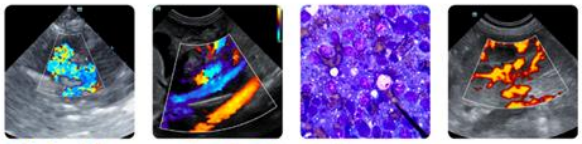

PATIENT

Xenia Guarini

SPECIES

Canine

BREED

Cattle dog/Aussie Mix

SEX

FS

AGE

13yr

WEIGHT

34kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Lindsay Powell, CVT

HOSPITAL NAME

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23234

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PRESENTING CLINICAL SIGNS

Acute hematuria PE: NS OU severe tartar/gingival erythema, halitosis Painful on caudal abdominal palpation small keratinaceous mass on L side of muzzle slow to rise hind end, moderate muscle atrophy of hind legs overconditioned

Abnormal PE/Chem/CBC/UA Results: Focal Urinary US: Markedly thickened, irregular bladder wall with focal bulge into the lumen; cystocentesis deferred due to concern for mass. Radiographs: Spondylosis of thoracic and lumbar spine. Thorax NSF, Abdomen NSF UA (free catch): USG 1.028, Protein 500 mg/dL, Blood 250 Ery/uL, *suspect presence rods Bacterial confirmation - no bacteria detected culture pending EPOC: HCT 51% PCV/TS: 55%/7.2

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder was subnormal in size owing to lack of urine distension which prohibited full evaluation of the urinary bladder walls. Significantly thickened ventral urinary bladder wall extending into the apical urinary bladder, asymmetrical luminal surface contour and mild non-homogenous non-mineralized mural echogenicity was present. The ventral urinary bladder wall measured 1.4 cm wall width. The trigone, cystourethral junction, and visible pelvic urethra to a depth of 3 cm exhibited normal thickness and tone. Minimal anechoic urine was present in the lumen with moderate accumulated hyperechoic sand to mild mineral.

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 or pyelonephritis was present. The left kidney measured 6.5 cm in length. The right kidney measured 6.8 cm in length.

The area of the iliac trifurcation was free of pathology including no evidence of medial iliac or sublumbar lymphadenopathy or masses.

Adrenal Glands

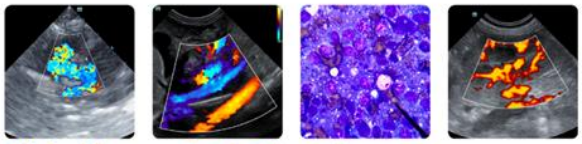
The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.8 cm width at the caudal pole.

The right adrenal gland was mildly enlarged in size with asymmetrical margination and heterogeneous parenchyma. Mid right adrenal non-disruptive mildly hypoechoic nodule was present measuring 1.0 cm x 0.8 cm. No obvious vascular invasion. The right adrenal gland measured 0.87 cm width at the caudal pole.

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.

Liver/Gallbladder



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Generalized hepatomegaly was present. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to benign parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion. A non-capsule deforming, non-homogeneous hypoechoic ventral left mass lesion was present measuring 3.3 cm in diameter. A separate similar appearing mass lesion was present in the caudate liver lobe measuring 5.3 cm in diameter.

The gallbladder was non-distended in size with thin walls and mild, non-organized hyperechoic debris. The common bile duct was not visualized without overt evidence of dilation or post hepatic obstructive criteria.

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 mechanical/metabolic ileus, obstruction or foreign material.

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

Pancreas

The pancreas was normal in size with capsule asymmetry and isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

Free Abdomen

No omental masses, overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

Primary

- Non-distended thickened urinary bladder wall with moderate urine sediment / sand- variable to significant chronic cystitis, infection, neoplasia all potentials
- Bilateral chronic renal changes
- Mildly enlarged nodular right adrenal gland- hyperplasia, adenomatous change, emerging adrenal tumor possible
- Hepatomegaly with left ventral and caudate lobe intraparenchymal mass lesions- hyperplasia, vacuolar changes, inflammation, hepatoma like mass lesions, neoplasia possible
- Non-organized gallbladder debris (non-mucocele)
- Pancreatic remodeling

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Correlation with pending urine C/S is recommended. Concurrent screening BRAF assay is warranted. Assuming normal clotting status and using a 25g needle, a hepatic mass lesion FNA for screening cytology is warranted for further assessment. Adrenal screening or workup recommended if clinical signs consistent with Cushing syndrome are present. Serial monitoring of systemic BP for evidence of hypertension, which may potentially allude to right pheochromocytoma is recommended.

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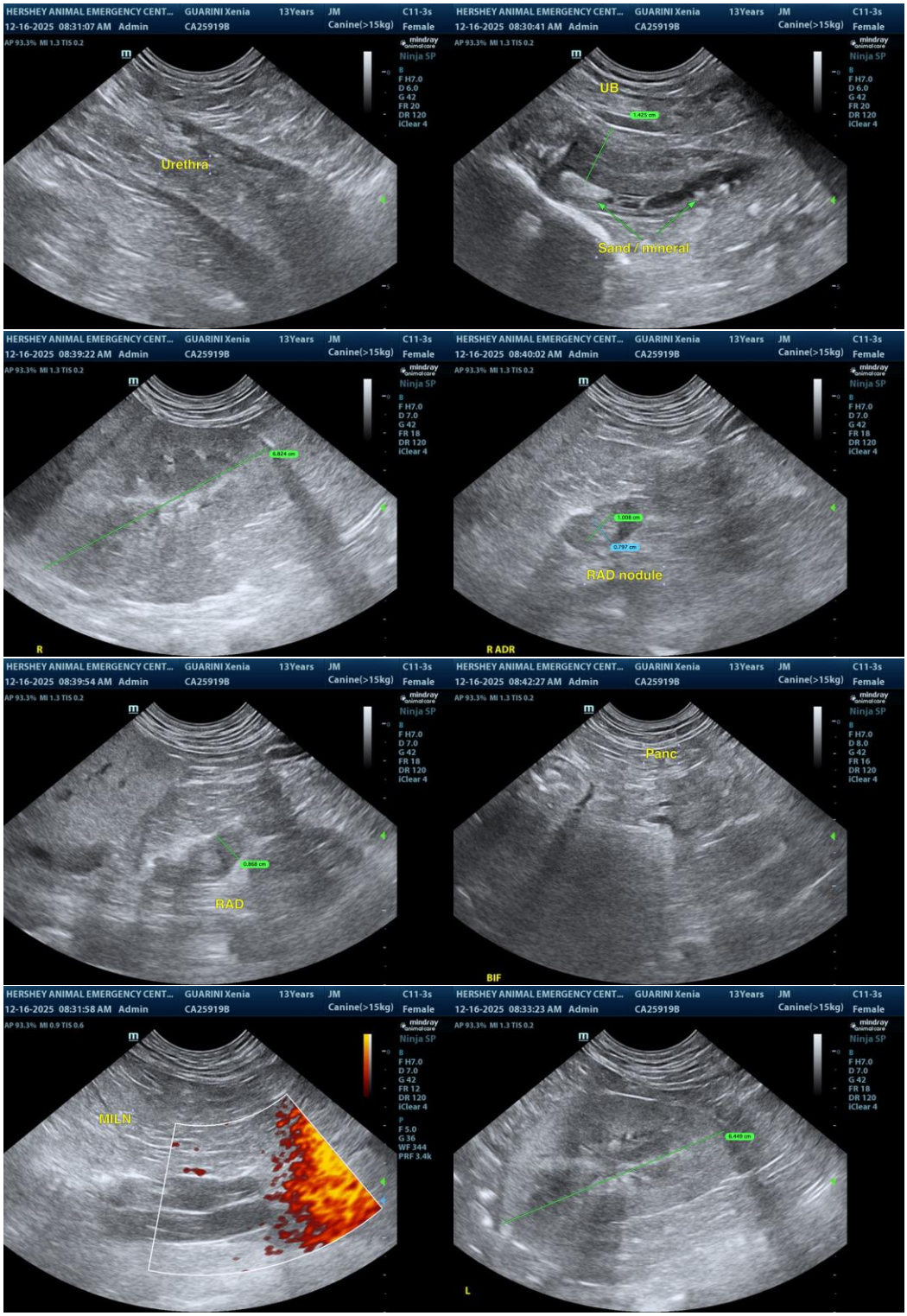

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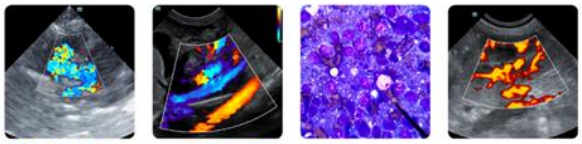

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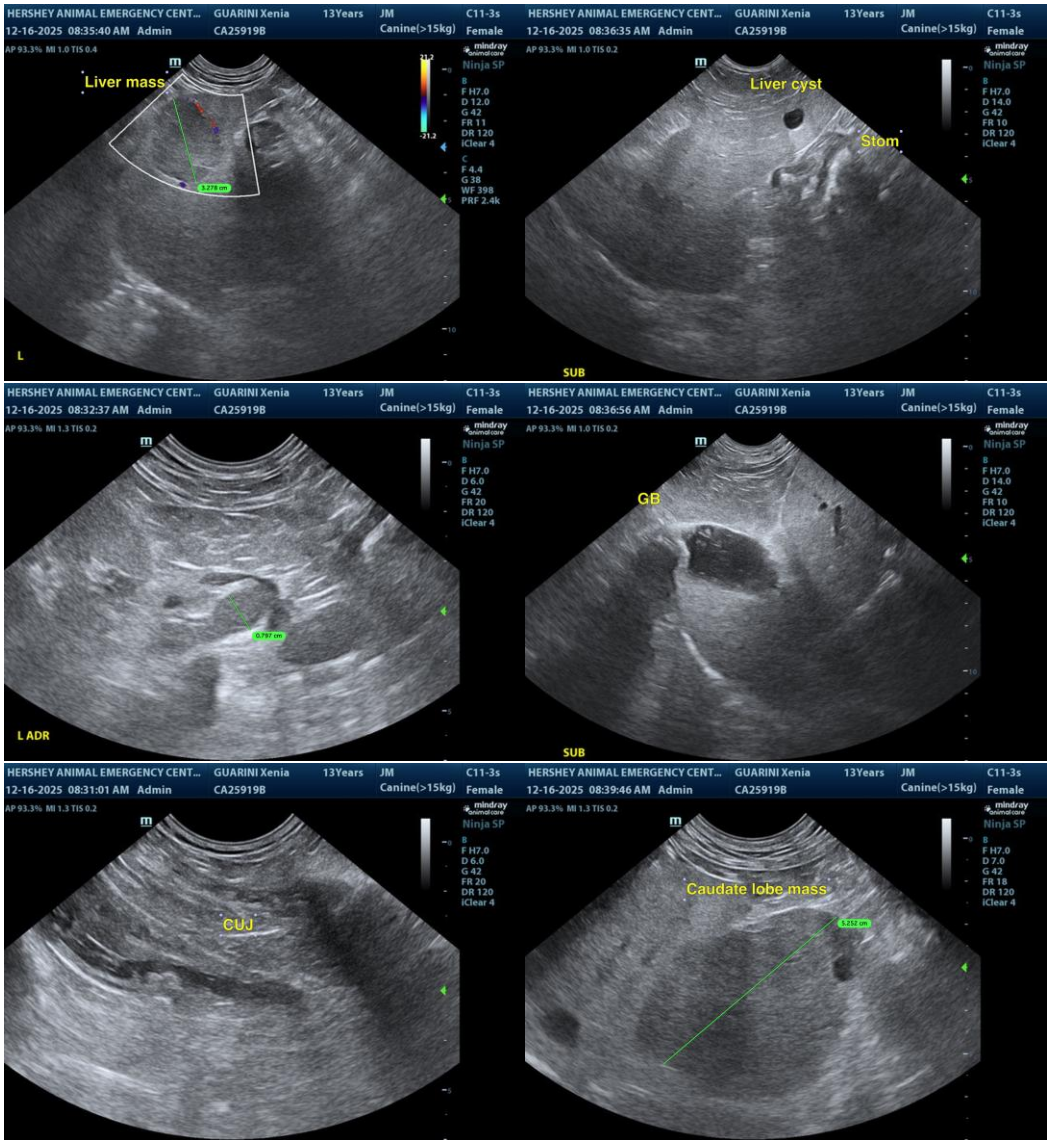

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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