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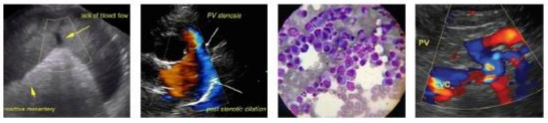


IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Charlie Young

SPECIES

Canine

BREED

Beagle

SEX

Neutered Male

AGE

12 Years

WEIGHT

17.9 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT LVT

HOSPITAL NAME

Roundhill AH

REFERRING VET

Dr. Carl Kelly

INVOICE

14427

DATE

3/21/22

PRESENTING CLINICAL SIGNS

History: "Charlie" Jon Young DOB = 1/21/2010 Male, Neutered Beagle 17.9 kg History: (3/14/22) O noticed increase in PU/PD 8 months ago. Free catch urine sample, UA shows hyposthenuria and proteinuria concern for Cushings or Hypercalcemia. (3/15/22) IDEXX blood results confirm hypercalcemia. (3/21/22) Had an episode of syncope in office while waiting for ultrasound. No nystagmus or anisocoria - normal behavior within 30 seconds post episode. Palpated lump on R side of pelvic floor. Chest rads appear to be clear.

Abnormal PE/Chem/CBC/UA Results: quick scan of parathyroid and left PTH seems slightly enlarged.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder was normal in overall size and tone with anechoic urine. Minimal nondependent particulate sediment was present. A solitary, sessile based, nonhomogeneous to mineralized mass was present, arising from the dorsal wall, extending subtly into the urinary bladder lumen, measuring approximately 1.6 cm in diameter. No evidence of macrocalculi. The visible pelvic urethra was normal to a depth of 2.0 cm.

The residual prostate was symmetrically normal in size with uniform parenchyma and slight coarse echotexture measuring 0.92 cm in diameter. No evidence of residual prostatic 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. Small cortical cysts present in both kidneys. Lateral cortical infarct was noted in the left kidney. The left kidney measured 6.1 cm in length. The right kidney measured 6.9 cm in length.

Adrenal Glands

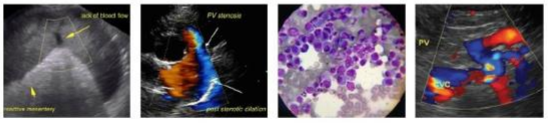
Both adrenal glands were mildly prominent in size, exhibiting symmetrical capsule contour and homogeneous to hypoechoic parenchymal. The left adrenal gland measured 1.1 cm width at the caudal pole and 1.1 cm width at the cranial pole. The right adrenal gland measured 0.73 cm width at the caudal pole and 1.1 cm width at the cranial pole.

Spleen

The spleen was normal in overall size and contour with subtle generalized splenic parenchyma heterogeneity. Focal to intermittent, non-expansive discreet hypoechoic nodules, an example of splenic nodule size measured 0.67 cm in diameter.

Liver

The liver exhibited generalized enlargement with primarily maintained symmetrical capsule contour. Nonhomogeneous parenchyma, exhibiting parenchymal remodeling along with intermittent, nonspecific, variably echogenic, solid nodules, an example of nodule size measured 3.0 cm in diameter. Concurrent, cystic appearing intraparenchymal mass was present in the deep mid to left liver, measuring approximately 6.0 cm in diameter.



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The gallbladder was non distended in size with minor gallbladder debris. The gallbladder was otherwise normal. The cystic duct and common bile ducts were normal without evidence of dilation.

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 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 was evident.

Free Abdomen

Indistinct, isoechoic to uniform mass was noted in the caudal abdomen, adjacent to and ventral to the colon, as well as dorsal to the urinary bladder, consistent with fat echogenicity and without overt evidence of neoplastic criteria. The mass measured approximately 4.0 cm in diameter.

ULTRASONOGRAPHIC FINDINGS

- Small, sessile based, dorsal urinary bladder mass, exhibiting parenchymal mineralization. Focal chronic cystitis or neoplasia, such as transitional cell carcinoma possible. Neoplastic criteria is favored.
- Indistinct to isoechoic, primarily uniform caudal abdominal mass, adjacent to the colon and urinary bladder- consistent with lipoma. No evidence of overt neoplastic criteria.
- Bilateral chronic renal changes with cortical cysts and focal left kidney cortical infarct
- Mild, bilateral, prominent adrenal glands- nonspecific yet without evidence of neoplastic criteria
- Hepatomegaly, exhibiting generalized nonhomogeneous to nodular parenchyma with concurrent cystic deep mid to left intraparenchymal mass- vacuolar hepatopathy, chronic hepatitis/cholangiohepatitis, fibrosis with areas of nodular to regenerative hyperplasia, hematopoiesis, lipogranulomas, cystic biliary adenoma or neoplasia, such as adenocarcinoma/cystic biliary adenocarcinoma possible.
- Nonspecific, non-expansive, focal to intermittent splenic nodules- hyperplasia, hematopoiesis, focal splenitis, infarct, while potential for neoplastic criteria cannot be excluded.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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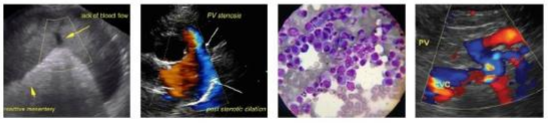

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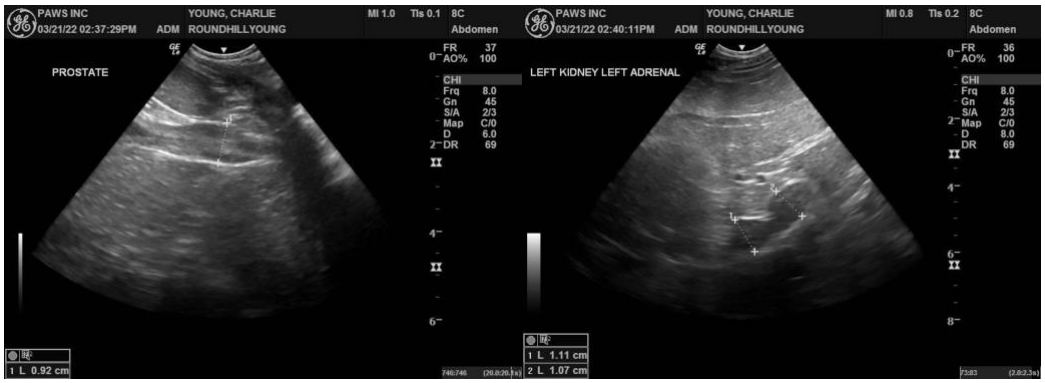
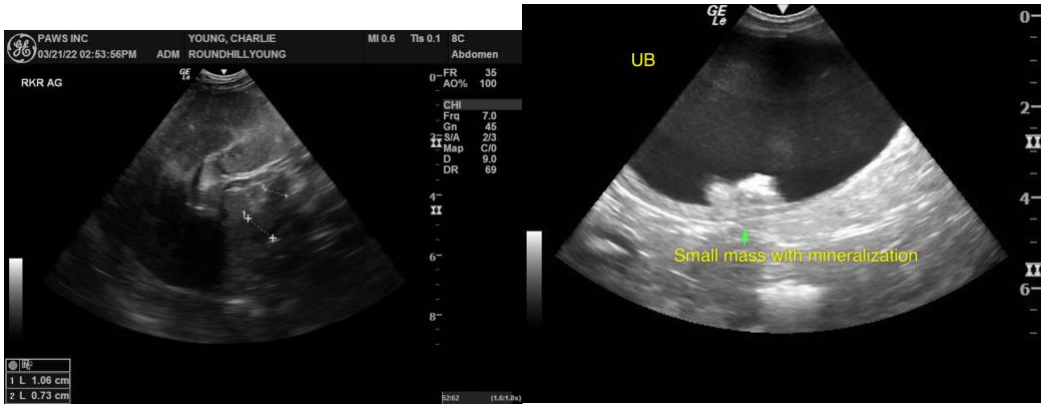
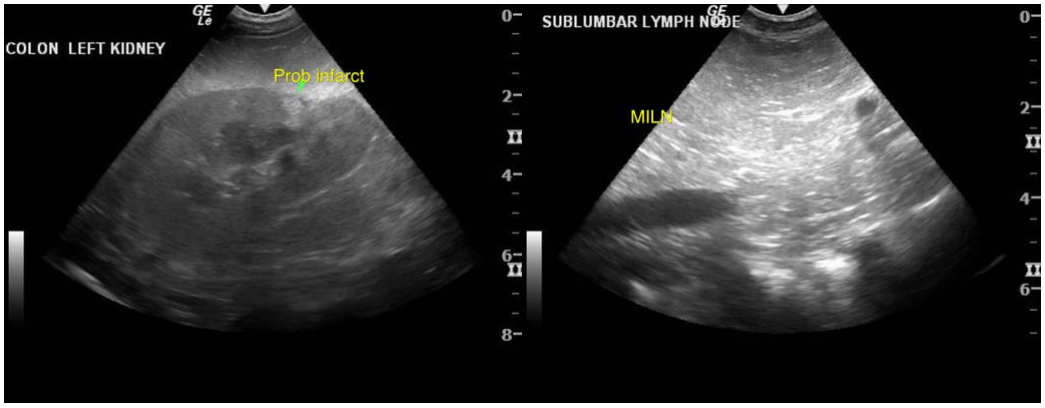
Screening BRAF assay and/or cytospin cytology of free catch urine sample to assess for atypical transitional epithelial cells could be considered.

Assuming normal clotting status, hepatosplenic parenchymal and/or nodule FNA, if accessible, using a 25-gauge needle, warranted for screening cytology.

Adrenal testing could be considered in this patient, if clinical suspicion for hyperadrenocorticism. Screening blood pressure recommended. Ionized calcium, PTH and PTHRP levels are recommended for further assessment of the hypercalcemia.







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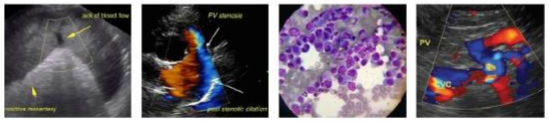

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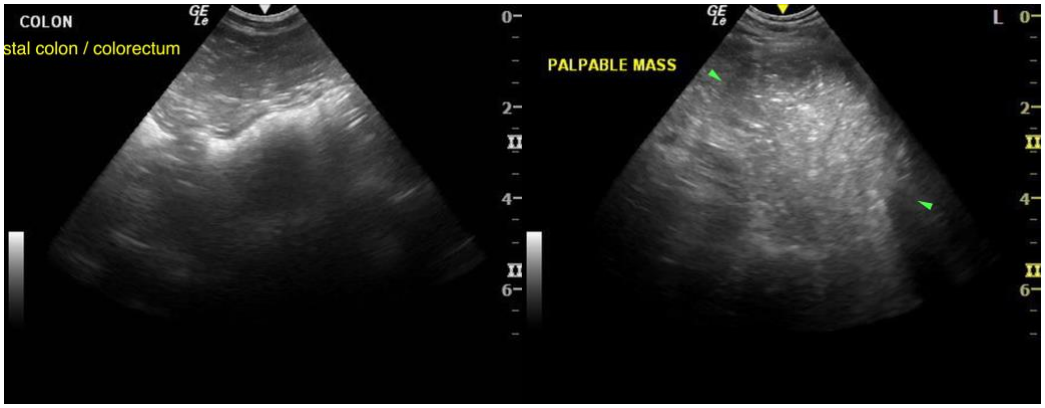

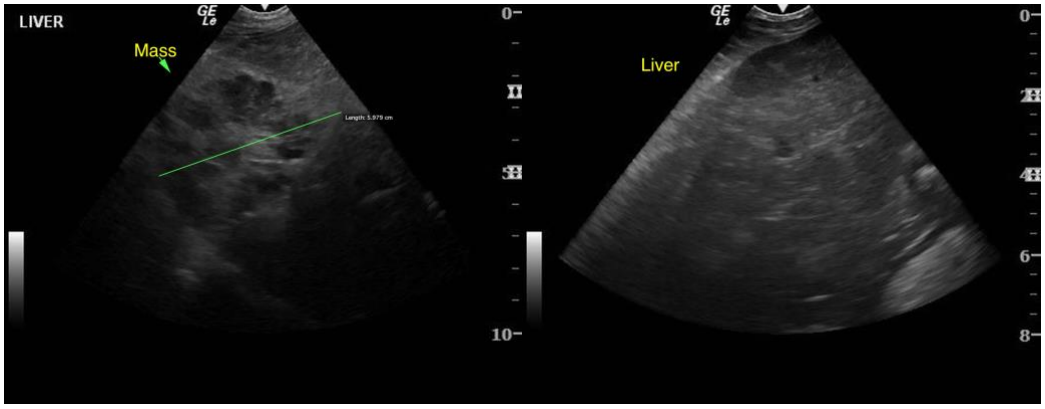

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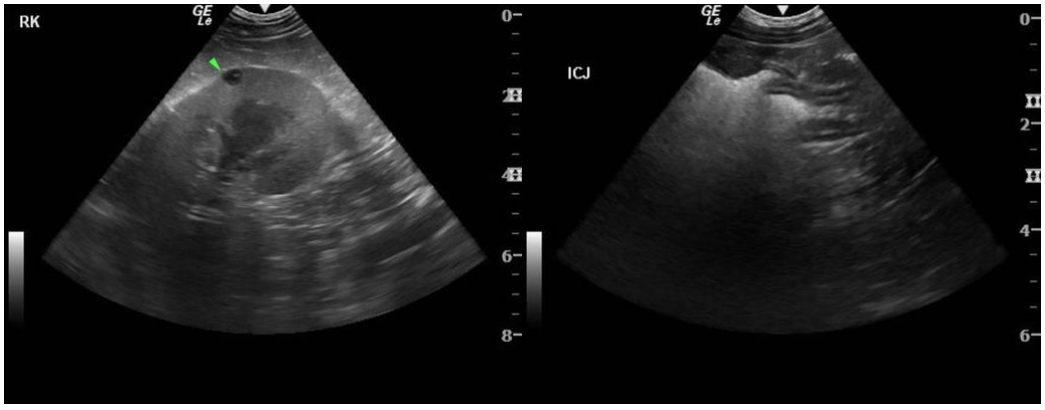

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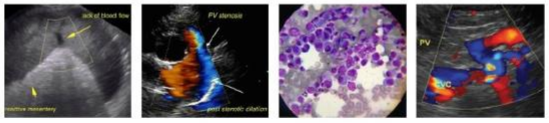

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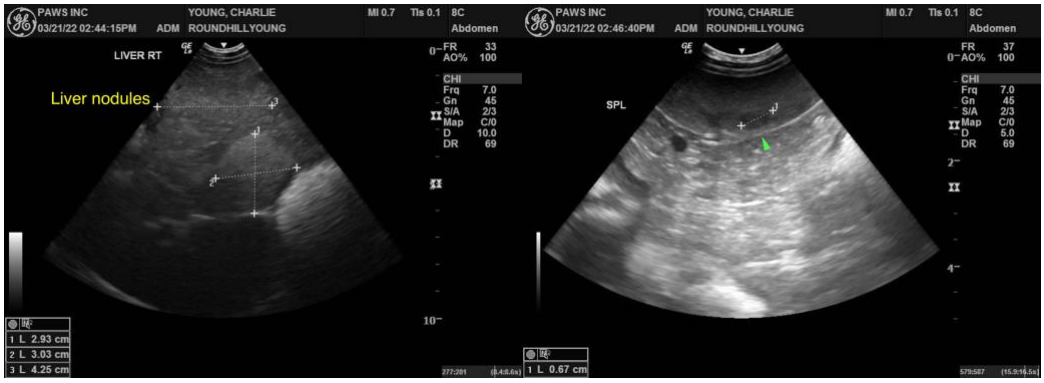

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)
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