



PATIENT

Ginger Dionne-Ball

SPECIES

Canine

BREED

Miniature Dachshund

SEX

Spayed female

AGE

14 years

WEIGHT

13.5 pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Pamela Harrigan
RDMS

HOSPITAL NAME

Rhode Island Animal
Medical Center

REFERRING VET

Dr. Rachel Rogoff

INVOICE

10131ag

DATE

03/04/2022

PRESENTING CLINICAL SIGNS

History: Bloody diarrhea; hyporexia; drooling. Sedated with torb/midazolam.

Abnormal PE/Chem/CBC/UA Results: Glob 3.9; ALT 391, ALP 817; GGTP 16; lymph 31; eosin 1, USG 1.053, protein 2+, Bili 1+, WBC 2-3, Calcium oxylate 2-3.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder presented mildly subnormal in size owing to recent urination and exhibited no overt pathology. The trigone, cystourethral junction, and visible pelvic urethra to a depth of 2 cm exhibited normal thickness and tone. Mild 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.

Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some mildly increased echogenicity and loss of corticomedullary symmetry and definition expected for the age of the patient. The right kidney exhibited a solitary cortical cyst measuring 0.67 cm in diameter. Minor bilateral pyelectasia was noted. The left kidney measured 4.1 cm in length. The right kidney measured 4.4 cm in length.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. A subtle non expansive nodule was present in the caudal pole of the left adrenal gland with mild associated symmetrical capsule expansion. The nodule did not exhibit signs of mineralization or vascular invasion. The nodule measured 0.4 cm in diameter. The left adrenal gland measured 0.54 cm width at the caudal pole and 0.39 cm width at the cranial pole. The right adrenal gland was normal in size. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The right adrenal gland measured 0.45 cm width at the caudal pole and 0.45 cm width at the cranial pole.

Spleen

The spleen exhibited a mildly expansive hypoechoic to nonhomogeneous micronodule to small mass in the mid to cranial spleen measuring 3.2 cm in diameter. The capsule primarily maintained symmetrical contour yet mild distortion secondary to the micronodule to small mass was present. The rest of the spleen exhibited finely textured homogeneous parenchyma.

Liver

The liver presented normal in size. The hepatic parenchyma revealed mild hypoechoic parenchyma echogenicity compared to the spleen and renal cortical parenchyma with a mild coarse echotexture. Mild increased portal vein prominence was evident. The capsule of the liver was normal in margination. A solitary subtle mildly echogenic parenchymal nodule measuring 1.7 cm in diameter was noted. The hepatic and portal vasculature were normal in appearance. The gallbladder was non-distended in size with moderate nondependent mildly congealed yet nonorganized gallbladder debris. The cystic and common bile ducts were normal.

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were



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normal in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. No evidence of peripheral gallbladder inflammation. 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 mild to moderated distended with retained anechoic fluid. No signs of ileus, pyloric outflow obstruction or foreign material. The gastric body wall measured 0.25 cm.

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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. The duodenum wall measured 0.43 cm. The jejunum wall measured 0.45.

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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.

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Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

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ULTRASONOGRAPHIC FINDINGS

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- Hepatopathy exhibiting subjective reduced parenchyma echogenicity with nonspecific yet likely benign parenchymal nodule.
- Moderate gallbladder debris (non mucocele).
- Mildly expansive splenic macro nodule to small mass.
- Subtle left adrenal nodule-suspect adenoma.
- Hypomotile stomach with concurrent mild colitis pattern.
- Bilateral mild chronic renal changes exhibiting minor pyelectasia and right kidney cortical cyst.

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RDCS

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Assuming normal clotting status, hepatic parenchymal and splenic macro nodules/small mass FNA using a 25g needed is recommended for screening cytology. Vacuolar hepatopathy, inflammatory/immune mediated hepatopathy, nodular hyperplasia, lipogranuloma, hematopoiesis or other hepatopathy is possible. Given the appearance of the splenic mass, neoplastic criteria is of concern although benign etiologies such as hyperplasia, hematopoiesis, splenitis, granuloma or other are possible.

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Empirical therapy for gastroenterocolitis with gastric stasis would be reasonable. Assuming no evidence of thoracic pathology on three view chest radiographs, splenectomy with hepatic biopsy and gross inspection of the gastrointestinal tract could be considered. Pending cytology sonographic monitoring of the splenic macro nodule/small mass and assessment of gastrointestinal response would be a more conservative approach.

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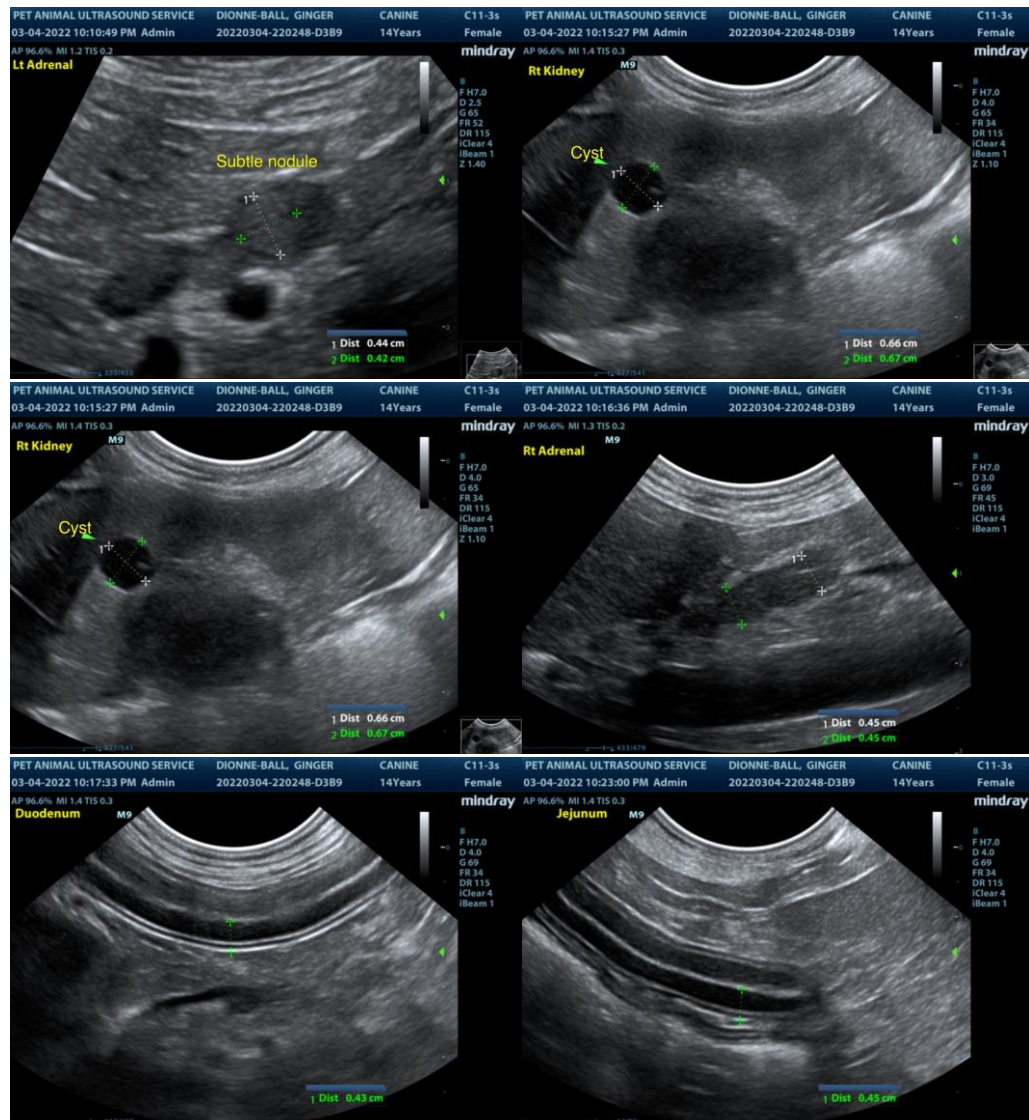
Dr. Rachel Rogoff

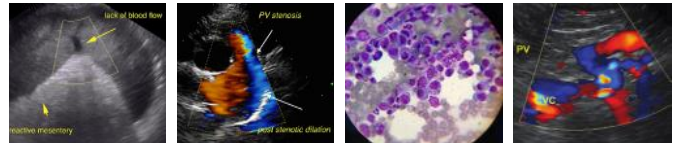
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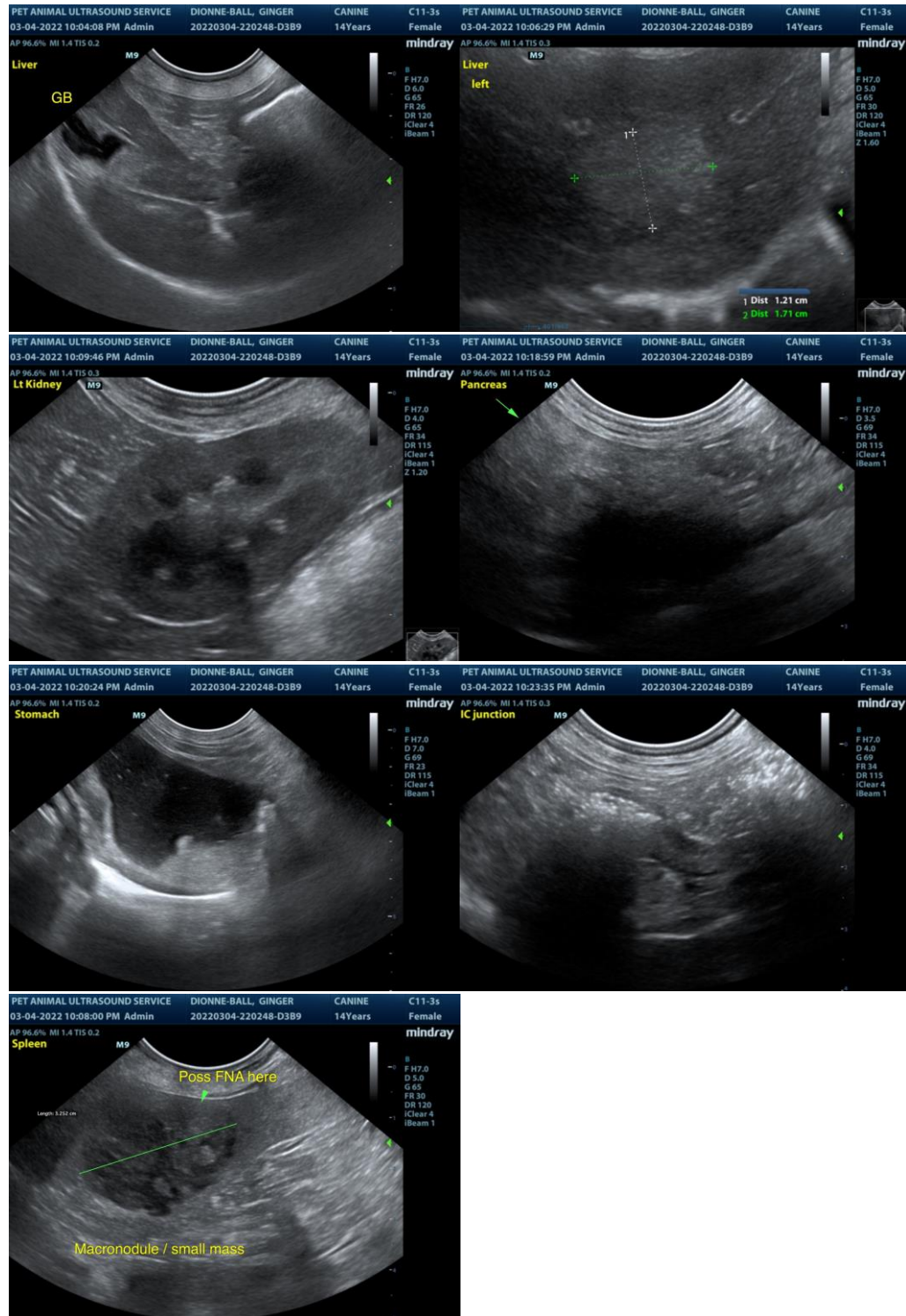
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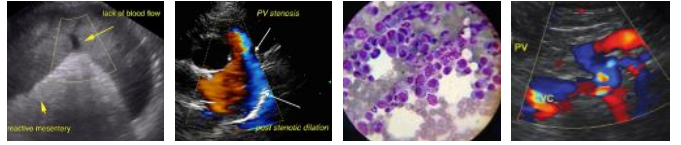
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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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