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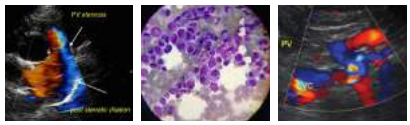

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DATE

10/4/21

PATIENT

Molly Bohn

SPECIES

Canine

BREED

Pug

SEX

Female Spayed

AGE

7/15/11

WEIGHT

17.6 lbs.

INTERPRETED BY

Andrea Nicastro, DVM, Diplomate ACVIM (Small Animal Internal Medicine)

HOSPITAL NAME

Belvedere Veterinary Center

REFERRING VET

Dr. Moulder

INVOICE

11951kk

PRESENTING CLINICAL SIGNS

History: Evaluated at another vet hospital for a history of inappetence, lethargy ~3 weeks ago. Started with seizures more frequently over last 3 weeks (historically had an occasional juvenile epileptic seizure). Serial blood work indicated a severe hepatopathy. ALT value 'improved' but other liver values increased. Patient showed minimal to no improvement over the three weeks and presented for second opinion.

Current Medications: Not provided by the veterinarian.

Lab Results: Blood results (past---> present), ALT- >1000, 838, 677, GGT- 21, 35, 58, Alk P- 1841, >2000, >2000, TBili- 3.8, 0.7, 2.1

Radiographs: Not provided by the veterinarian.

Date of Previous IntraPet Ultrasound: No previous IntraPet scans.

Sedation: Sedation not required for scan.

Stat Report: STAT report not requested by the veterinarian.

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 mildly 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 left kidney is normal size (4.06 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. Renal vasculature is normal.

The right kidney is normal size (4.54 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. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.60 cm at cranial pole) (0.51 cm at caudal pole) (1.77 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 right adrenal gland is normal size (0.48 cm at cranial pole) (0.66 cm at caudal pole) (2.08 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.

Spleen

The spleen is normal in size (1.48 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A 1.06 x 0.91 cm ill-defined, hypoechoic nodule is observed within the parenchyma. Splenic vasculature is normal.

Liver
The liver is subjectively normal in size with slightly irregular peripheral contours. The parenchyma is hypoechoic relative to the spleen. A 4.44 x 2.89 cm swelling/mass is observed in the deep left to mid-liver. The lesion causes capsular expansion. Several, ill-defined, hypoechoic nodules are observed throughout the remaining parenchyma. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion. The gall bladder lumen is moderately distended. The wall is thin and smooth. A moderate amount of aggregated, echogenic, partially dependent sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal
The gastric lumen is distended with fluid and ingesta and is hypomotile. The gastric wall and pylorus are normal in thickness with a normal layering pattern. Within a 4.48 cm segment of proximal duodenum, an irregular, hypoechoic mass-effect is present. The wall in this region is thickened (up to 1.28 cm) with a loss of the normal layering pattern. Surrounding mesentery is hyperechoic. The small intestinal lumen is segmentally dilated with chyme. The remaining small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. The colonic wall is normal.

Pancreas
The right limb of the pancreas is prominent in size with slightly irregular peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat. No distinct focal lesions are observed. The pancreatic duct is not overtly dilated. Surrounding mesentery is hyperechoic.

Free Abdomen
Trace free fluid is observed in the cranial abdomen. Several prominent to enlarged, hypoechoic lymph nodes are observed in the right cranial quadrant, the largest measuring 2.00 cm in length.

Other
A brief echocardiogram reveals no evidence of pericardial effusion.

ULTRASONOGRAPHIC FINDINGS

- Proximal duodenal mass with possible partial obstruction (versus functional gastric ileus). Neoplasia (i.e., adenocarcinoma, lymphoma) is considered likely with a lower possibility of severe inflammatory disease. Regional peritonitis is present. The adjacent abdominal lymphadenopathy may be secondary to infiltrative neoplasia, reactive lymphadenitis, or lymphoid hyperplasia.

- The pancreatic changes are consistent with mild to moderate pancreatitis, likely secondary to duodenal pathology.

- The hepatic nodules may represent metastatic lesions. Alternatively, multi-focal inflammatory disease +/- concurrent age-related pathology is also possible.

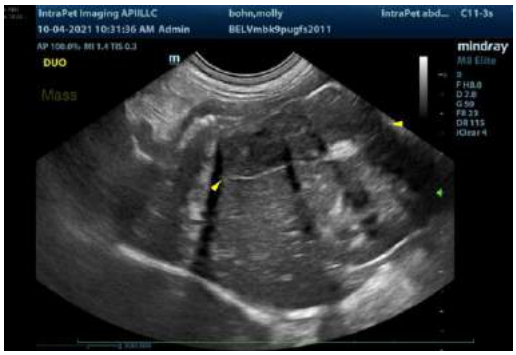
- The splenic nodule may also represent a metastatic lesion or potential benign pathology (i.e., a focus of extramedullary hematopoiesis or lymphoid hyperplasia).

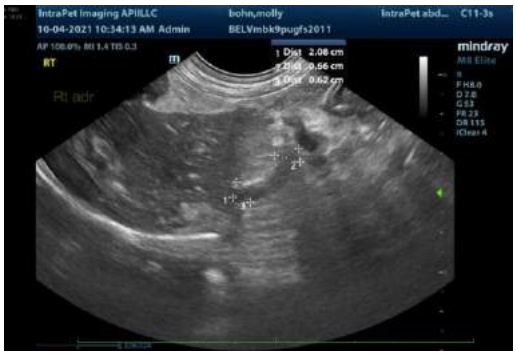
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

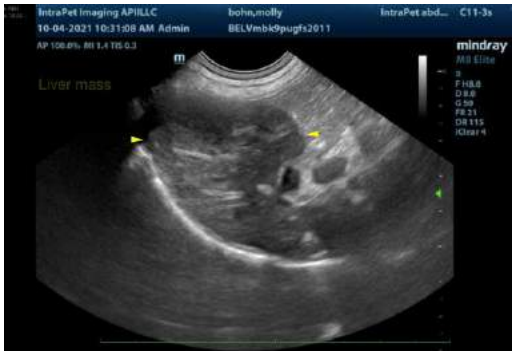
1. Three-view thoracic radiographs are recommended to assess for pulmonary metastases.

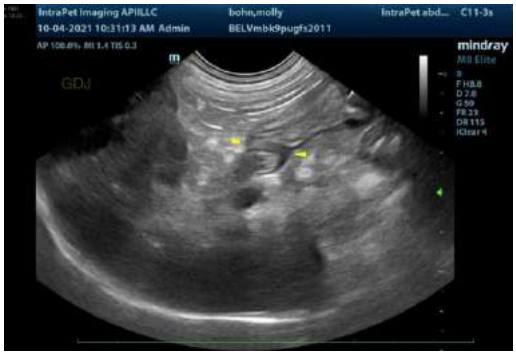
2. If accessible, fine needle aspirates of the hepatic, splenic, and duodenal lesions are recommended (if clotting status is appropriate). 25-gauge needles should be used. If the lesions are not accessible

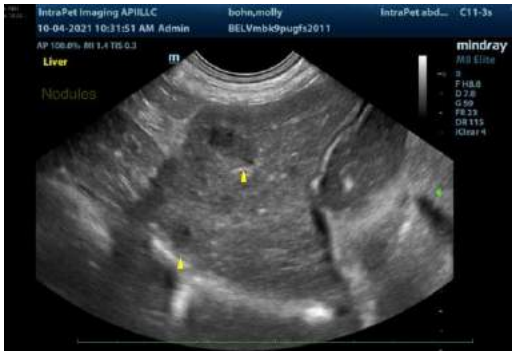
and/or cytology results are inconclusive, an abdominal exploratory with biopsies can be considered if there is no evidence of pulmonary metastatic disease.

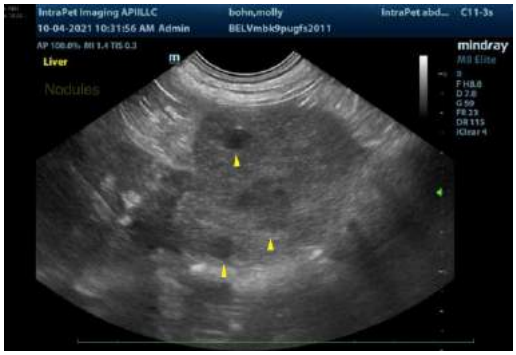


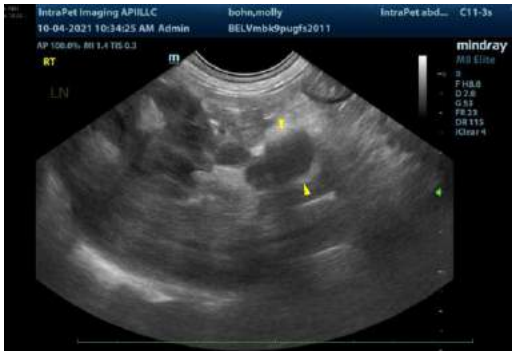












The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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