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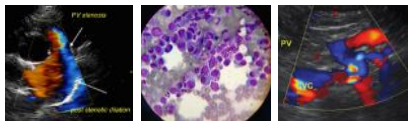

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DATE

12/22/2021

PATIENT

BB Klausmeier

SPECIES

Canine

BREED

Labrador Retriever

SEX

Spayed Female

AGE

10/2/2021

WEIGHT

75.9 Lb.

INTERPRETED BY

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

IMAGING PERFORMED BY

Stephanie Pearce RDCS, RVT

HOSPITAL NAME

Northwind Animal Hospital

REFERRING VET

Dr. Repsher

INVOICE

10060

PRESENTING CLINICAL SIGNS

History: difficulty passing stools. some dribbling of loose stool starting in beginning of December. Possible dietary indiscretion. Treated w/Metronidazole ad Proviable. little to no improvement. Repeat x rays showed formed stool in rectum not appearing able to pass. Started Gabapentin. Rectal exam strictured area palpable at fingertip.

Current Medications: stopped Metro and Proviable; administered 3 cc Dex SP IM 12/20.
Lab Results: mild elevation in ALP; mild elevation in sodium; mild elevation Lipase; mild elevation neutrophils. Attached separately.
Radiographs: possible mass in pelvic inlet; organomegaly - spleen/liver.
Date of Previous IntraPet Ultrasound: No previous scans noted.
Sedation: Not required for a full diagnostic ultrasound.
Stat Report: Not requested.

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 is moderately distended. A scant amount of echogenic debris is observed within the lumen. 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 (7.60 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney presented normal size (7.15 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 (0.64 cm at cranial pole) (0.65 cm at caudal pole) (2.90 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 enlarged (1.29 cm at cranial pole) (0.63 cm at caudal pole) (2.26 cm in length), with a slightly irregular shape. A 1.60 x 1.40 hyperechoic nodule is observed at the cranial pole. The glandular echogenicity and detail at the caudal pole are normal. Surrounding vasculature appears normal.

Spleen

The spleen is normal in size (1.79 cm in width at the level of the hilus) with a normal capsular contour. A light micronodular pattern is present throughout the parenchyma. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively prominent in size with swollen curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and exhibits mild heterogeneity. No distinct focal lesions are observed. Hepatic vasculature and 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 small to moderate amount of echogenic debris, most of which is partially dependent, and a small amount of which is suspended, is

observed within the lumen. The cystic and common bile ducts are normal.

Gastrointestinal
The gastric lumen is not distended. The gastric wall is normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. Two segments of descending colon are severely thickened and irregular with a loss of the normal layering pattern. The more cranial segment measures approximately 4 cm. The wall in this region is up to 2.07 cm in width. In the more distal section (at the level of the cysto-urethral junction), the thickened segment is approximately 6 cm. The wall in this segment measures up to 1.56 cm in width. The mesentery effacing the serosal surface of the thickened colonic wall is hyperechoic. The wall areas of wall are vascular There is shadowing fecal material within the lumen of the thickened segments. Partial colonic obstruction is suspected.

Pancreas
The region of the pancreas is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional inflammation or effusion.

Free Abdomen
Trace free fluid is observed. There is no evidence of inflammation or effusion. One to two enlarged irregular hypoechoic caudal abdominal lymph nodes are visualized, the largest measuring 3.36 cm in length.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Descending colonic wall masses with suspected partial obstruction. Neoplasia (i.e., lymphoma, adenocarcinoma) is suspected with a lower possibility of benign pathology (i.e. severe pyogranulomatous inflammation). Regional peritonitis is present.

Secondary Findings

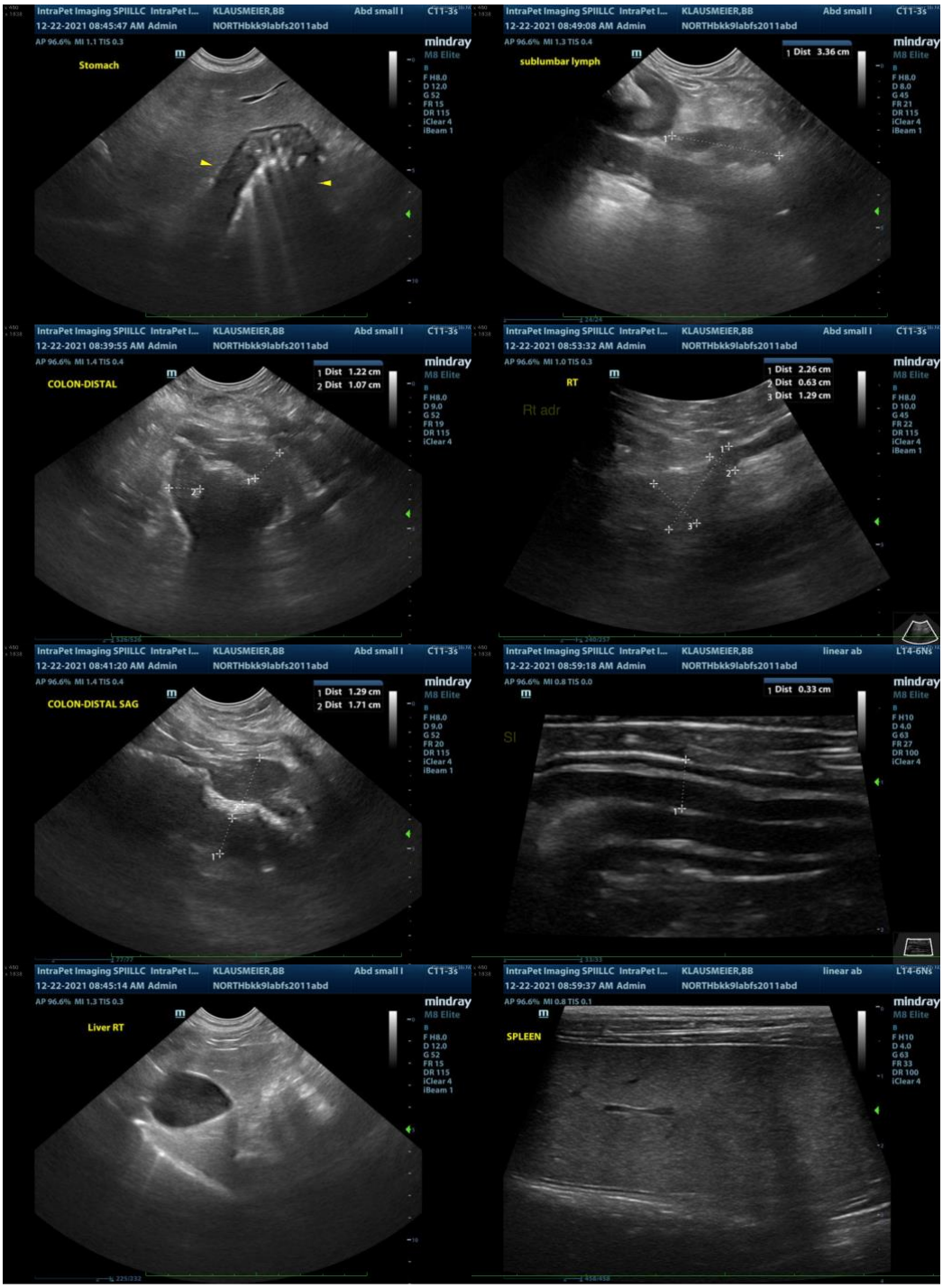
- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory and infiltrative disease are considered less likely.
- Gall bladder debris-incidental
- The splenic parenchyma changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis or splenitis with a low possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).
- The right adrenal nodule could be consistent with benign pathology (i.e., nodular hyperplasia). Alternatively, emerging neoplasia may be present.

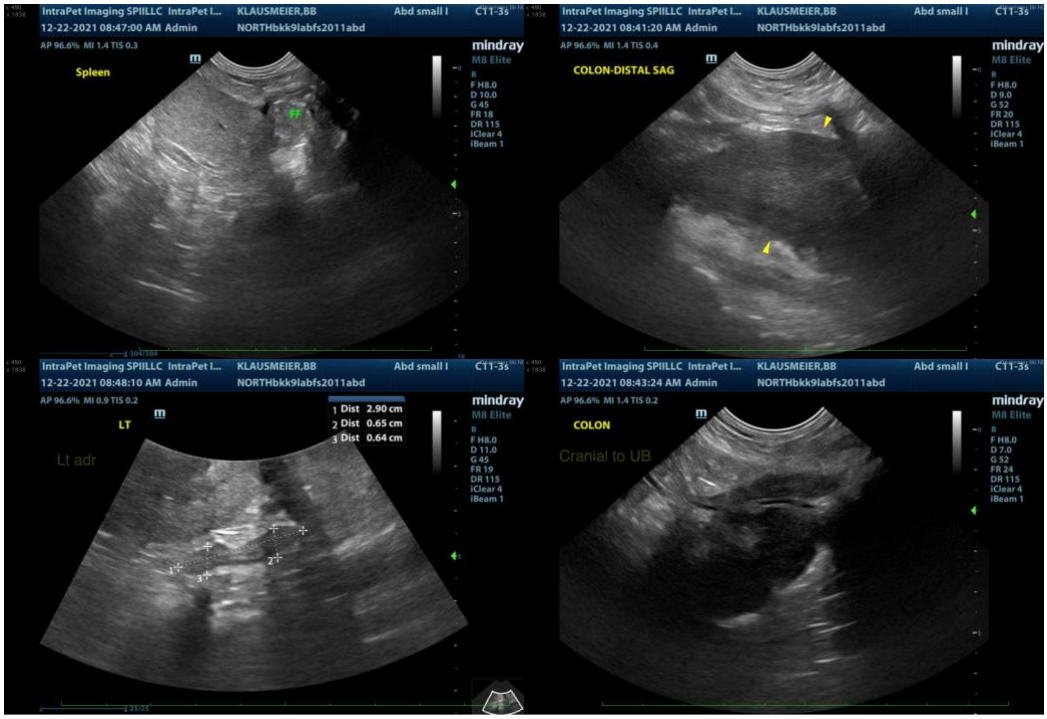
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
- Fine-needle aspirates of the thickened colonic wall segments are recommended if clotting status is appropriate. Care should be taken to avoid penetrating the colonic lumen with the needle. If

cytology results are inconclusive, surgical or endoscopic biopsies may be necessary to get a definitive diagnosis.

- In the meantime, consider a stool softener (i.e., lactulose) to help facilitate defecations.





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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