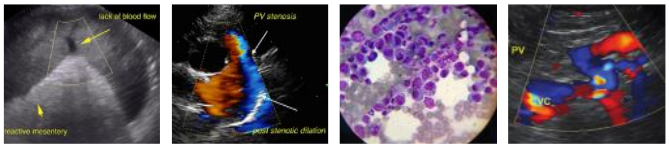
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Toby Rosado

SPECIES

Canine

BREED

Maltese

SEX

MN

AGE

12 yrs

WEIGHT

Not Provided

INTERPRETED BY

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

IMAGING PERFORMED BY

Jessica Miller

HOSPITAL NAME

Hamburg VC

REFERRING VET

Dr. Martens

INVOICE

15703

DATE

12/27/22

PRESENTING CLINICAL SIGNS

Elevated liver enzymes.
Abnormal PE/Chem/CBC/UA Results: ALT 192, Alk Phos 1128, Platelet 439 UA:Protein 2+, Rods 10-25 SG: 1.046

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 4.0 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 residual prostate was symmetrically normal in size with uniform parenchyma and slight coarse echotexture.

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 moderate loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. Intermittent small cortical cysts were present in both kidneys. The left kidney measured 4.3 cm in length. The right kidney measured 4.6 cm in length.

Adrenal Glands

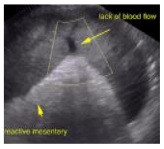
The bilateral adrenal glands were normal in size. The adrenal glands exhibited heterogeneous, indistinctly nodular parenchyma, likely consistent with age-related adrenal changes, minor benign hyperplasia, or minor adenomatous change. Mild capsule asymmetry was present. No evidence of adrenal neoplastic criteria. The left adrenal gland measured 1.5 cm length x 0.69 cm width at the caudal pole. The right adrenal gland measured 1.8 cm length x 0.53 cm width at the caudal pole.

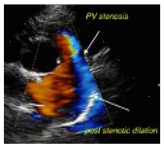
Spleen

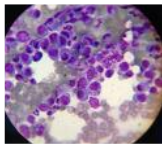
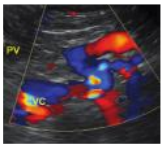
A nonhomogeneous to irregular mass involving the cranial spleen with associated splenic capsule distortion was present. The parenchyma of the mass was nodular to cavitated. Generalized splenic parenchyma heterogeneity was noted in the mid to caudal spleen with a maintained symmetrical capsule contour. Normal splenic vascularity was present. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Regional omental inflammation was present around the mass.

Liver/ Gallbladder

The liver exhibited generalized enlargement with areas of capsule asymmetry. Nonhomogeneous to irregular generalized hepatic parenchyma was present exhibiting intermittent well-demarcated to indistinct nonhomogeneous intraparenchymal nodules with an example measuring 1.8 cm diameter. Concurrent, intermittent, small, intraparenchymal hepatic cysts were present. The gallbladder was non-distended in size containing primarily anechoic content with mild, nonorganized, echogenic,





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luminal gallbladder debris. No evidence of gallbladder or peripheral gallbladder inflammation 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 pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum, likely consistent with age-related pancreatic changes and incidental. No signs of active inflammation or neoplasia.

Free Abdomen

Mild volume free fluid was noted primarily around the spleen and around the liver. Perisplenic to perihepatic nonuniform hyperechoic mesentery was noted. Potential for omental adhesions to the spleen or splenic mass are possible. No overt lymphadenopathy was present.

Rapid view of the heart revealed no evidence of pericardial masses or effusion in the visible window.

ULTRASONOGRAPHIC FINDINGS

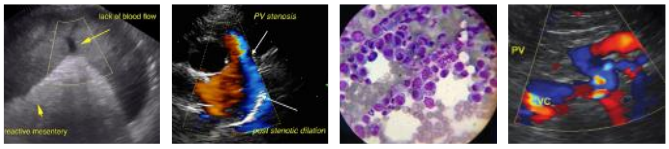
- Irregular mixed echogenic to cavitated splenic mass
- Enlarged irregular / nodular heterogeneous liver
- Mild gallbladder debris (non-mucocele)
- Bilateral chronic renal changes with cortical cysts
- Perihepatic / perisplenic nonuniform hyperechoic mesentery and mild volume free fluid, potential omental adhesions to splenic mass possible

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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.

The hepatic presentation was more nonspecific with potential considerations including chronic vacuolar hepatopathy, inflammatory / immune-mediated disease, nodular hyperplasia, hematopoiesis, fibrosis, benign parenchymal remodeling, concurrent primary or metastatic neoplasia are all potentials. Concern for hepatic metastatic disease, given the presence of the splenic mass, is warranted, although not definitive. Initial screening hepatic FNA cytology could be considered.

Assuming no evidence of pathology on three view chest radiographs, splenectomy with hepatic biopsy, assuming normal clotting status would be a more aggressive approach. However, given the



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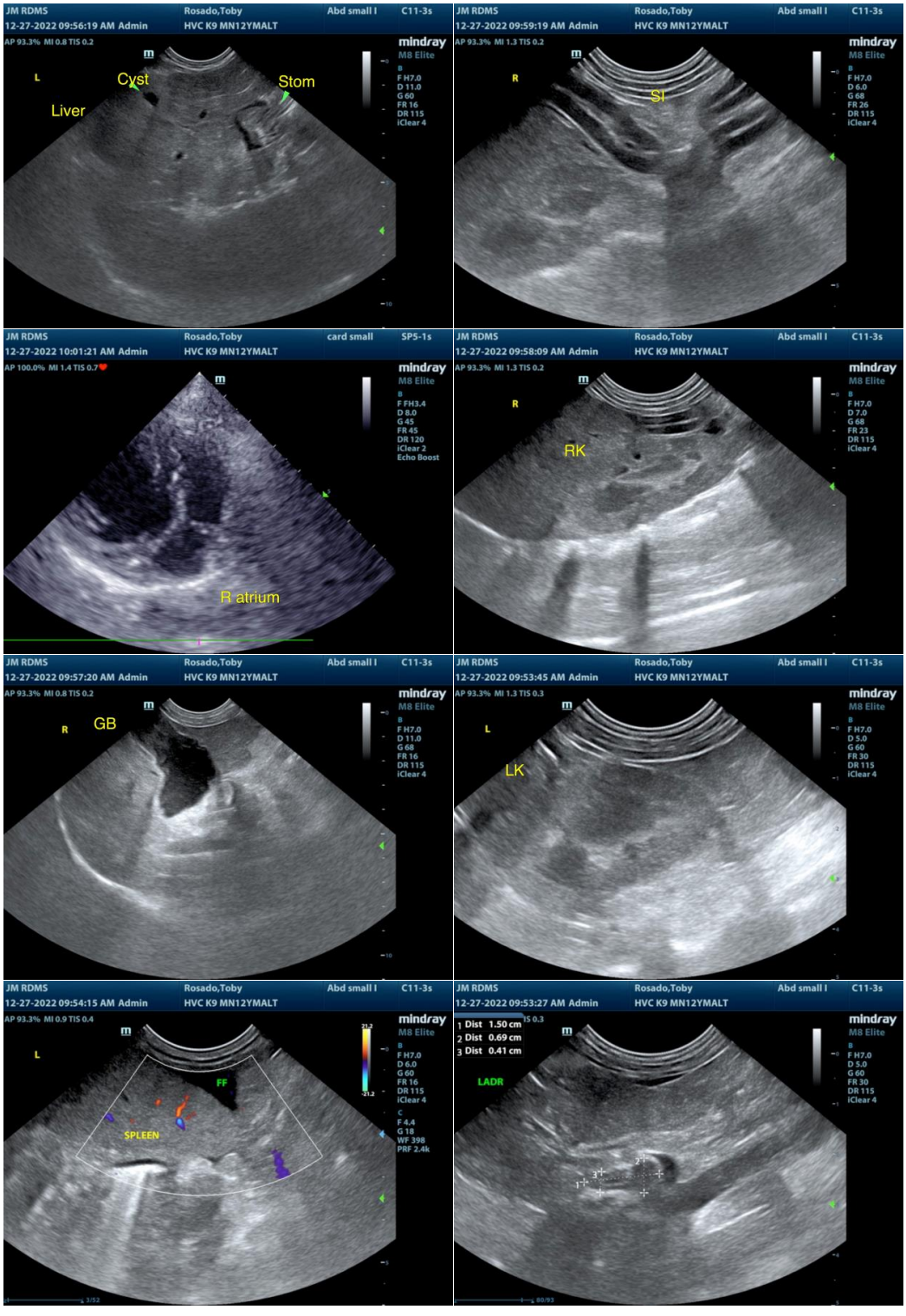
hepatic presentation and perisplenic / perihepatic omental appearance, potential for perisplenic to hepatic metastasis is of high concern.



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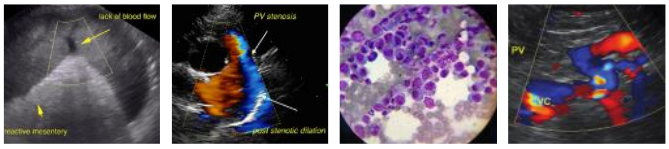

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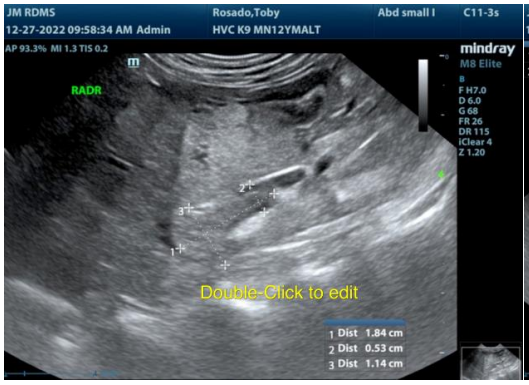

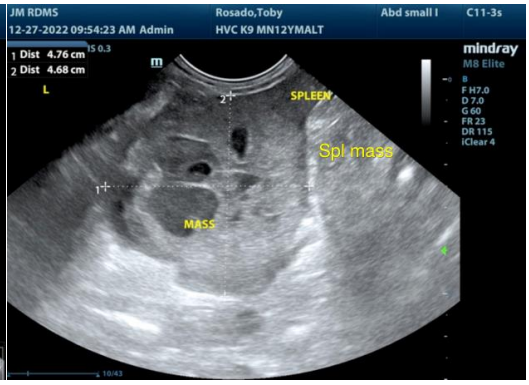

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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