



PATIENT

Max Frey

SPECIES

Canine

BREED

Shih Tzu Mix

SEX

MN

AGE

12

WEIGHT

14.2 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Brian Klug

HOSPITAL NAME

Sondel Family
Veterinary Clinic

REFERRING VET

Chelsea Mohney

INVOICE

13894

DATE

5/17/22

PRESENTING CLINICAL SIGNS

was seen by Dr. Wallisch a couple weeks ago for ADR, lethargy, anorexia. was started on Carprofen x 5 days and Amoxi Clav x 10 days. appetite is better than before o brought him in but he's still "off" at the end of the Amoxi-Clav course and for an additional 3 days after this course of meds, he was feeling great - playful, normal Max. the last 3-4 days, he's been back to being lethargic and just overall ADR, not his happy, playful self. just sleeps all the time and no interest in going outside with o or engaging with her hx of tooth abscesses when o first adopted him 3 years ago current food: - GI low fat - eating some kibble and some canned food current meds: - Carprofen - 1/2 T po q 24 hours
OBJECTIVE: BCS: 5/9 T: 101 F P: 120 bpm R: 24 brpm GENERAL: bright, alert, responsive, active, friendly CV: normal rhythm, no murmur, strong synchronous pulses RESP: normal bronchovesicular sounds throughout all lung fields, eupneic EENT: no ocular or nasal discharge, eyes clear, no cough on palpation of trachea ORAL: mucous membranes pink and moist, CRT <2s, moderate to severe periodontal disease LN: no peripheral lymphadenopathy INTEG: full, healthy hair coat, no areas of seborrhea, pruritus, alopecia, or erythema MS: no pain on palpation of long bones or joints, normal ambulation, normal musculature, good body condition UG: no evidence of urinary incontinence, normal conformation NEURO: normal mentation and ambulation, menace and palpebral reflexes normal ABD: non-painful abdomen, no organomegaly or masses appreciated RECTAL: not performed ASSESSMENT: 1) Moderate to severe periodontal disease 2) Anemia - ddx: hemorrhage vs. less likely hemolysis vs. anemia of chronic inflammation vs. other 3) Elevated ALK P 4) Leukocytosis secondary to neutrophilia PLAN: 1) Recommended post-poning dental and working him up further 2)

Recommended next step abdominal ultrasound with Dr. Mohney at EAST tomorrow and bringing in first AM urine as we haven't gotten urine on him yet. also consider reticulocyte count to see if he's regenerative or not 5/17 radiographic finding needle like opacity within stomach. Able to visualize mass within abdomen

Abnormal PE/Chem/CBC/UA Results: 4/28 ALBUMIN 2.6g/dL GLOBULIN 3.7g/dL Alk Phosphatase 330IU/L BUN 31mg/dL WBC 20.2103/dL HGB 11.4g/dL Platelet Count 462x10³/μL 5/17 Absolute Reticulocytes 145,600/μL

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and cystourethral junction 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 was 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 mild to moderate loss of corticomedullary symmetry and definition expected for the age of the patient. Pinpoint hyperechoic corticomedullary foci, which although nonspecific may indicate pinpoint areas of microinfarction, fibrosis, or mineralization, were present. Left and right cortical cysts were also present. No evidence of pelvic dilation was present. The left kidney measured 3.8 cm in length. The right kidney measured 4.2 cm in length.



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Adrenal Glands

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The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.56 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 0.53 cm width at the caudal pole and 0.54 cm width at the cranial pole.

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Spleen

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A moderately expansive, mixed echogenic non-cavitated mass involving the spleen with secondary capsule expansion and disruption was present and measured approximately 4.2 cm in diameter. A potential second mass lesion noted subjectively cranial to the splenic mass with potential connection and exhibiting subjective cystic component was also present measuring approximately 6.0 cm in diameter. 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.

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Liver/ Gallbladder

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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. Intermittent nonhomogeneous to cystic intraparenchymal nodules were present. An example of a liver nodule measured 1.8 cm in diameter.

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(Canine and Feline)

The gallbladder was non-distended in size containing primarily anechoic content with moderate, congealed yet nonorganized, nonmineralized gallbladder debris. The gallbladder was otherwise normal. The cystic and common bile ducts were normal.

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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.

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.

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Pancreas

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The right pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia. This is likely consistent with age-related right pancreatic changes and considered incidental.

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Free Abdomen

Minor perisplenic reactive mesentery was present. No overt evidence of splenic mass rupture with secondary hemoabdomen or peritoneal free fluid was present.



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ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Expansive mixed echogenic splenic mass
- Potential undifferentiated mass effacing and directly cranial to the splenic mass, potential extension of the splenic mass into the cranial perisplenic omentum, separate unspecified cranial abdominal mass possible
- Nonspecific yet suspicious Intraparenchymal hepatic nodules

Secondary Findings

- Bilateral chronic renal changes with cysts
- Moderate gallbladder debris (non-mucocele)

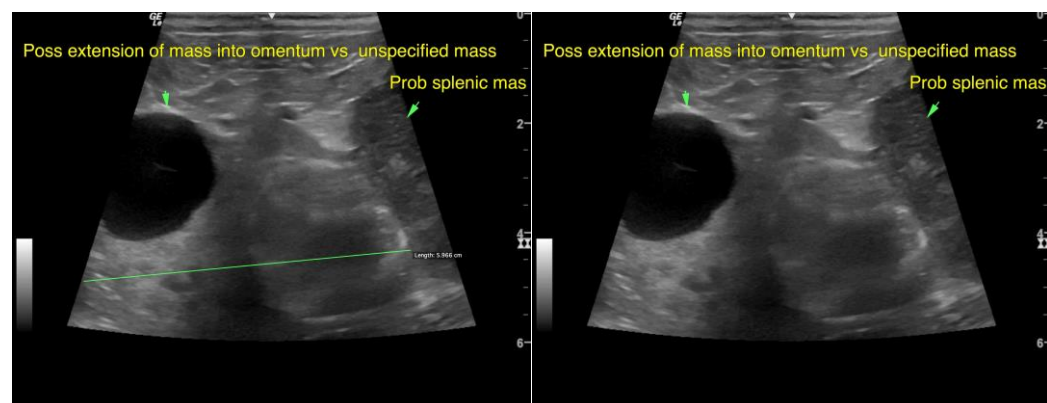
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This study confirms the presence of a splenic mass, which although nonspecific with multiple etiologies possible including hyperplasia, hematopoiesis, granuloma, hematoma, etc., neoplastic criteria such as sarcoma, round-cell neoplasia, or other, is considered likely. It is unclear if the splenic mass is expanding into the cranial perisplenic omentum vs. separate cranial abdominal mass, omental metastasis, atypical yet significant lymphadenopathy, or potential involvement of the left pancreatic limb, are possible. This unspecified mass did not overtly appear to involve the left caudal liver, yet this potential cannot be definitively excluded.

Likewise, although benign etiologies for the hepatic intraparenchymal nodules are possible, concern for intrahepatic metastasis is warranted.

Assuming normal clotting status, screening FNA including the splenic mass, unspecified mass cranial to the spleen, as well as hepatic nodule could be considered.

Given this presentation, especially if surgical considerations are possible, abdominal CT is likely ideal. Three view chest radiographs are recommended.





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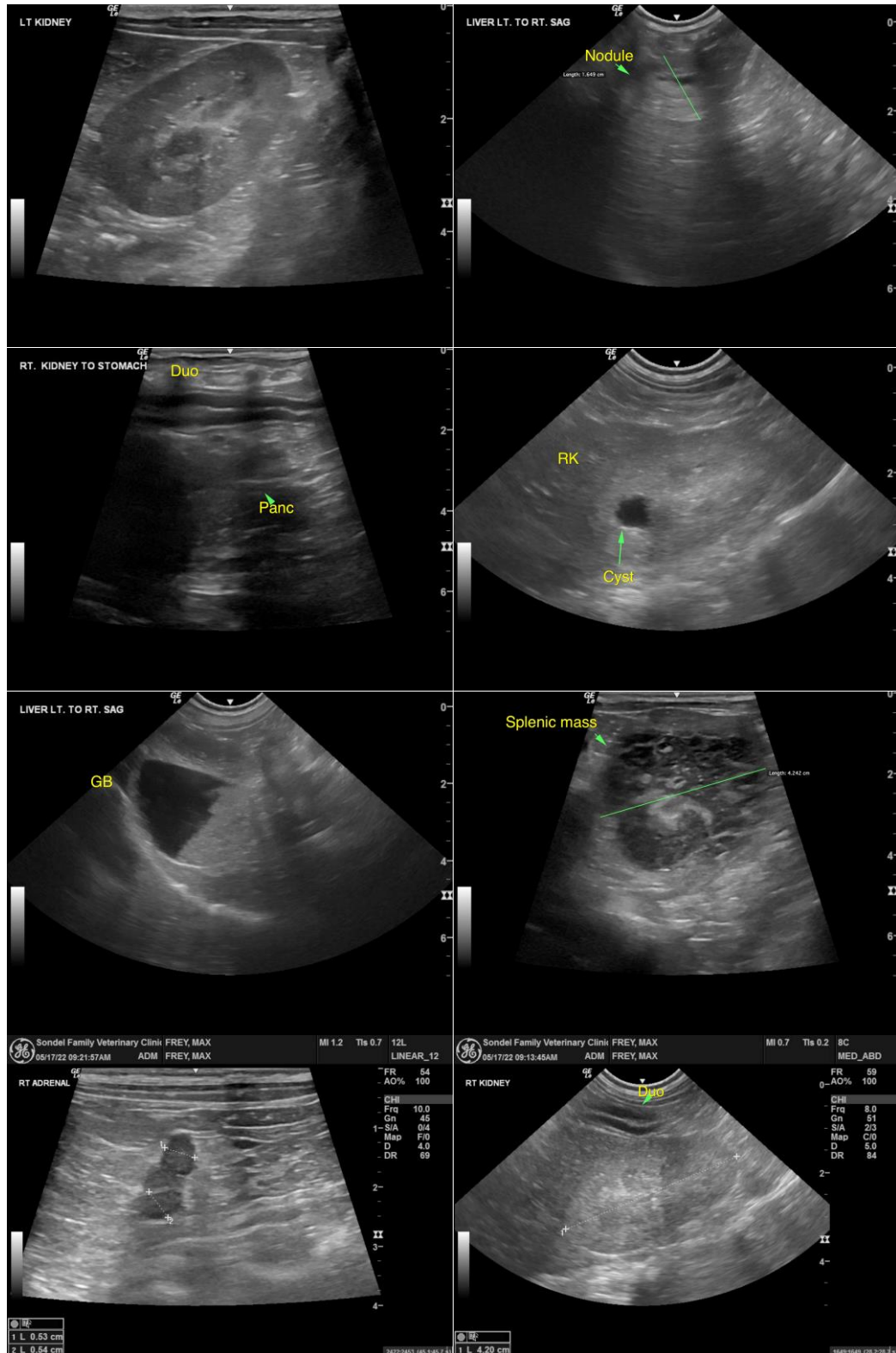
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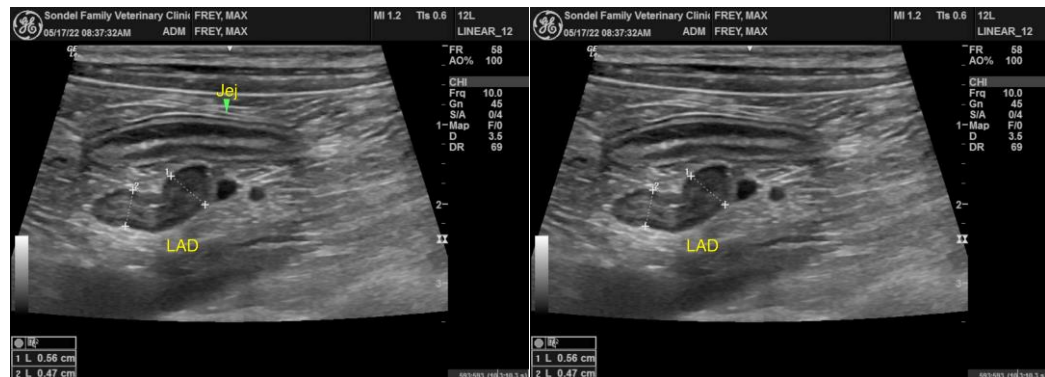
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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