**PATIENT**

Josey Miller

SPECIES

Canine

BREED

Min Schnauzer

SEX

Spayed Female

AGE

13 Years

WEIGHT

16 Pounds

INTERPRETED BYR. McKenzie Daniel,
DVM, DABVP
(Canine and Feline)**IMAGING PERFORMED BY**

Amy Mayhew, LVT

HOSPITAL NAME

SVS Imaging Michigan

REFERRING VET

Family Pet Practice

INVOICE

36160

DATE

3/14/22

PRESENTING CLINICAL SIGNS

Diagnosed with diabetes within last month. Currently eating Glycobalance and RC GI canned. Receiving Novolin-N 2u BID. Not acting like herself since Saturday. Appeared painful with labored breathing/panting/wheezing noted at home. Vomited one time Friday and one time Saturday. Ate boiled chicken well over the weekend with no further vomiting noted.

Abnormal PE/Chem/CBC/UA Results: See attached BW from 3/10/22. Patient was tense on abdominal palpation. **cystocentesis obtained AFTER images taken per DVM request.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**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 were 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 loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. Areas of non-obstructive medullary renolithiasis noted in both kidneys. The left kidney measured 4.8 cm. The right kidney measured 5.3 cm.

Adrenal Glands

The bilateral adrenal glands were normal in size. Mild parenchyma heterogeneity and mild capsule asymmetry was present. The left adrenal gland measured 0.52 cm at the cranial pole and 0.50 cm at the caudal pole. The right adrenal gland measured 0.67 cm at the cranial pole and 0.76 cm at the caudal pole. No evidence of adrenal hyperplasia or neoplastic criteria.

Spleen

The spleen revealed a moderately sized to expansive non-homogeneous mass appearing to originate from and occupy the caudal spleen, measuring approximately 7-8 cm in diameter. Prominent cystic component to areas of moderate cavitation containing primarily anechoic fluid with mild cellular component were present within the mass. Concurrent non-associated, non-expansive, hypoechoic to anechoic, potentially cystic intraparenchymal nodules were noted in the mid to cranial spleen. Example of small splenic nodule measured 0.50 cm diameter. Subtle evidence of perisplenic reactive mesentery noted without evidence of splenic mass rupture or secondary perisplenic to peritoneal free fluid.

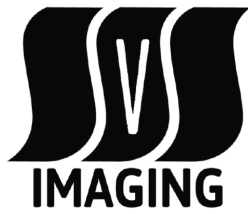
Liver

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. The capsule of the liver was symmetrically rounded to mildly swollen in margination. Intermittent, indistinct, non-expansive, variably echogenic intraparenchymal nodules were present. Example measured 1.9 cm diameter. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with moderate inspissated to mildly non-dependent yet non-organized gallbladder debris. No evidence of inflammatory gallbladder wall changes or evidence of peripheral gallbladder inflammation. The common bile duct was normal.

Gastrointestinal

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The stomach presented intact wall layering with a normal wall layer ratio. Minor retained ingesta/chyme noted.

The duodenum exhibited intact wall layering with propensity for mildly prominent duodenal mucosal. The remainder of the small intestine was unremarkable.

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. No signs of active inflammation or neoplasia.

Free Abdomen

No evidence of significant neoplastic or overt metastatic lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

- Cystic to cavitated non-homogeneous caudal splenic mass with concurrent mid to cranial splenic intraparenchymal nodules
- Hepatopathy exhibiting intermittent, indistinct, non-specific, intraparenchymal nodules
- Moderate inspissated to non-dependent gallbladder debris – possible early non-inflamed gallbladder mucocele.
- Mild chronic renal changes with non-obstructive medullary renoliths
- Suspect mild gastroduodenitis
- Heterogeneous pancreas – suspect age related pancreatic changes, not consistent with active pancreatitis.

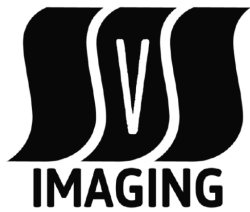
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Considerations for the splenic mass, which was non-specific, may include hyperplasia, hematopoiesis, granuloma, hemangioma, hematoma, splenitis, or malignant neoplasia such as sarcoma, round cell neoplasia or other with significant cystic to cavitated component. Although the mass does not appear to exhibit rupture criteria at this time, concern for splenic mass rupture going forward is warranted.

Although not definitive, the indistinct hepatic intraparenchymal nodules were suggestive of areas of potential nodular to regenerative hyperplasia, lipogranulomas, or hematopoiesis. Technically, the potential for early hepatic metastasis from the splenic mass cannot be definitively excluded. Assuming no evidence of thoracic metastasis, and normal cardiopulmonary status on 3-view chest radiographs, splenectomy with gross inspection of the liver and perisplenic omentum could be considered.

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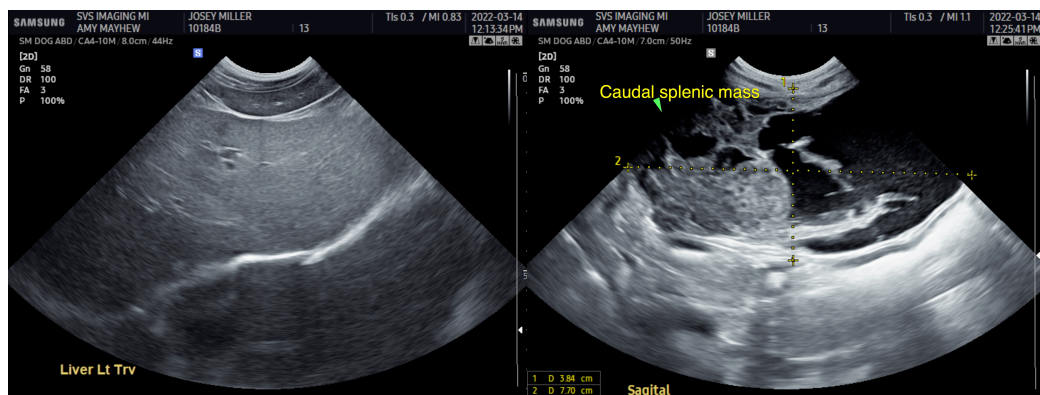
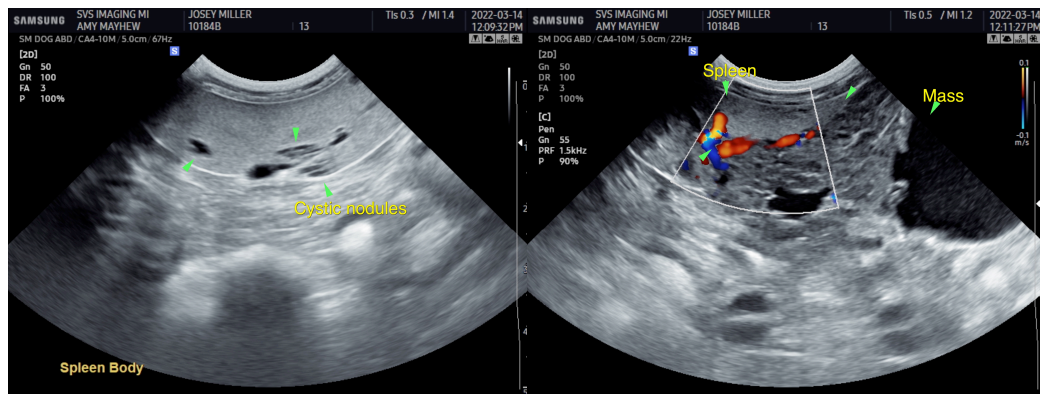
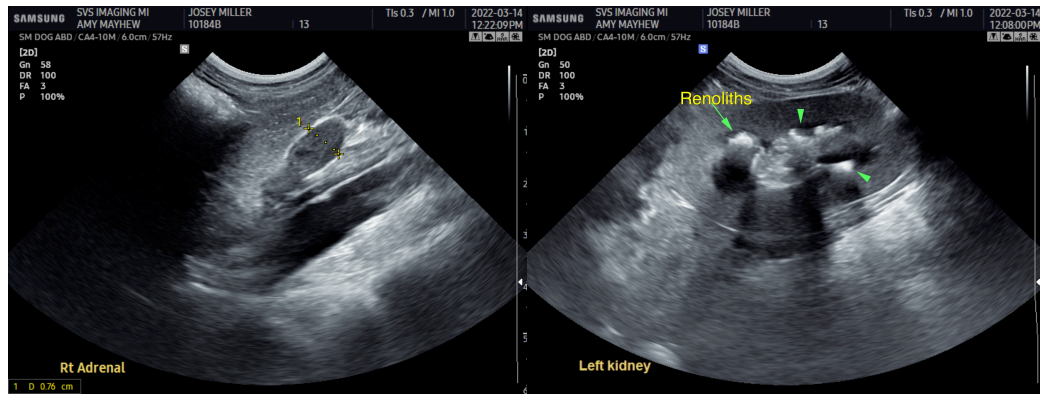
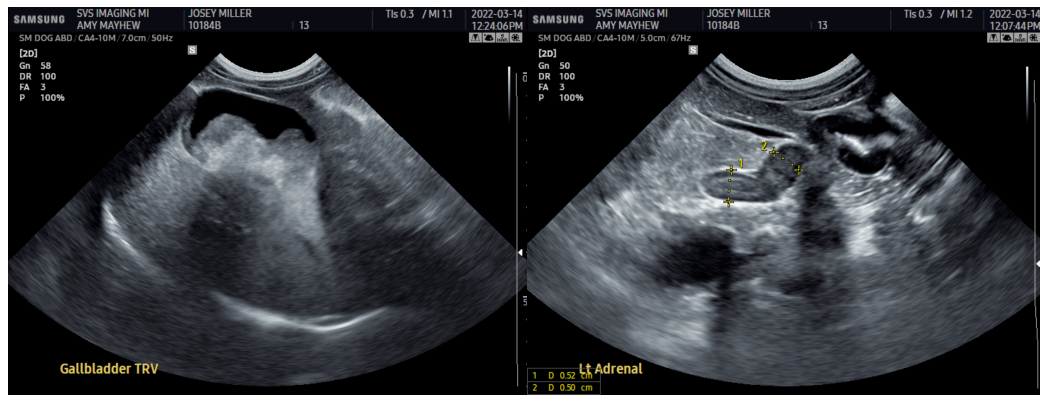
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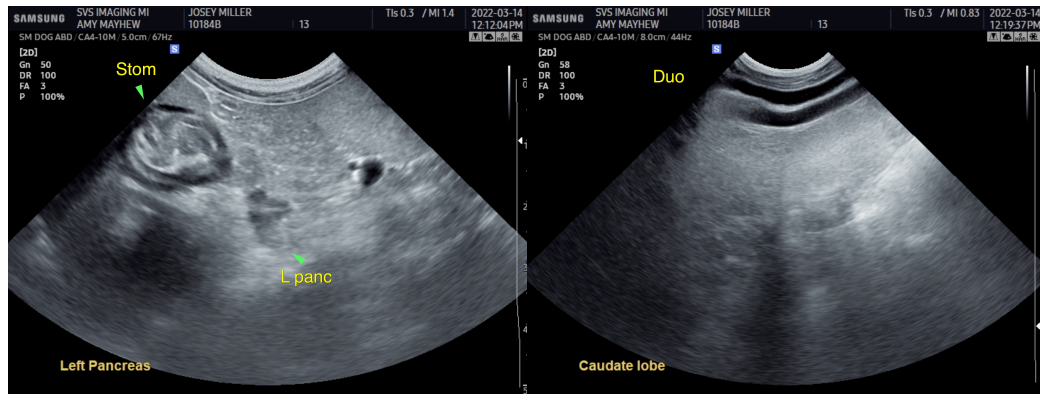
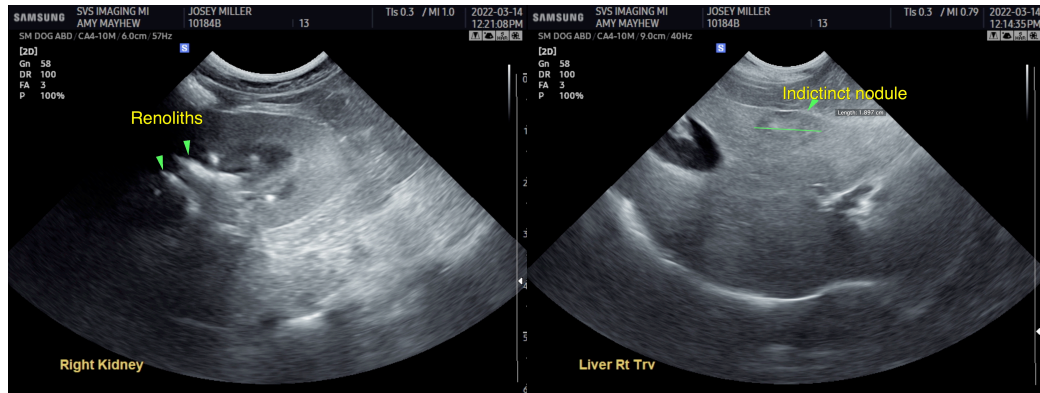
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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