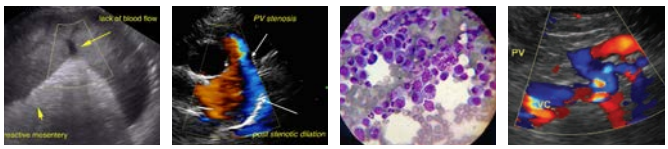

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1-800-838-4268 info@sonopath.com

PATIENT

Molly Moate

SPECIES

Canine

BREED

Labradoodle

SEX

Spayed Female

AGE

14 Years

WEIGHT

14 Years

INTERPRETED BY

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

IMAGING PERFORMED BY

Nicole Gotfredson

HOSPITAL NAME

Buffalo Vet Center

REFERRING VET

Dr. Garry Gotfredson

INVOICE

38910

DATE

6/20/22

PRESENTING CLINICAL SIGNS

seen on 6/3/22 for annual check up and vaccines. BUN=31, ALKP=368, cbc=wnl, came in today for lethargic, ataxic, not eating and vomiting. Weight loss of 8lbs.

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. Mild asymmetrical luminal surface to micropolyploid changes were present likely associated with age related mural changes. 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.

The area of the aortic trifurcation was free of pathology.

Normal size and margination were present in the left kidney. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and moderate loss of corticomedullary symmetry and definition expected for the age of the patient. Minor pyelectasia noted and intermittent cortical cysts.

The right kidney was not definitively visualized.

Adrenal Glands

A non-disruptive, non-expansive nodule was present in the caudal pole of the left adrenal gland. The nodule did not exhibit signs of mineralization or vascular invasion. The nodule measured 0.88 cm x 0.67 cm. The remainder of the adrenal parenchyma was mildly non-homogeneous.The overall left adrenal gland measured 0.85 cm at the cranial pole and 0.88 cm at the caudal pole.

The right adrenal gland was not definitively visualized.

Spleen

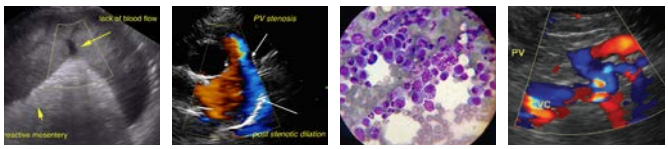
A moderately sized, primarily spherical, non-homogeneous, focally cystic to cavitated cranial splenic mass was present, measuring 5.0 cm in diameter. Generalized mild splenic parenchyma heterogeneity. Concurrent intermittent separate, well demarcated, hyperechoic splenic nodules were also present.

Liver

The liver was mildly enlarged. 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 mildly echogenic to prominent gallbladder walls. Moderate non-dependent yet non-organized, hyperechoic gallbladder debris was present. No evidence of peripheral gallbladder inflammation. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented wall thickening secondary to moderate echogenic mucosa hypertrophy and increased prominence of rugal folds. Intact wall layering was maintained and distinct. Mild hyperechoic to focally shadowing ingesta present in the stomach. No overt evidence of mechanical pyloric outflow obstruction.



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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. Mild segmental duodenojejunal mucosal speckling noted.

Normal visible colon wall layers were present with apparent formed feces in lumen.

Pancreas

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

Free Abdomen

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

Subtle generalized increased omental echogenicity noted. No free fluid.

Rapid view of the heart revealed no overt evidence of pericaudal effusion or obvious cardiac tumors.

ULTRASONOGRAPHIC FINDINGS

- Non-homogeneous cystic to cavitated cranial splenic mass with concurrent separate, likely benign nodules, consistent with probable myelolipomas.
- Vacuolar hepatopathy pattern with parenchymal remodeling – subjectively benign.
- Moderate gallbladder debris – possible early mucocele or mild cholecystitis.
- Non-specific left adrenal nodule – suspect adenoma. Potential for minor benign hyperplasia or emerging primary versus metastatic neoplasia (i.e., pheochromocytoma, adenocarcinoma, or other).
- Gastroenteritis pattern with moderately thickened gastric mucosa and retained focally shadowing ingesta – potential for gastric foreign material cannot be excluded.
- Intermittent, subjectively benign/reactive mesenteric lymph nodes.

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). No overt evidence of perisplenic or intraabdominal metastasis .

Screening blood pressure to assess for evidence of hypertension, which may allude to a left pheochromocytoma, is suggested. Radiographic or sonographic monitoring for evidence of gastric emptying recommended, as well as correlation with most recent meal ingestion. Ideally, sonographic monitoring of the left adrenal nodule is suggested for evidence of progression.

Assuming no evidence of thoracic pathology on 3-view chest radiographs, splenectomy with gross inspection of the stomach as well as gastrointestinal biopsies, gross inspection of the liver and gallbladder, with potential for manual gallbladder expression could be considered.

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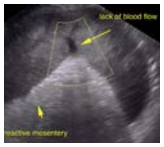
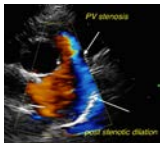
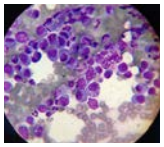
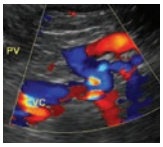

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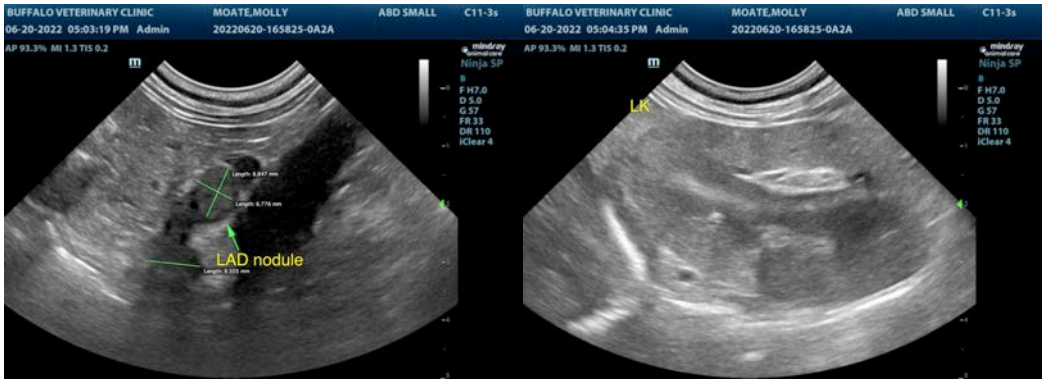
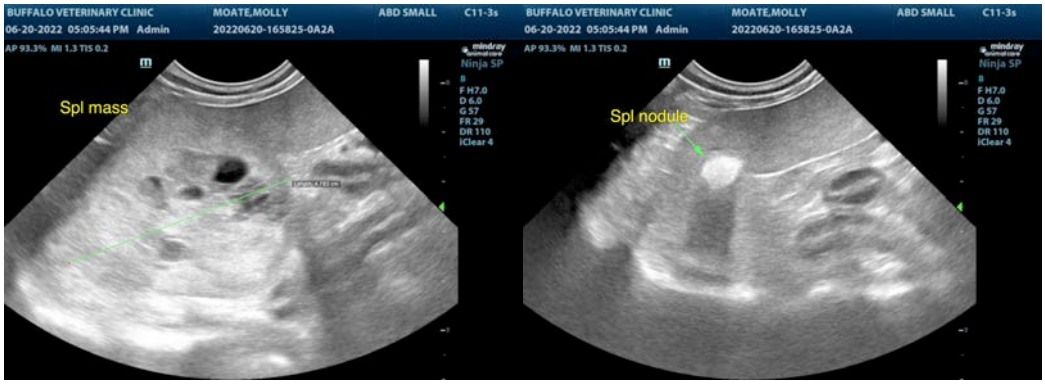
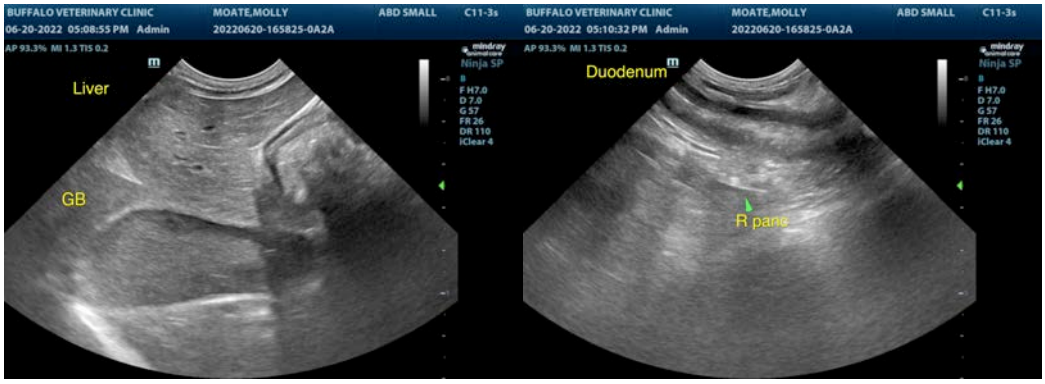
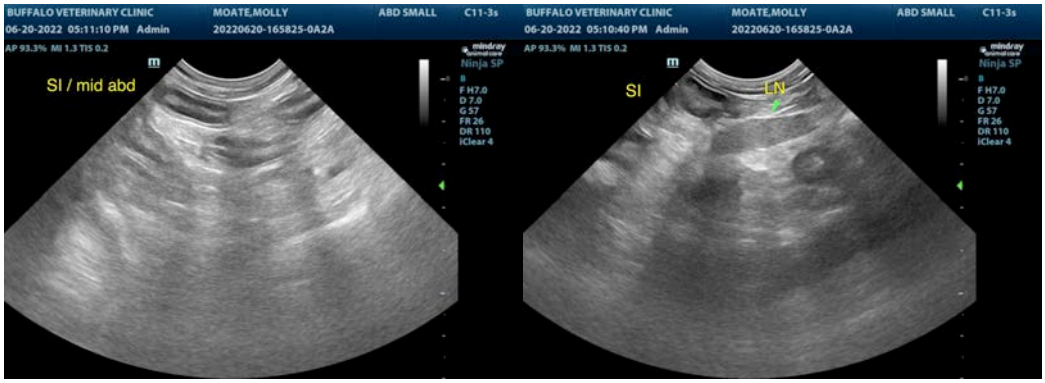
As needed gastrointestinal and hepatic support, GI panel to include PLI, TLI, cobalamin and folate, and sonographic monitoring of the splenic mass would be a more conservative approach.









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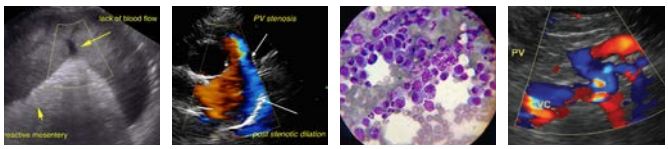

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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