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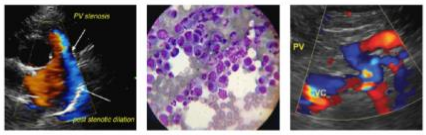
fredgromalak@gmail.com



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

PATIENT

Bailey Kloth 34704B

SPECIES

Canine

BREED

German Shorthaired Pointer

SEX

Neutered Male

AGE

10 Years

WEIGHT

44.96 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VET

Dr. Thomas- Madison VS

INVOICE

16202

DATE

6/21/22

PRESENTING CLINICAL SIGNS

History: Patient presented for a suspect hemoabdomen.

Abnormal PE/Chem/CBC/UA Results: Hemoabdomen confirmed on abdominocentesis.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra 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 mild loss of corticomedullary symmetry and definition expected for the age of the patient. Both kidneys exhibited minor pyelectasia. A moderately sized thinly walled cyst was present, occupying the left kidney pole, measuring 3.9 cm in diameter. The left kidney measured 8.4 cm in length. The right kidney measured 7.9cm in length.

Adrenal Glands

Both adrenal glands were indistinctly visualized owing to increased periadrenal omental artifact yet without overt pathology. The left adrenal gland measured 0.55 cm at the cranial pole and 0.84 cm at the caudal pole, The right adrenal gland measured 0.48 cm at the cranial pole and 0.43 cm at the caudal pole.

Spleen

A moderately sized, asymmetrically marginated mixed echogenic to cavitated mass, involving the subjective caudal spleen was noted, measuring approximately 10.0 cm in diameter. Concurrent mildly expansive separate hypoechoic nodule was present in the cranial spleen, measuring approximately 3.5 cm in diameter. The splenic parenchyma not involved with the splenic mass and nodule exhibited generalized heterogeneity. Splenic vascularity was normal.

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. A solitary discreet isoechoic intraparenchymal nodule was present, measuring 3.7 cm in diameter.

The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

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.

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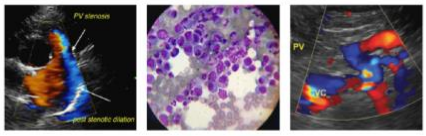

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Normal visible colon wall layers were present with subjective sem- formed feces in lumen.

Pancreas

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

Free Abdomen

intermittent, mildly prominent to enlarged mesenteric lymph nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). An example of lymph node measured 2.1 cm x 0.70 cm width.

Regional perisplenic nonuniform mesentery was noted primarily around the caudal splenic mass. No overt splenic omental adhesions yet cannot be definitively excluded.

Moderate volume peritoneal free fluid was noted, exhibiting mild echogenic changes.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Mixed echogenic to asymmetrical caudal splenic mass with concurrent separate mildly expansive cranial splenic nodule
- Regional nonuniform perisplenic omentum and intermittent nonspecific mesenteric lymphadenopathy
- Moderate volume peritoneal free fluid with mild echogenic changes consistent with hemoabdomen
- Hepatic parenchymal remodeling with solitary discreet to isoechoic nonspecific intraparenchymal nodule

Secondary Findings

- Mild 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 discreet to isoechoic hepatic nodule may indicate a benign process, such as nodular to regenerative hyperplasia, hematopoiesis, small lipogranuloma or similar. Likewise, the perisplenic omental changes and concurrent mesenteric lymphadenopathy, which subjectively exhibited primarily maintained width to length ratio <0.5, may indicate secondary reactive or possible inflammatory perisplenic omental changes and reactive to benign mesenteric lymphadenopathy. However, the possibility of hepatic metastasis, regional perisplenic omental seeding and/or early neoplastic or metastatic mesenteric lymphadenopathy cannot be definitively excluded.

If no evidence of thoracic pathology on three-view chest radiographs, as well as normal cardiopulmonary status, laparotomy with expectations towards splenectomy, gross inspection of the liver +/- hepatic biopsy, as well as gross inspection of the perisplenic omentum and regional mesenteric lymph nodes could be considered. Given the likelihood of aggressive to malignant primary splenic neoplasia, a very guarded to potentially unfavorable long-term prognosis is likely indicated.

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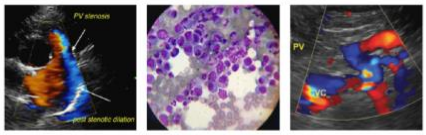

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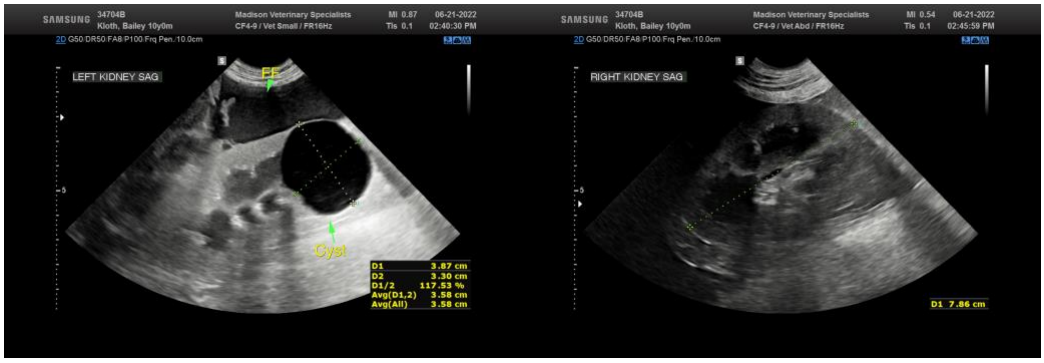

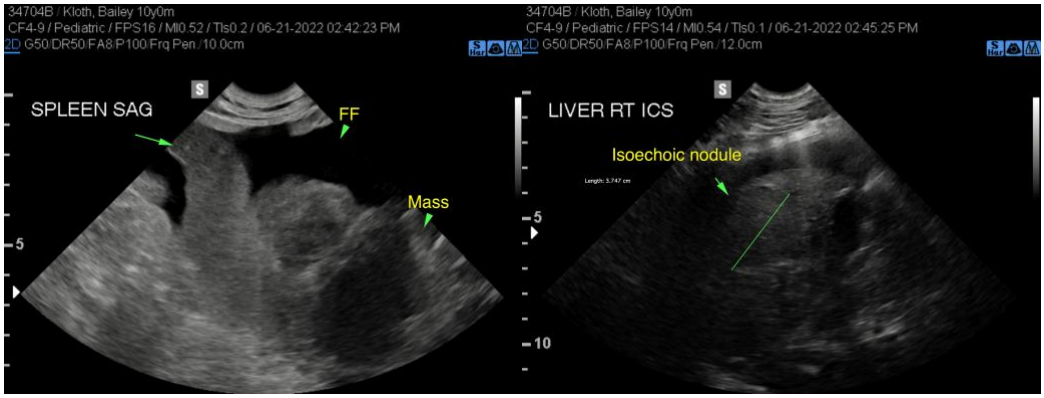

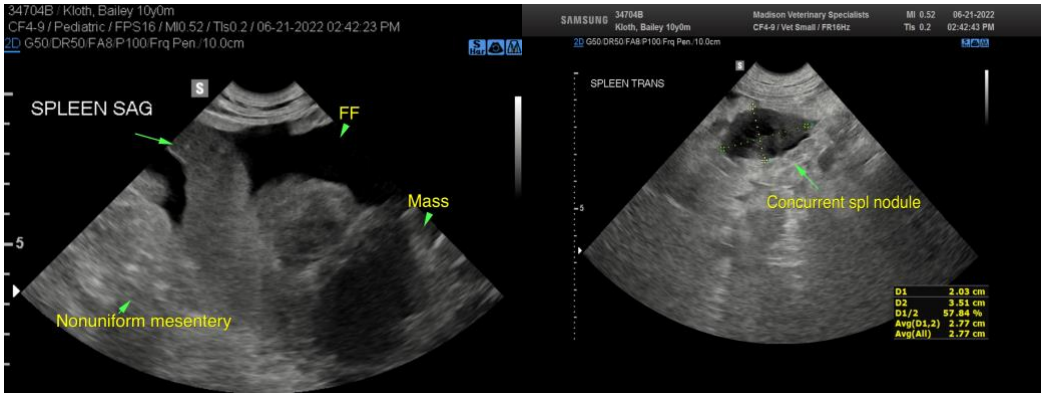

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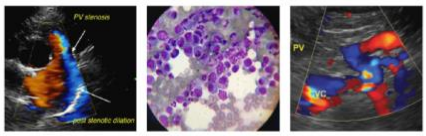

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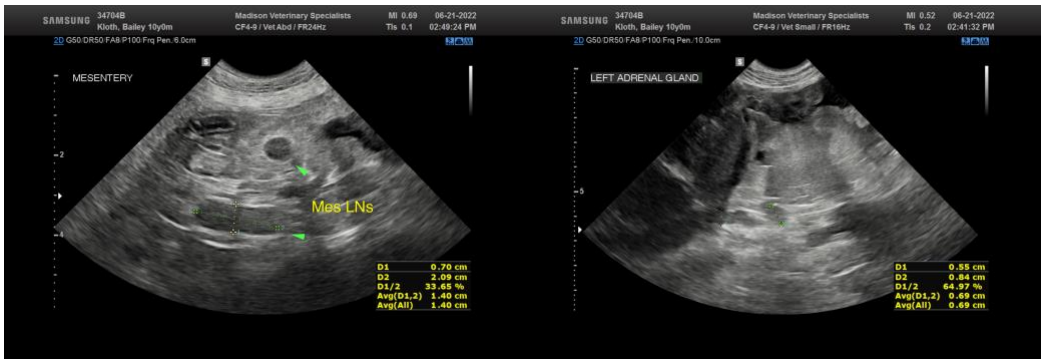

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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