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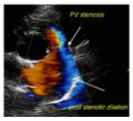
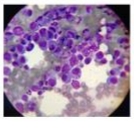
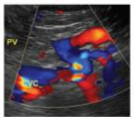

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PATIENT

Cole Gunnink 269620

SPECIES

Canine

BREED

Labrador Retr

SEX

Neutered Male

AGE

6 years

WEIGHT

31.8 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VET

WVRC-Dr. Blanco

INVOICE

11106

DATE

6/17/22

PRESENTING CLINICAL SIGNS

History: 1 month history of vomiting; AXR 6/16 show mass-effect in right cranial abdomen (soft tissue/fluid + gas + mineral opacity within mass), large distended stomach, concern for possible obstructive GI mass. Otherwise healthy
Abnormal PE/Chem/CBC/UA Results: albumin 1.7 (normal glob); otherwise WRI CBC/Chem/Unremarkable abdomen

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

The left kidney is normal size (6.69 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.

The right kidney is normal size (6.97 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.

Adrenal Glands

The left adrenal gland is normal size (0.64 cm at cranial pole) (0.72 cm at caudal pole); 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 in size (0.70 cm in width); normal shape, glandular echogenicity and detail. Surrounding vasculature appears normal.

Spleen

The spleen is normal in size (2.13 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.

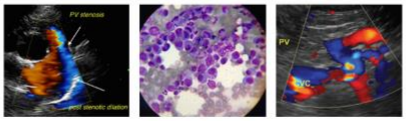
Liver

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 lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is severely fluid distended and hypomotile. An irregular hyperechoic shadowing structure is observed within the fluid. The gastric wall is normal in thickness with a normal layering



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pattern. The pyloric outflow tract is difficult to visualize, but appears patent. The proxomal duodenal lumen is severely fluid-distended and hypomotile. A few centimeters from the pyloric outflow tract, a >10 cm, irregular, hypoechoic mass effect is arising from the duodenal wall. There is a complete loss of the normal layering pattern in this region. The mesentery surrounding this lesion is hyperechoic to saponofied with suspected dissecting free fluid. Distal to the mass effect, there is a short segment of bowel that is dialted with chyme. The remaining small intestinal loops are empty. The small intestinal wall distal to the mass is normal in thickness with a normal layering pattern and appropriate mural detail. The colonic wall is normal.

Pancreas

The region of the pancreas left limb is isoechoic relative to surrounding omental fat. No obvious pathology seen in this region. The base/right limb is largely obscured by the large duodenal mass. In the visualized portions, the pancreas appears prominent to enlarged with irregular peripheral contours. The parenchyma is hypoechoic. Surrounding mesentery is hyperechoic

Free Abdomen

A small amount of anechoic free fluid is visualized. A 1.60 medial iliac lymph nodes is visualized. The node is normal in shape and echogenicity.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Large duodenal mass effect. Neoplasia (i.e., lymphoma, adenocarcinoma) is suspected. However, a severe inflammatory process (i.e., secondary to a perforated foreign body) cannot be completely excluded. Cranial peritonitis is present, likely secondary to bowel pathology. The lesion appears to be at least partially obstructive. Bowel perforation is a consideration.
- The shadowing material within the gastric lumen may represent fecal material and/or normal ingesta.
- The pancreatic changes in the right limb are suggestive of acute pancreatitis, likely secondary to the duodenal mass effect.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A fine-needle aspirate of the mass with a STAT cytology. However, due to the concern for the possibility of a bowel obstruction (+/- perforation) an abdominal exploratory with biopsy, +/- removal of the duodenal mass should be considered. If surgery is pursued, referral to a board-certified surgeon is recommended due to the potential for perioperative complications. Depending on the appearance of the pancreas at the time of surgery, a jejunostomy tube may be warranted to provide post-operative nutrition, given the likelihood of worsening pancreatitis following surgery.

Thoracic radiographs are recommended prior to anesthesia to assess for occult aspiration pneumonia.

Given the sonographic changes, the prognosis for this patient is considered guarded.

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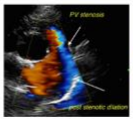
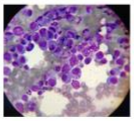
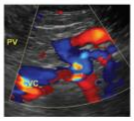

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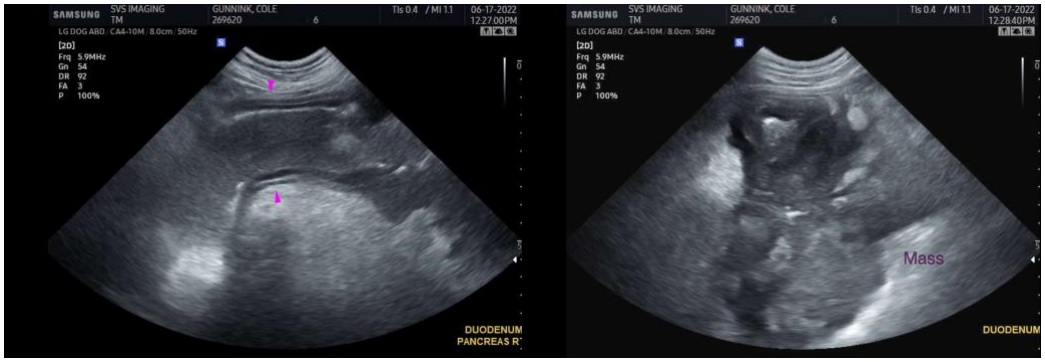

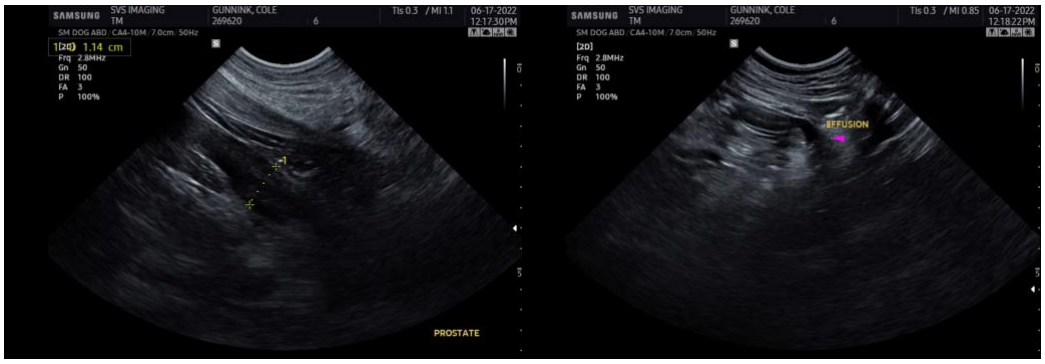

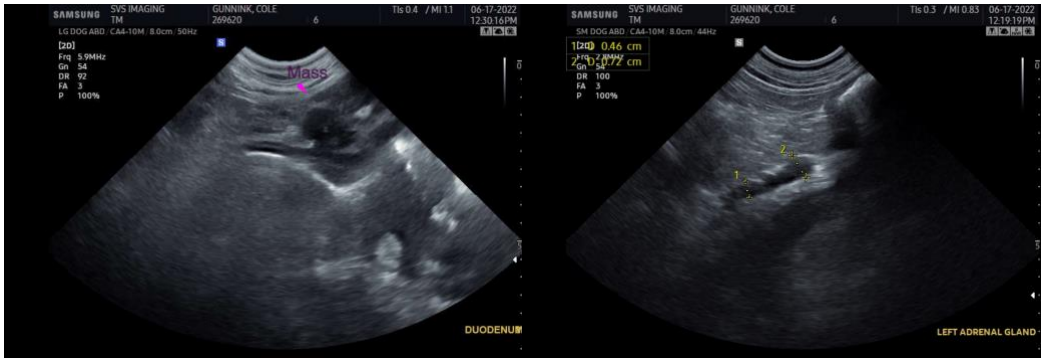

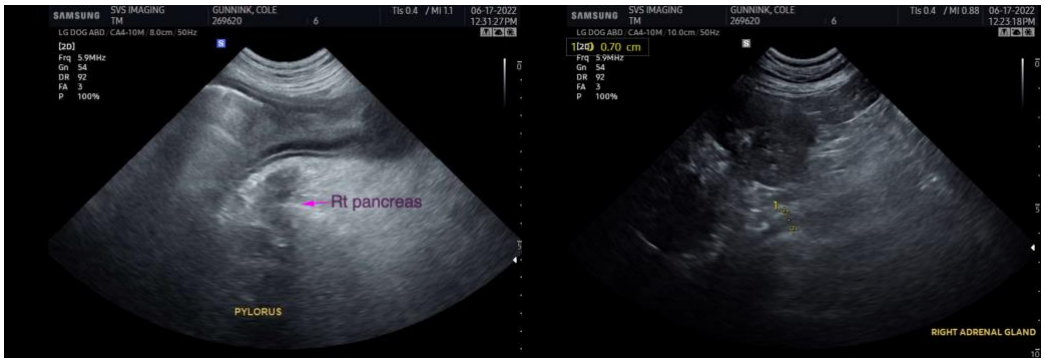

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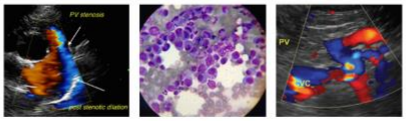

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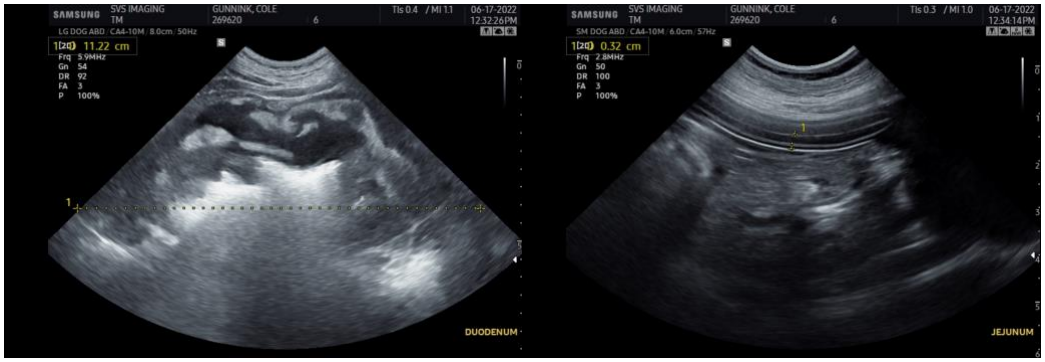

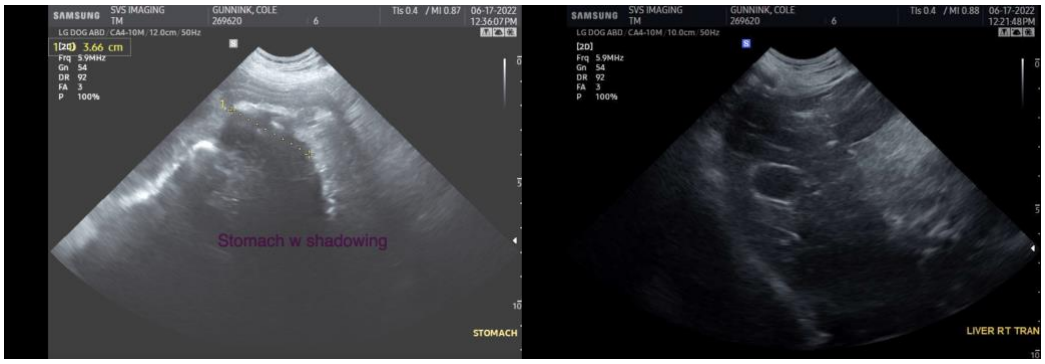

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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