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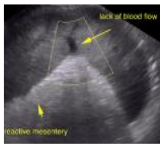
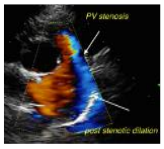
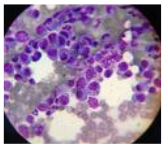
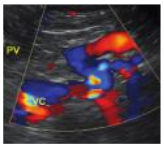

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1-800-838-4268 info@sonopath.com

PATIENT

Quasimodo Waugaman

SPECIES

Canine

BREED

Puggle

SEX

Neutered Male

AGE

13 Years

WEIGHT

28 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Kelly Vazquez

HOSPITAL NAME

Pompton Lakes AH

REFERRING VET

Dr. Taylor McConnell

INVOICE

14599

DATE

4/4/22

PRESENTING CLINICAL SIGNS

History: Patient presents for suspect abdominal mass, initial complaint was for vomiting on 3/29/22.
Current meds: Cerenia/Pepcid injectibles on 3/29/22.
Abnormal PE/Chem/CBC/UA Results: Abnormal CPL, RBC 5.3, HCT 36.8, HGB 12.6, retics. U/A: pH 7.5, protein 2+, protein/creat. ratio 1.1, retics 219, USG 1.010.

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 tone. Mild nonuniform thickening of the urinary bladder wall was present. Hyperechoic focal echogenicities with distal acoustic shadowing were present in the dependent lumen. The echogenicities were (small, variably sized, large) with (symmetrical, asymmetrical) contour. Pinpoint suspected adhered ventricle apical luminal mineral, as well as mild nondependent pinpoint mineral was present.

The residual prostate was symmetrically normal in size with uniform parenchyma and slight coarse echotexture measuring 0.5 cm in diameter.

The area of the aortic trifurcation was normal without evidence of iliac masses, medial iliac lymphadenopathy or sublumbar lymphadenopathy.

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 mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. Nonobstructive medullary renoliths were present in both kidneys. The left kidney measured 4.5 cm in length. The right kidney measured 4.5 cm in length.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.47 cm width at the caudal pole and 0.47 cm width at the cranial pole.

The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.46 cm width at the caudal pole and 0.67 cm width at the cranial pole.

Spleen

The discernable visualized spleen exhibited primarily maintained symmetrical capsule contour. Mild generalized parenchyma heterogeneity, including multiple nondisruptive uniform hyperechoic medial parenchymal nodules adjacent to the hilus, an example measured 0.72 cm in diameter.

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. The hepatic and portal vasculature were normal in appearance without signs of congestion.

The gallbladder was non distended in size with moderate congealed gallbladder debris, primarily in the cranial lumen. The gallbladder was otherwise normal. The cystic duct and common bile ducts were normal without evidence of dilation.

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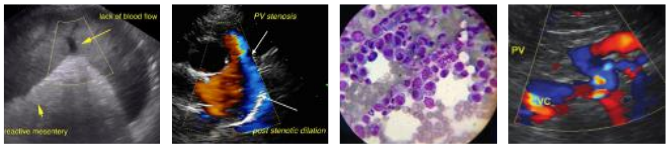

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Gastrointestinal

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. No signs of active inflammation or neoplasia.

Free Abdomen

Moderately sized, primarily spherical nonhomogeneous regional cystic to cavitated mass was present in the mid abdomen, medial to and directly adjacent to the spleen. The mass measured approximately 8-9 cm in diameter. Focal nonhomogeneously hyperechoic intramass nodule was present, measuring 1.9 cm in diameter. Mild associated regional mild nonuniform mesentery and scant free fluid noted around the mass. No overt lymphadenopathy.

Other

A rapid view of the heart revealed no evident pathology.

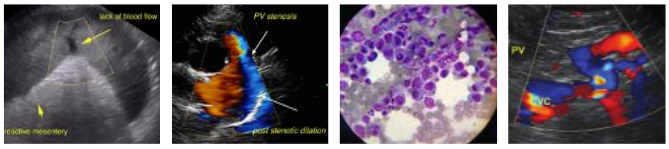
ULTRASONOGRAPHIC FINDINGS

- Mild cystitis pattern with pinpoint nondependent to adhered mineral
- Moderate chronic renal changes with nonobstructive medullary renoliths
- Nonhomogeneous regionally cystic to cavitated nodular mid abdominal mass adjacent to and medial to the spleen- likely splenic origin
- Benign splenic nodules- consistent with probable myelolipomas
- Hepatic parenchymal remodeling- subjectively benign
- Moderate gallbladder debris (non-mucocele)
- Bilateral chronic renal changes with nonobstructive medullary renoliths

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This patient is suspected to be passing small amounts of mineral from the kidneys into the urinary bladder. Further renal staging to include urine C/S and protein: creatinine ratio on sterile urine sample may be considered.

The confirmed mid abdominal mass is suspected to be splenic in origin given its location and appearance and without overt origin or involvement of the bilateral kidneys, adrenal glands, gastrointestinal tract, liver and with location caudal to the area of the pancreas. Considerations may include, hyperplasia, hematopoiesis granuloma, splenitis or neoplasia, such as sarcoma, round cell neoplasia or other. Technically, potential for non-splenic origin such as unspecified omental or



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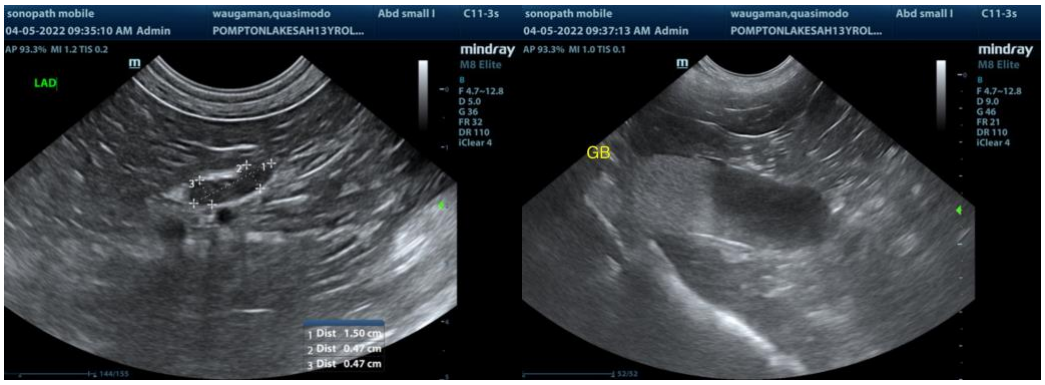
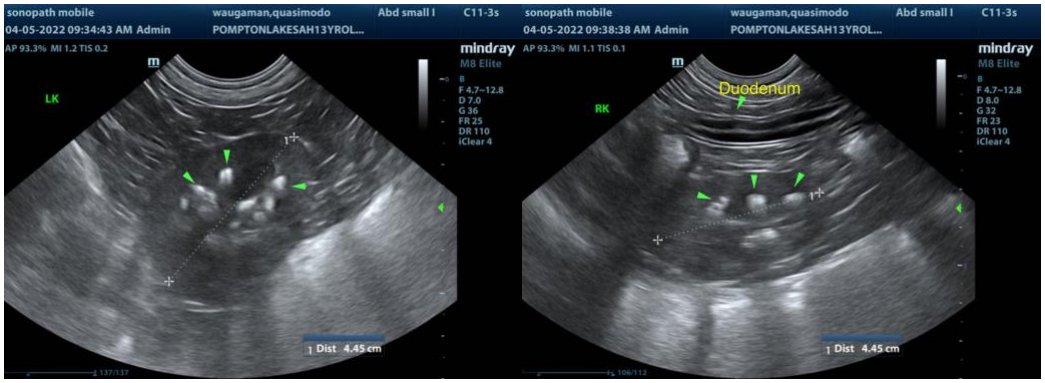
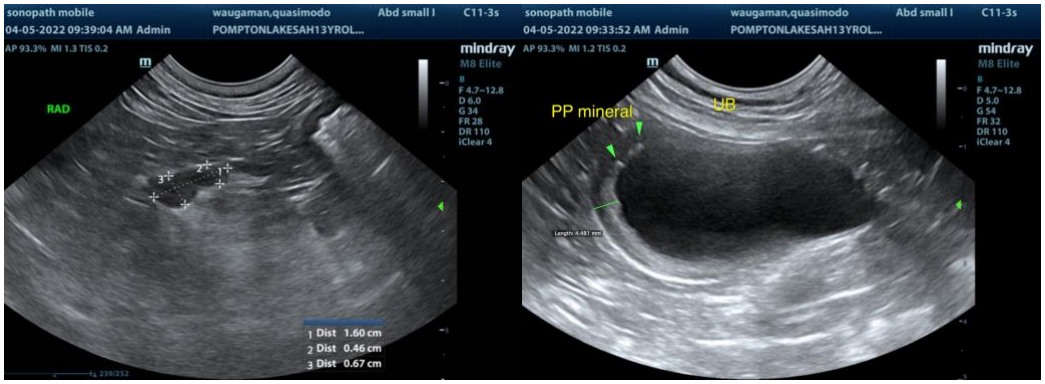
lymphatic mass possible yet thought less likely. Overt evidence of major organ metastasis was not sonographically evident, yet the possibility of regional omental seeding or nonsonographically evident metastasis/micrometastasis cannot be definitively excluded.

Assuming no evidence of thoracic pathology on three-view chest radiographs, laparotomy with gross inspection of the mass and likely expectation toward splenectomy could be considered.







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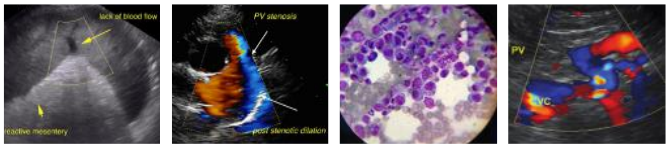

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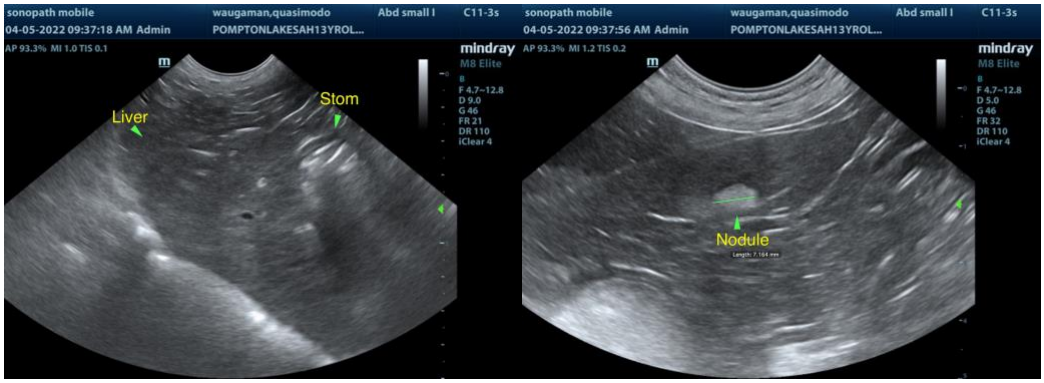

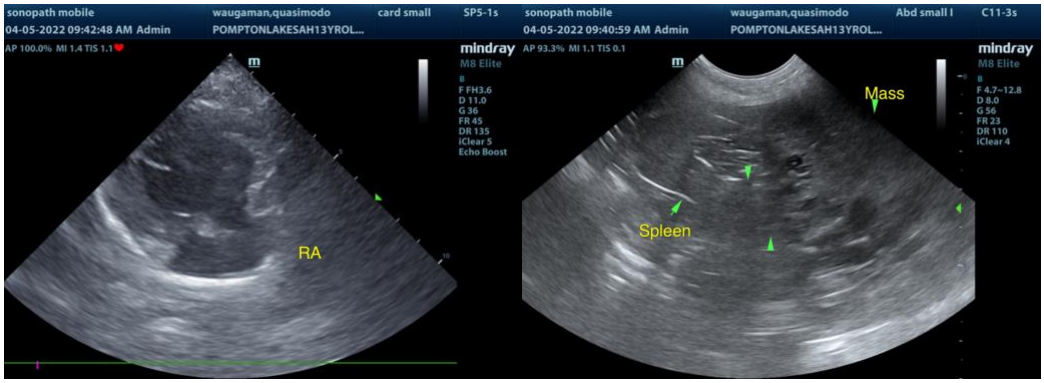

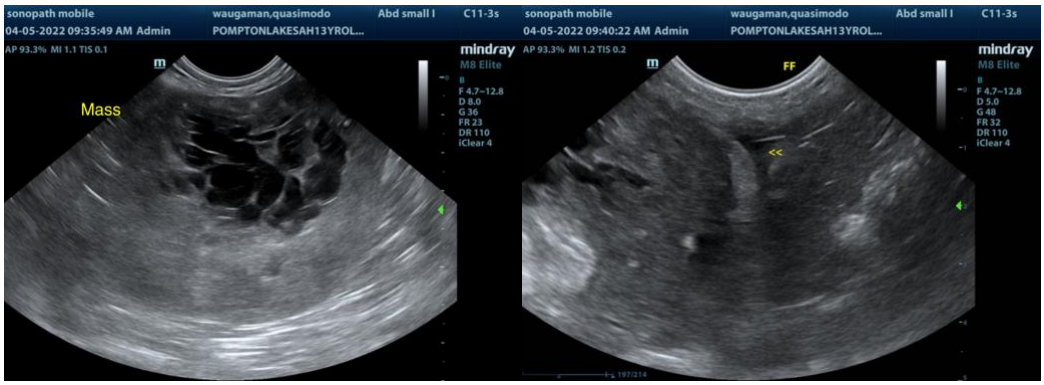

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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