



PATIENT

Annie Thorpe

SPECIES

Canine

BREED

King Charles Cavalier
Spaniel

SEX

Spayed Female

AGE

13 Years

WEIGHT

7.21 Pounds

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

Dr. Alastair Westcott

HOSPITAL NAME

Dr. Alastair Westcott

REFERRING VET

Dr. Alastair Westcott

INVOICE

35960

DATE

3/8/22

PRESENTING CLINICAL SIGNS

Recently discovered splenic mass. Has been presumptively diagnosed with stage B2 cardiac disease based on radiologists, radiograph interpretation of mild cardiomegaly and a systolic murmur. Is currently on pimobendan 1.25mg Q12 hrs as per EPIC trial. Suspected renal insufficiency and longstanding GI issues. This client is considering splenectomy and the purpose of the ultrasound is a comorbidity hunt and/or a gross metastasis hunt. A full echo is also being sent for evaluation. Abnormal PE/Chem/CBC/UA Results: Grd IV/VI systolic murmur PMI left apex with some radiation to the right. Slightly reduced body condition score. Mild abdominal discomfort on palpation. Mild cardiomegaly with LAE on radiographs. No pulmonary vessel distension. Mild perihilar interstitial patterning. No evidence of metastatic disease or primary neoplasia. Mild, non regenerative anemia. Mild thrombocytopenia. Elevated SDMA/ BUN. Marked elevation in AMYLASE and LIPASE. cPL is pending. Isosthenuria with strip-proteinuria (awaiting UPC for quantification)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 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.

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 mineral to dystrophic mineralization noted along with small cortical cysts. The left kidney measured 4.4 cm. The right kidney measured 4.5 cm.

Adrenal Glands

The adrenal glands were uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 1.8 cm length x 0.50 cm at the caudal pole. A subtle, non-expansive, uniform, mildly hyperechoic yet non-shadowing nodule was present in the cranial aspect of the right adrenal gland with mild associated symmetrical capsule expansion. The nodule did not exhibit signs of mineralization or vascular invasion. The nodule measured 0.49 cm in diameter. The overall right adrenal gland measured 2.08 cm length x 0.47 cm at the caudal pole.

Spleen

A mass involving the subjective mid caudal spleen with secondary capsule expansion and disruption was present, measuring 5.8 cm. The parenchyma of the mass was heterogeneous to mixed echogenic without areas of cavitation. The non-affected spleen exhibited primarily finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis.

Liver

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to benign parenchymal remodeling. A focal discrete, isoechoic to subtle hypoechoic intraparenchymal nodule was present. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non distended in size with mild, primarily dependent debris, exhibiting hyperechoic foci, potentially indicative of emerging mineralization, primarily in the area of the caudal



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lumen and gallbladder neck. No evidence of gallbladder or peripheral inflammation. The cystic duct and common bile ducts were normal without evidence of dilation.

Gastrointestinal

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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. Gastric body wall measured 0.40 cm.

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The small intestine presented intact wall layering with generalized propensity for mildly prominent muscularis layer. Jejunum wall measured 0.54 cm. Duodenum wall measured 0.44 cm. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material.

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The colon presented intact yet minor subjective prominent wall layering containing subjective formed feces.

Pancreas

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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

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Focal, mildly prominent to enlarged medial iliac lymph node was present, measuring 0.40 cm in width. The lymph node was essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5).

No overt lymphadenopathy or effusion.

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ULTRASONOGRAPHIC FINDINGS

- No-cavitated splenic mass
- Chronic renal changes with medullary dystrophic mineral and cortical cysts
- Subtle right adrenal nodule – suspect adenoma.
- Hepatic parenchymal remodeling with focal to intermittent discreet parenchymal nodule – subjectively benign, hematopoiesis, small lipogranulomas, nodular to regenerative hyperplasia suspected.
- Mild gallbladder debris (non-mucocele)
- Heterogeneous pancreas – not consistent with active pancreatitis. Parenchymal remodeling associated with age or low-grade to chronic pancreatitis possible.
- Inflammatory enteropathy pattern with potential minor colitis – suspect inflammatory bowel.
- Benign/reactive medial iliac lymph node – not consistent with inflammatory or neoplastic/metastatic criteria.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The splenic mass is nonspecific with considerations including hyperplasia, hematopoiesis, granuloma, splenitis, or neoplasia (sarcoma, round cell neoplasia, other). Overt evidence of perisplenic or intraabdominal metastasis from the splenic mass was not definitively evident. Pending echocardiogram assessment and assuming no evidence of thoracic pathology on 3-view chest radiographs, splenectomy with potential for gastrointestinal biopsies (given the patient's history of chronic gastrointestinal signs) could be considered.

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Screening blood pressure recommended. The possibility of very early to emerging right adrenal neoplastic nodule such as pheochromocytoma or adenocarcinoma cannot be definitively excluded.



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Sonographic monitoring of this nodule for evidence of progression is recommended.

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Further renal staging to include urine C/S and protein: creatinine ratio on sterile urine sample may be considered. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended.

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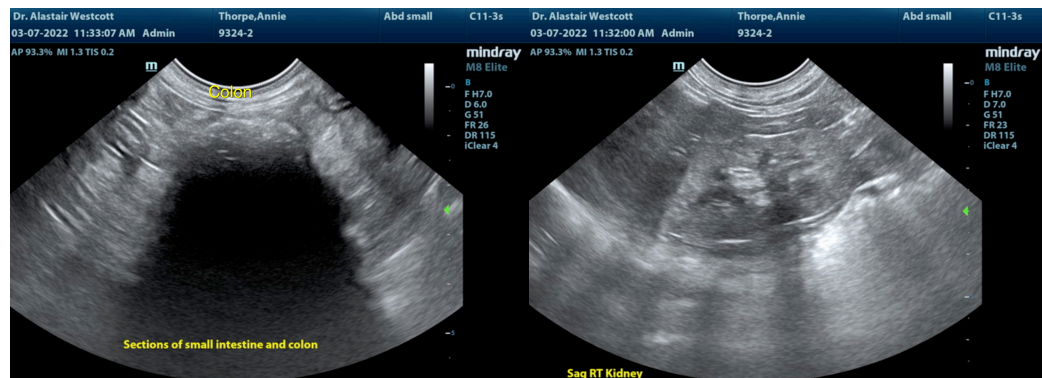
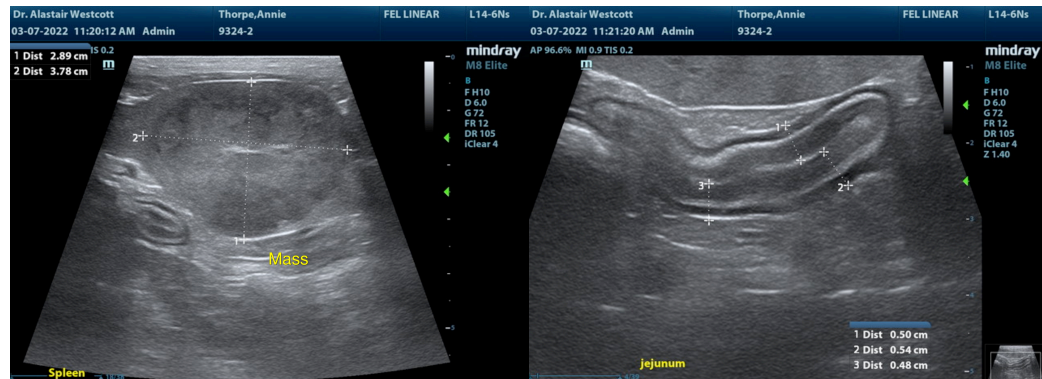
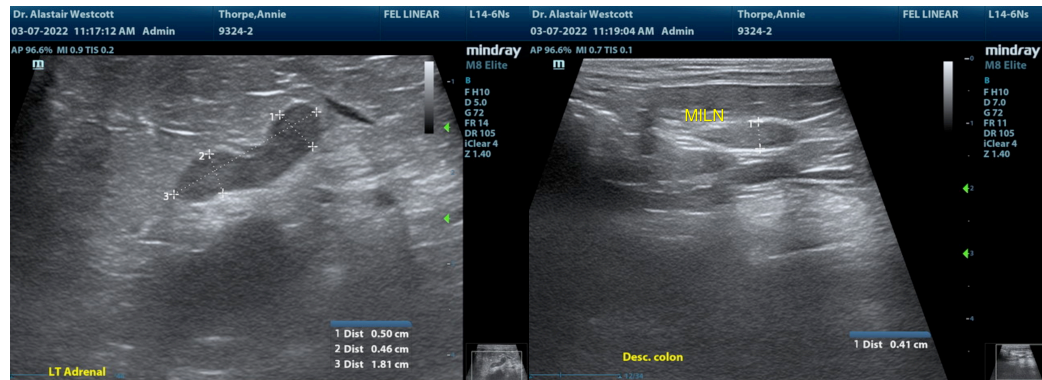
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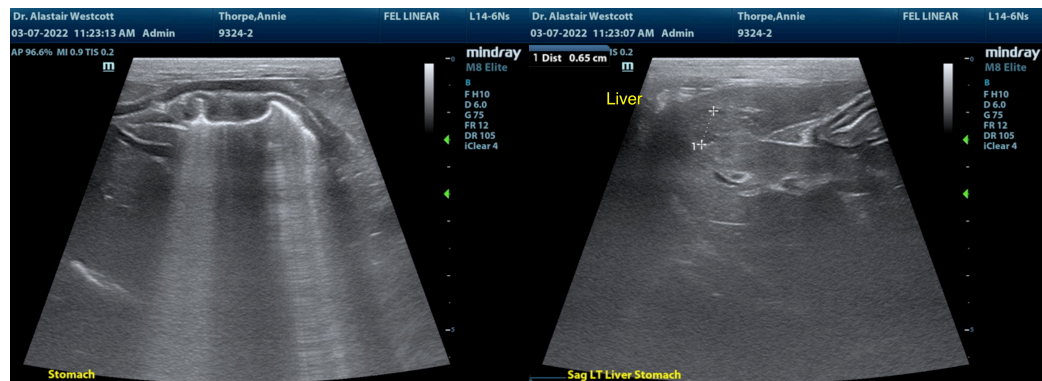
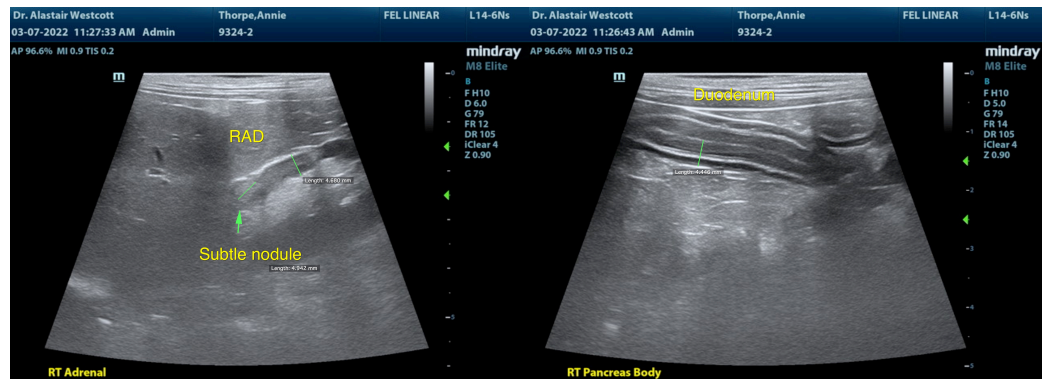
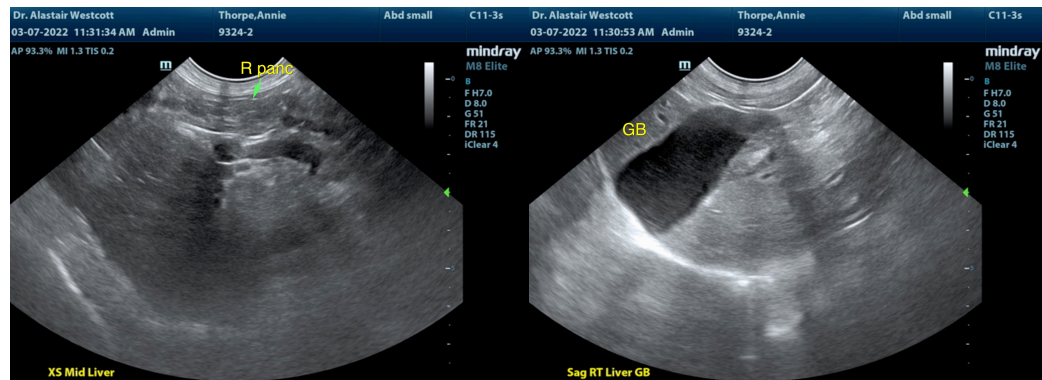
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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