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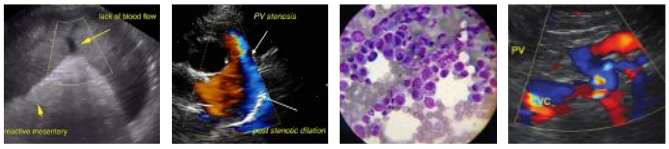

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1-800-838-4268 info@sonopath.com

PATIENT

Pixie Leclerc

SPECIES

Canine

BREED

Chihuahua Mix

SEX

FS

AGE

10 years

WEIGHT

13.3 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Ebersole

HOSPITAL NAME

Scanvet

REFERRING VET

Dr. Berberich

INVOICE

13988

DATE

6/2/22

PRESENTING CLINICAL SIGNS

Not eating well, sluggish. Cranial abdominal mass palpated on exam.
Abnormal PE/Chem/CBC/UA Results: PE: BCS 7/9, very thin hair coat on trunk. abdominal discomfort and palpable abdominal mass on the L side, caudal to ribs. BW: Alb 2.0 Glob H, TP H. T-4 low but TSH normal. RADS: cranial abdominal mass, unable to determine if splenic or hepatic in origin.

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 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 loss of corticomedullary symmetry and definition expected for the age of the patient. Pinpoint areas of medullary mineral were present in both kidneys. No evidence of pelvic dilation was present. The left kidney measured 4.5 cm in length. The right kidney measured 4.2 cm in length.

Adrenal Glands

The left adrenal gland was indistinctly visualized owing to regional left periadrenal omental artifact, yet without overt pathology. The left adrenal gland subjectively measured 0.37 cm width at the caudal pole.

The right adrenal gland was mildly prominent in size, given the patient's size and breed, exhibiting symmetrical capsule contour and primarily homogeneous parenchyma. The right adrenal gland measured 1.7 cm length x 0.74 cm width at the caudal pole.

Spleen

A moderately expansive, nonhomogeneous to mixed echogenic mass involving the spleen with secondary capsule expansion and disruption was present and measured 7.0-8.0 cm in diameter. The parenchyma of the mass was nonhomogeneous 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/ Gallbladder

The liver presented subjective mild enlargement. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion. No hepatic masses or nodules were noted. The gallbladder was non-distended in size with mild to moderate gallbladder debris. The gallbladder was otherwise normal with no evidence of gallbladder or peripheral gallbladder inflammation noted. The cystic and common bile ducts were normal.

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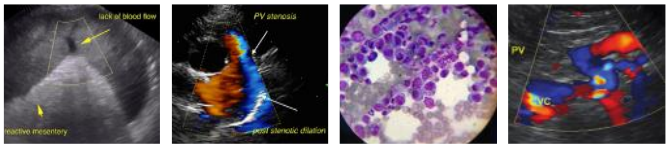

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Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained moderate nonshadowing ingesta / chyme most consistent with post prandial presentation without 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 base and proximal right pancreatic limb exhibited subtle prominent size with mild uniform hypoechoic parenchymal compared to mildly reactive peripancreatic omentum.

Free Abdomen

Regional perisplenic hyperechoic mesentery was present. Small pockets of scant perisplenic free fluid and mildly prominent perisplenic lymphadenopathy were present. An example of a perisplenic lymph node measured 2.0 cm x 1.0 cm. Rapid view of the heart revealed no evidence of pericardial masses or effusion in the visible window.

ULTRASONOGRAPHIC FINDINGS

- Expansive nonhomogeneous splenic mass
- Associated regional perisplenic hyperechoic mesentery, nonspecific splenic lymphadenopathy, and scant perisplenic free fluid
- Mild vacuolar hepatopathy pattern - subjectively benign
- Mild to moderate nonorganized gallbladder debris (non-mucocele)
- Overtly normal gastrointestinal tract with gastric ingesta - post prandial presentation vs. possible gastric hypomotility if documented NPO
- Possible low-grade pancreatitis
- Bilateral chronic renal changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Although histopathology is required for definitive diagnosis, the splenic mass is most suggestive of neoplasia such as sarcoma or other. Benign pathologies are possible, yet considered less likely. The perisplenic hyperechoic mesentery and associated splenic lymphadenopathy are nonspecific and may indicate secondary reactive or mild inflammatory omental changes and benign lymphadenopathy. However, the possibility of early perisplenic omental seeding and metastatic lymphadenopathy secondary to the splenic mass cannot be definitively excluded. No overt evidence of major organ metastasis, i.e., hepatic, renal metastasis.

Assuming no evidence of thoracic pathology or metastatic criteria on three-view chest radiographs, splenectomy with gross inspection of the perisplenic omentum, splenic lymph nodes, as well as major

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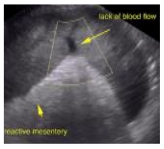
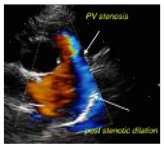
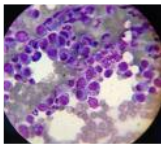
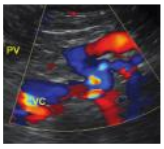

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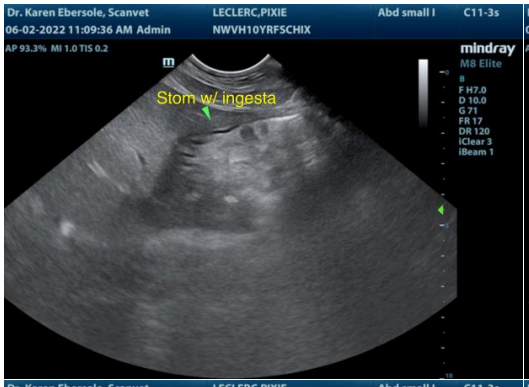
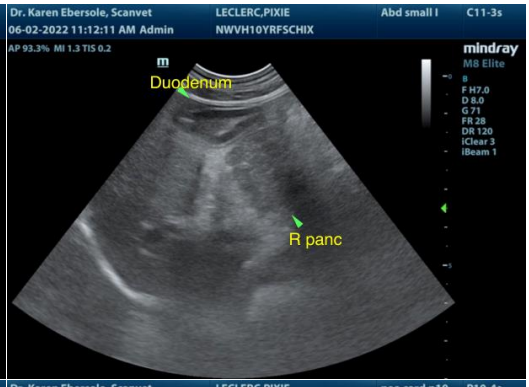
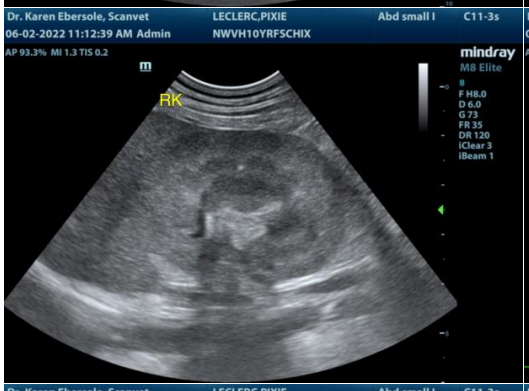
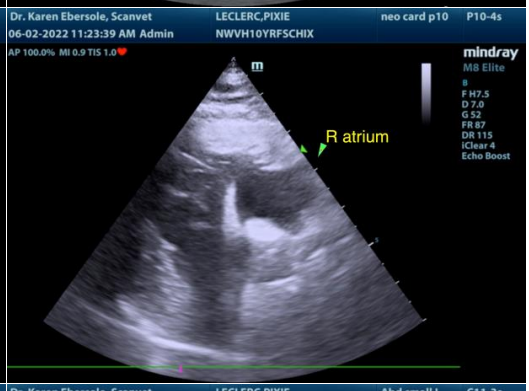
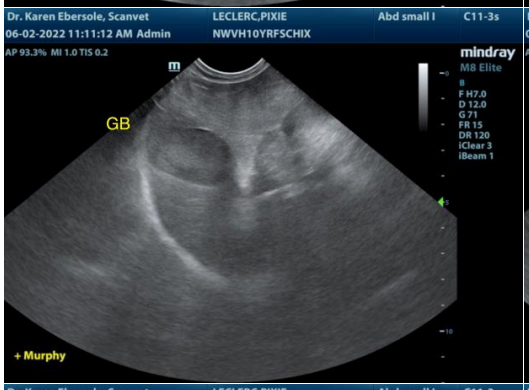
organs could be considered. A guarded prognosis pending splenic histopathology. A Spec cPL, as-needed gastrointestinal support, and conservative therapy for low-grade pancreatitis, if clinically indicated, would be reasonable.

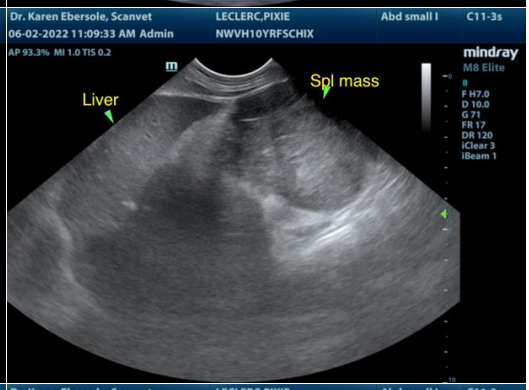


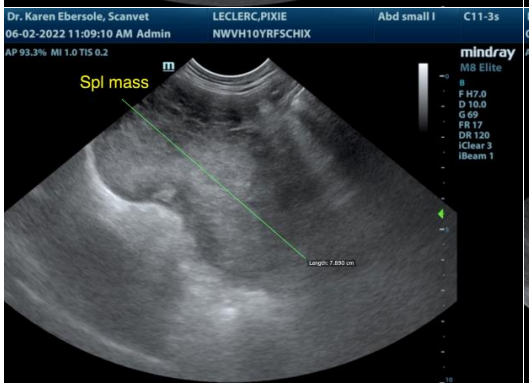


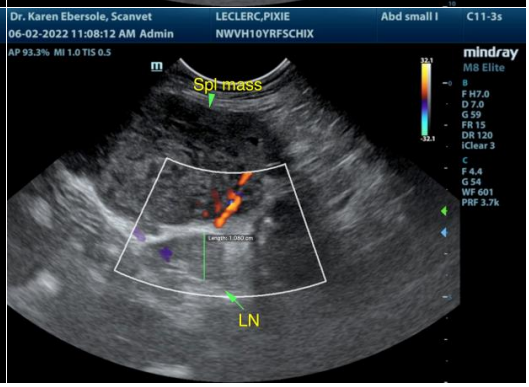












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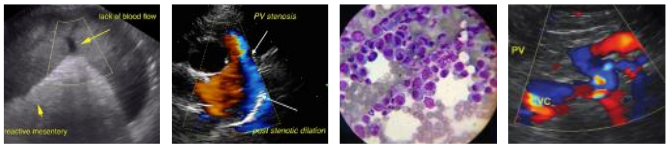

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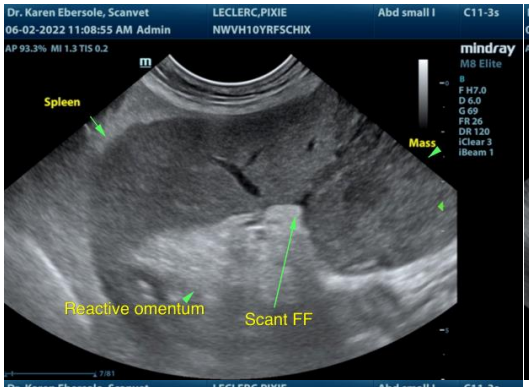

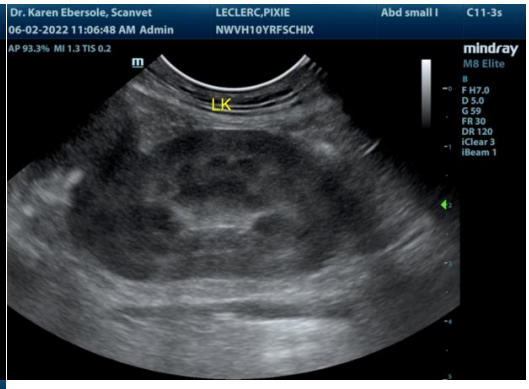

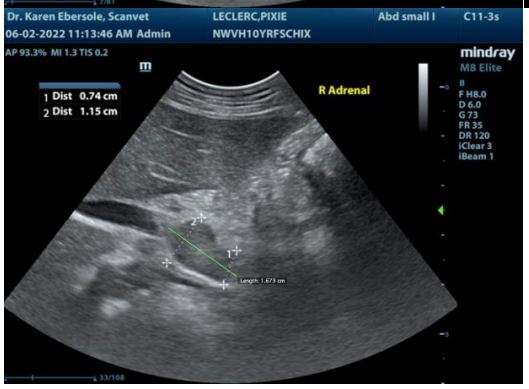

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@SonoPath.com