Appropriate CBC: RBC 4 (4.8-9.3), Hgb 9.8 (12.1-20.3), Hct 29 (36-60) (immune mediated, blood loss, other), NRBC 12 (0-1), Plt 54 (170-400), Band neutrophils 516 (0-300) (infection, tumor, tissue necrosis), rest WNL Chem: Amylase 1129 (290-1125), rest WNL T4: 1.3 (normal) UA (voided): SG 1.014, pH 8.5, trace protein

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 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 6.7 cm in length. The right kidney measured 6.8 cm in length.

Adrenal Glands

The left adrenal gland was indistinctly visualized, measuring 0.56 cm in width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.51 cm width at the caudal pole and 0.5 cm width at the cranial pole.

Spleen

The spleen exhibited multifocal, expansive, hypoechoic to nonhomogeneous Intraparenchymal nodules to nodular mass lesions, some of which resulted in distortion of the splenic capsule. An example of a nodule measured 2.8 cm in diameter. An example of a nodular mass measured 4.0 cm in diameter.



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Liver/ Gallbladder

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The liver presented enlarged in size. 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. A solitary, subtly expansive, hypoechoic nodule was noted in the subjective mid caudal parenchyma, measuring 1.3 cm in diameter. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with primarily anechoic luminal content. The cystic and common bile ducts were normal.

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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.

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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.

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Free Abdomen

Mild peritoneal free fluid primarily around the spleen but also present in the caudal abdomen was present. Subtle evidence of perisplenic reactive mesentery was noted. No overt lymphadenopathy was present.

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ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Infiltrative spleen with multifocal variably sized to variably expansive nodules to nodular masses
- Hepatomegaly with focal nonspecific yet suspicious nodule
- Sonographically unremarkable urinary bladder
- Mild age-related kidneys
- Mild peritoneal primarily perisplenic free fluid - concern for hemoabdomen

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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Although histopathology is required for a definitive diagnosis, the splenic nodules to nodular mass lesions are consistent with neoplastic criteria with considerations including sarcoma, round cell neoplasia, or other. Potential for benign splenic etiologies such as hyperplasia, hematopoiesis, or splenitis is considered less likely.



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The focal hepatic nodule may indicate focal area of hematopoiesis, hyperplasia, lipogranuloma, or similar. However, concern for possible concurrent hepatic involvement or focal hepatic metastasis is warranted.

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Three view chest radiographs are recommended. Ideally, sonographic assessment of the heart to assess for pericardial effusion or pericardial masses is recommended. Assuming normal clotting status, ultrasound-guided FNA of the spleen, as well as hepatic parenchyma and if accessible, hepatic nodule for cytology and potential oncology consultation may be considered. A very guarded to potentially unfavorable long-term prognosis, however, is indicated.

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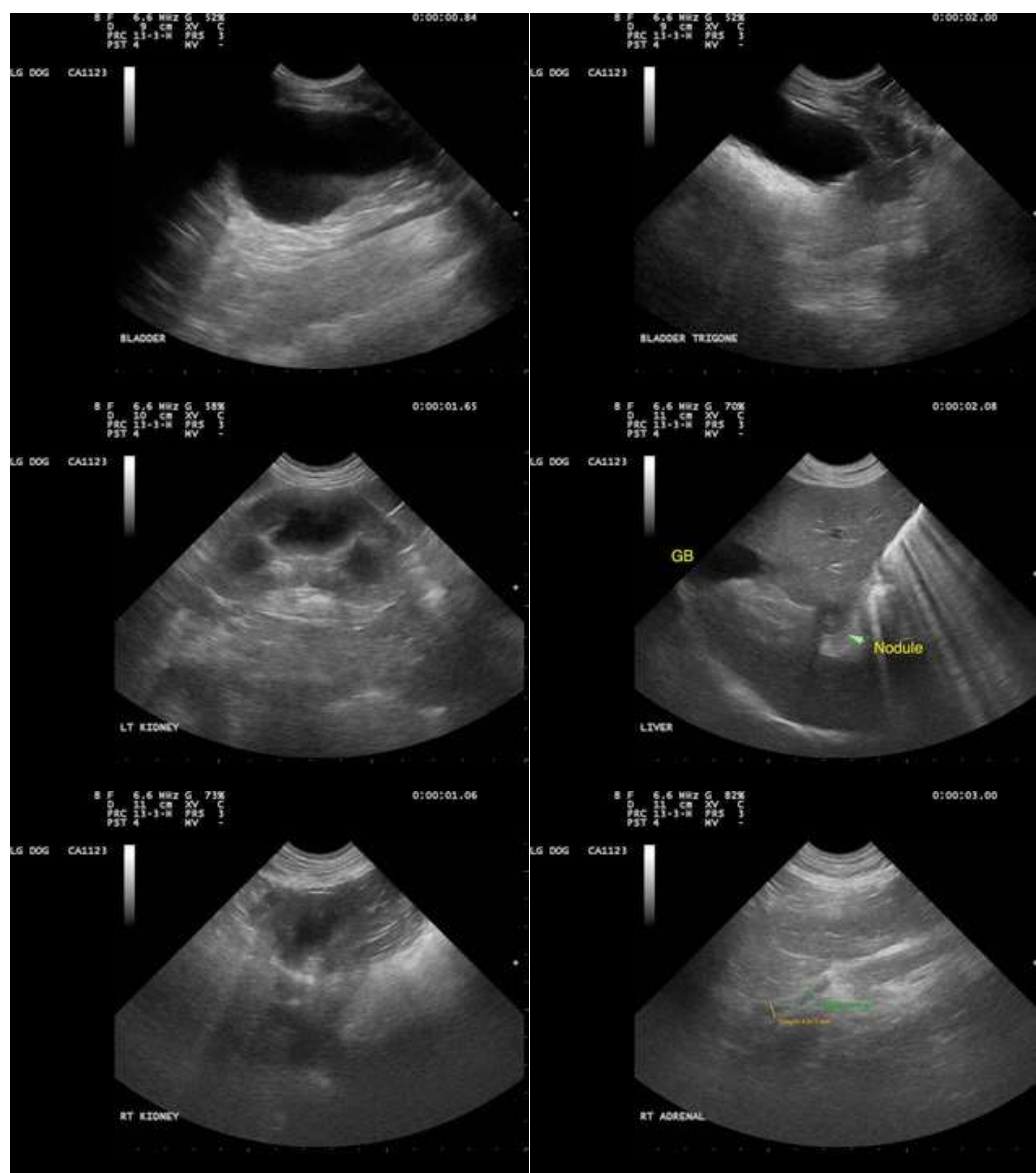
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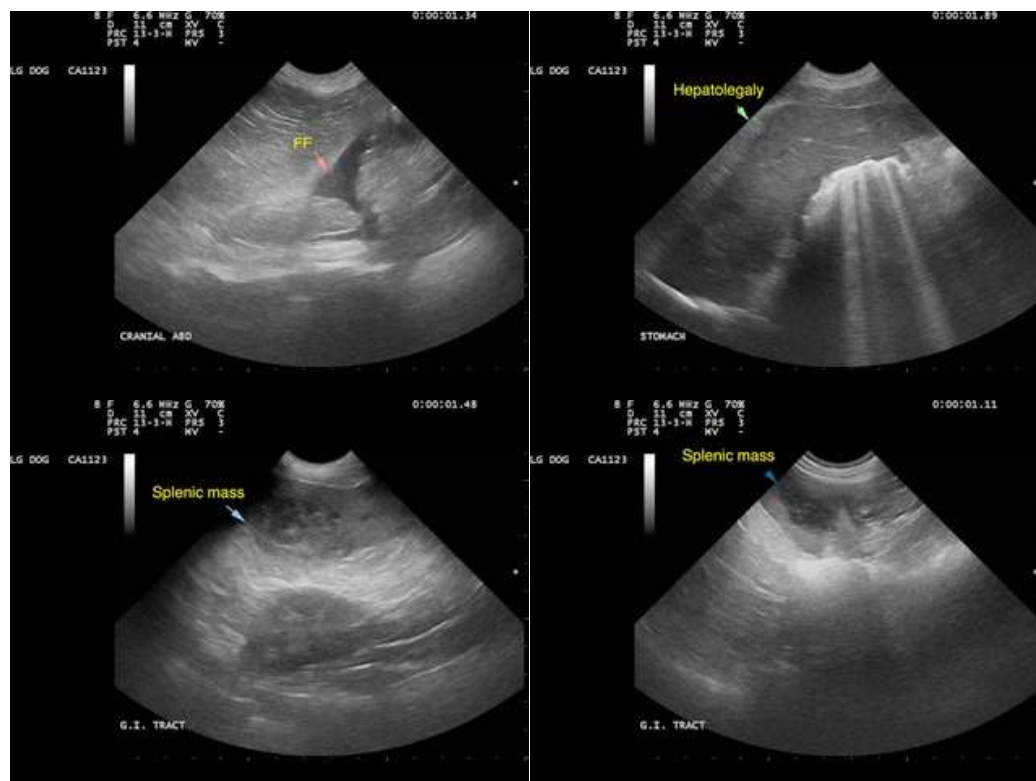
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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