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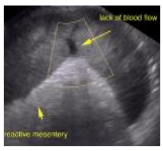
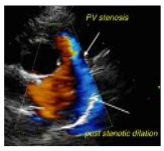
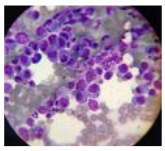
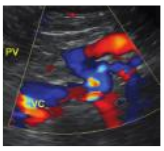

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1-800-838-4268 info@sonopath.com

PATIENT
Tonka Myers

SPECIES
Canine

BREED
English Bulldog

SEX
Neutered Male

AGE
6 Years

WEIGHT
47.6 Lbs.

INTERPRETED BY
Andrea Nicastro, DMV, Diplomate DACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY
Dr. Jo Goodman

HOSPITAL NAME
Evandale-Blue Ash PH

REFERRING VET
Dr. Jo Goodman

INVOICE
10106

DATE
1/5/22

PRESENTING CLINICAL SIGNS

History: Presented 12/6/21 for swollen left hind hock. Limping started in the summertime but has worsened in the last 4 weeks. Hx of Lyme. Owner thought he had pulled something while playing with housemate. CBC/Chem/UA/T4 with Quant C6 and ALB, TP and Glob decreased. Quant normal. Rads taken and sent out recommended arthrocentesis and the arthrocentesis was performed on 12/14/21 along with a recheck of BW and ultrasound. Decreased values returned to normal. Synovial fluid analysis results attached. Owner seeking out consult with oncologist for next steps.
Abnormal PE/Chem/CBC/UA Results: swelling 360 but worse portion is anterior with bilobe appear 12/6/21: ALB - 2.3 TP - 4.4 Glob - 2.1 12/14/21: ALB - 2.4 TP - 5.3 Glob - 3.0
Synovial fluid analysis is consistent with mesenchymal neoplasia.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are normal in thickness and the mucosal surface is smooth. The bladder lumen is moderately distended with anechoic urine. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The prostate is normal in size (1.34 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney presented normal size (6.66 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney presented normal size (6.44 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is normal size (0.69 cm at cranial pole) (0.72 cm at caudal pole) (2.85 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The caudal pole of the right adrenal gland is visualized and is normal size (0.62 cm in width) with a normal shape, glandular echogenicity and detail. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (2.08 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed.

The gall bladder is moderately distended. The wall is slightly thickened (up to 1.16 cm) and hyperechoic. Luminal contents are anechoic. The cystic and common bile ducts are normal/not seen.

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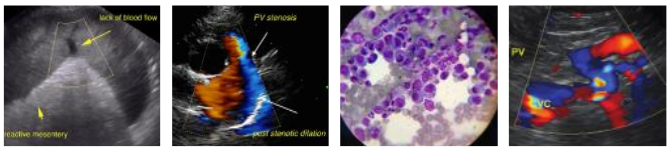

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Gastrointestinal

The gastric lumen is mildly distended with ingesta. The gastric wall is normal in thickness with a normal layering pattern. The small intestinal lumen is segmentally dilated with gas and chyme. The small intestinal wall thickness is normal with a normal layering pattern. There is evidence of mucosal fogging and mucosal striations in some segments. Discreet masses are not identified. The ileocecal cholic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas

The right limb is prominent in size with minimal deviation from the normal peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat. No distinct focal lesions are observed. The pancreatic duct is is visible but not overtly dilated.

Free Abdomen

There is no evidence of free fluid. A prominent left-medial ileac lymph node is visualized (1.24 cm in length). A few prominent jejunal lymph nodes are visible, the largest measuring 1.13 cm in length.

ULTRASONOGRAPHIC FINDINGS

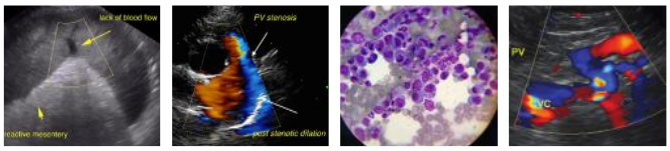
Primary Findings

- Given the history of panhypoproteinemia and the sonographic changes, a protein-losing enteropathy (i.e., inflammatory bowel disease, lymphangiectasia, infectious/parasitic disease), infiltrative neoplasia (less likely)) is suspected.
- The lymph node changes are most consistent with reactive lymphadenitis or lymphoid hyperplasia.
- The thickened gall bladder wall could be consistent with cholecystitis or benign age-related hyperplasia. Correlation with clinical findings is recommended.
- The pancreatic changes may be a normal variant for this patient or could be consistent with mild, chronic pancreatitis. Correlation with clinical findings is recommended.

*There is no obvious evidence of neoplasia in the abdomen.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for pulmonary metastatic disease, if not already performed.
- To further evaluate for a protein-losing enteropathy, consider the following:
  1. Malabsorption panel, including serum cobalamin and folate TLI and PLI
  2. Fecal evaluation for ova and Giardia
  3. Endoscopic or surgical gastrointestinal biopsies.
- To further investigate for concurrent causes of hypoalbumenia, consider the following:
  1. UPC (if proteinuria is present)



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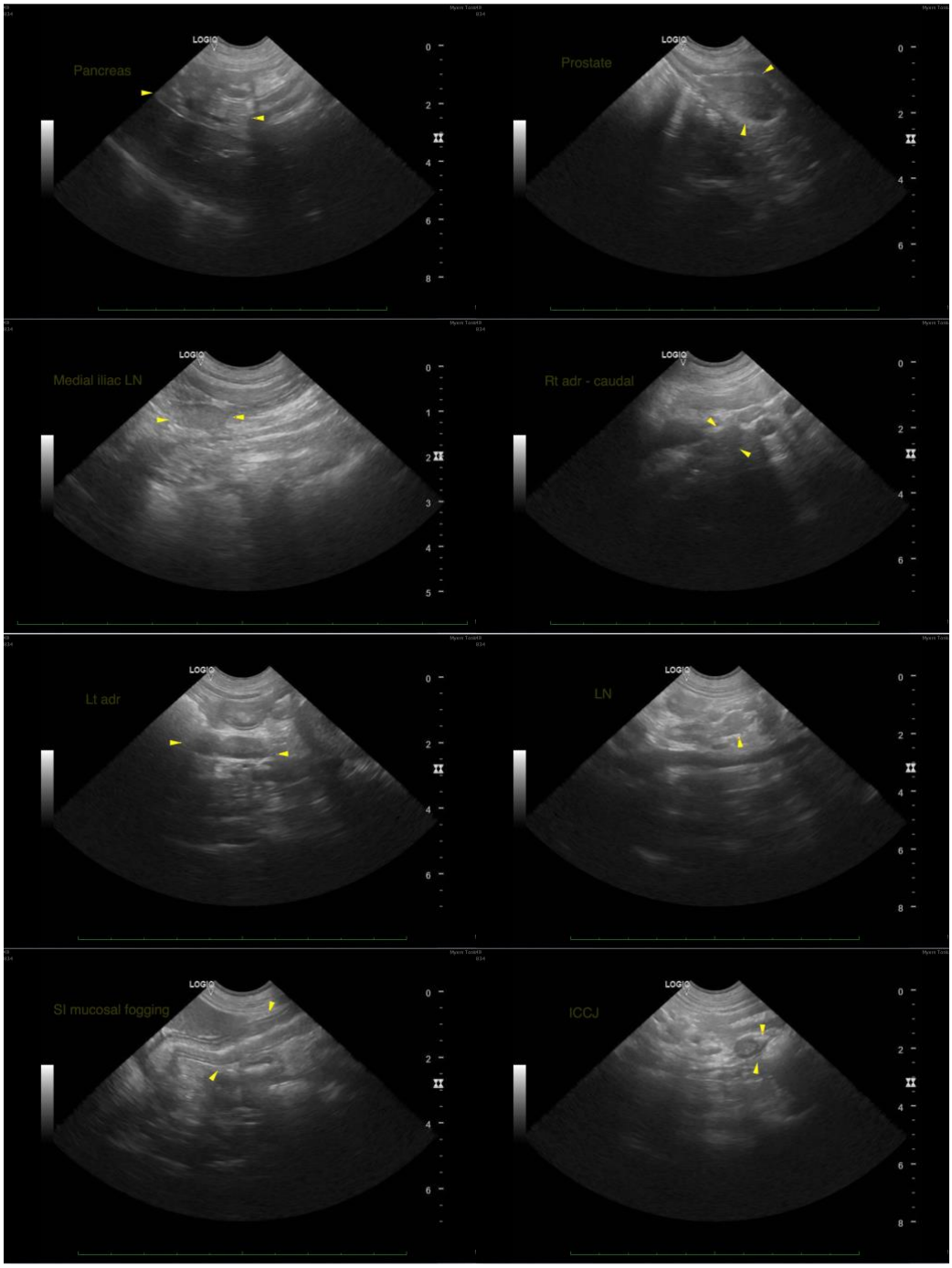
2. Pre- and post-prandial serum bile acids.

3. A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended.



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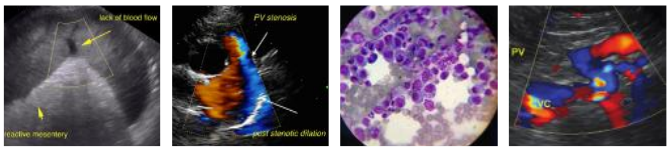

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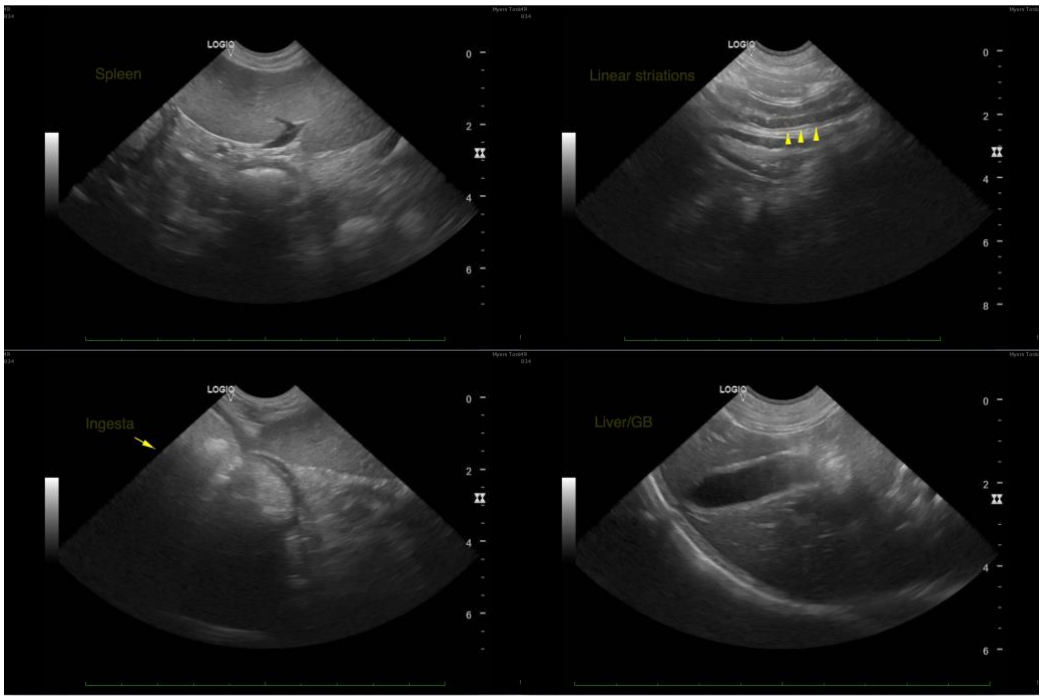

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com