



PATIENT

Wilson Stewart

SPECIES

Canine

BREED

Boxer

SEX

Male Neutered

AGE

10 Years

WEIGHT

68.2 lbs.

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

Potomac Mobile
Veterinary Ultrasound

HOSPITAL NAME

Vets and Pets Animal
Hospital

REFERRING VET

Dr. Jarrett

INVOICE

11671kk

DATE

8/19/21

PRESENTING CLINICAL SIGNS

History: Diarrhea going on for months. Recently moved from Arizona to West Virginia. Dramatic weight loss; has lost over 20lbs in last couple of months. Lost 4 pounds since last week. Now has started vomiting, not eating. Given Metronidazole 500 mg 1 bid, which isn't helping (client has a hard time getting him to keep down medication). Trembling at home at times.

Abnormal PE/Chem/CBC/UA Results: Chem- ALB 2.5, ALP 446, BUN 5 Precision PSL 258 CBC Plt 455 T4 1.0 Fecal neg 4dx neg Lateral left view of chest- NSF

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is minimally distended. The wall is of appropriate thickness for the level of repletion. Several small (< 0.5 cm) cystic calculi are visualized. A small amount of mineralized sand is observed in the urinary bladder neck/proximal urethra. The remaining luminal contents are anechoic. The region of the trigone and the proximal urethral wall are normal.

The prostate is normal in size (2.41 cm in length, 0.92 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 (5.97 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. Renal vasculature is normal.

The right kidney is normal size (5.64 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.

Adrenal Glands

The left adrenal gland is normal size (0.77 cm at cranial pole) (0.74 cm at caudal pole) (2.69 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.

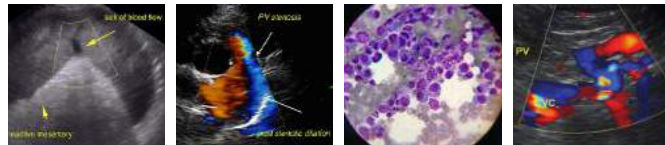
The right adrenal gland is normal size (0.64 cm at cranial pole) (0.55 cm at caudal pole) (2.70 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (1.54 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/Gall bladder

The liver is subjectively normal in size. Most of the peripheral contours appear normal. The parenchyma is hypoechoic relative to the spleen and is slightly mottled in appearance. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion. See also "Other" category.



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The gall bladder lumen is moderately distended. The wall is thin and smooth. A moderate amount of gravity-dependent echogenic debris is observed within the lumen. A small amount of debris is also adhered to the luminal surface. The cystic and common bile ducts are normal/not seen.

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Gastrointestinal

The gastric lumen is mildly fluid distended and hypomotile. The gastric wall is normal in thickness with a normal layering pattern. The small intestinal lumen is segmentally fluid distended. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The wall of the descending colon is mildly thickened (up to 1.01 cm) with retention of the normal layering pattern. The lumen of the descending colon contains granular appearing fecal material. There is no obvious evidence of obstruction.

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Pancreas

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The region of the left and right limbs appears isoechoic relative to surrounding omental fat. No obvious pathology is observed in these regions. See also "Other" category.

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Free Abdomen

There is no evidence of free fluid.

Lymph Nodes

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See "Other" category below.

Other

A 5.32 x 3.38 cm echogenic mass-effect is observed just cranial to the stomach at the caudal aspect of the liver. The lesion exhibits mild heterogeneity and is hyperechoic relative to the liver.

INTERPRETED BY

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

ULTRASONOGRAPHIC FINDINGS

- The colonic wall changes are most consistent with colitis. Differentials include histiocytic ulcerative colitis, granulomatous colitis (i.e., fungal), lymphoplasmacytic colitis/inflammatory bowel disease, emerging neoplasia, other.
- Mild gastrointestinal stasis likely secondary to underlying GI pathology.
- Mass-effect in the cranial abdomen. The origin of which is unclear. It may be arising from liver, pancreas, lymph node, or other. A hepatic origin is suspected. Neoplasia is possible; although, a granuloma or other benign pathology (i.e., hepatocellular swelling) cannot be completely excluded.
- Cystic calculi.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

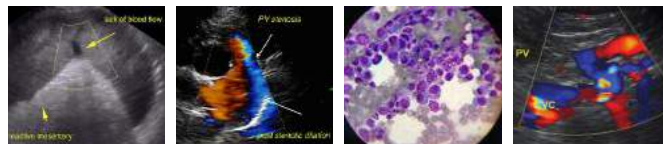
1. Given the possibility of intrabdominal neoplasia, three-view thoracic radiographs are recommended to assess for pulmonary metastatic disease.
2. Regarding the gastrointestinal signs, the following diagnostics/therapeutics are recommended:
 - a. A fecal evaluation for ova/Giardia

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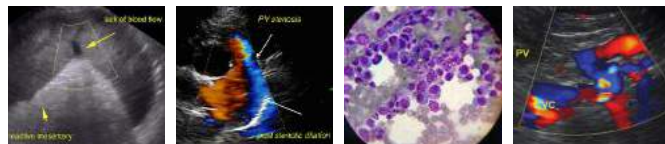
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- b. Prophylactic deworming with Fenbendazole at 50 mg/kg once a day for 5 days is recommended. Repeat above protocol in 3 weeks.
- c. A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended.
- d. A 6-week limited antigen diet trial.
- e. Consider empirical treatment for histiocytic, ulcerative colitis with enrofloxacin. A positive response should be seen within 2 weeks of initiating therapy if this disease is present. However, a full 8-12 weeks of therapy is recommended if a response is seen. If a more aggressive approach is desired, consider an abdominal exploratory with biopsy or removal of the cranial abdominal mass along with gastrointestinal biopsies. Colonic biopsies should also be obtained, preferably via colonoscopy (which can be performed either immediately before or following surgery). Fluorescent *in situ* hybridization (FISH) should be performed on colonic tissue samples to assess for invasive *E. coli* within colonic macrophages, which is integral to diagnosis of the disease. An abdominal CT scan would be useful in presurgical planning, particularly with regard to the cranial abdominal mass-effect. If surgery is pursued, the cystic calculi should also be removed and submitted for stone analysis and culture. Thoracic radiographs (3-view) should be performed prior to any anesthetic event.





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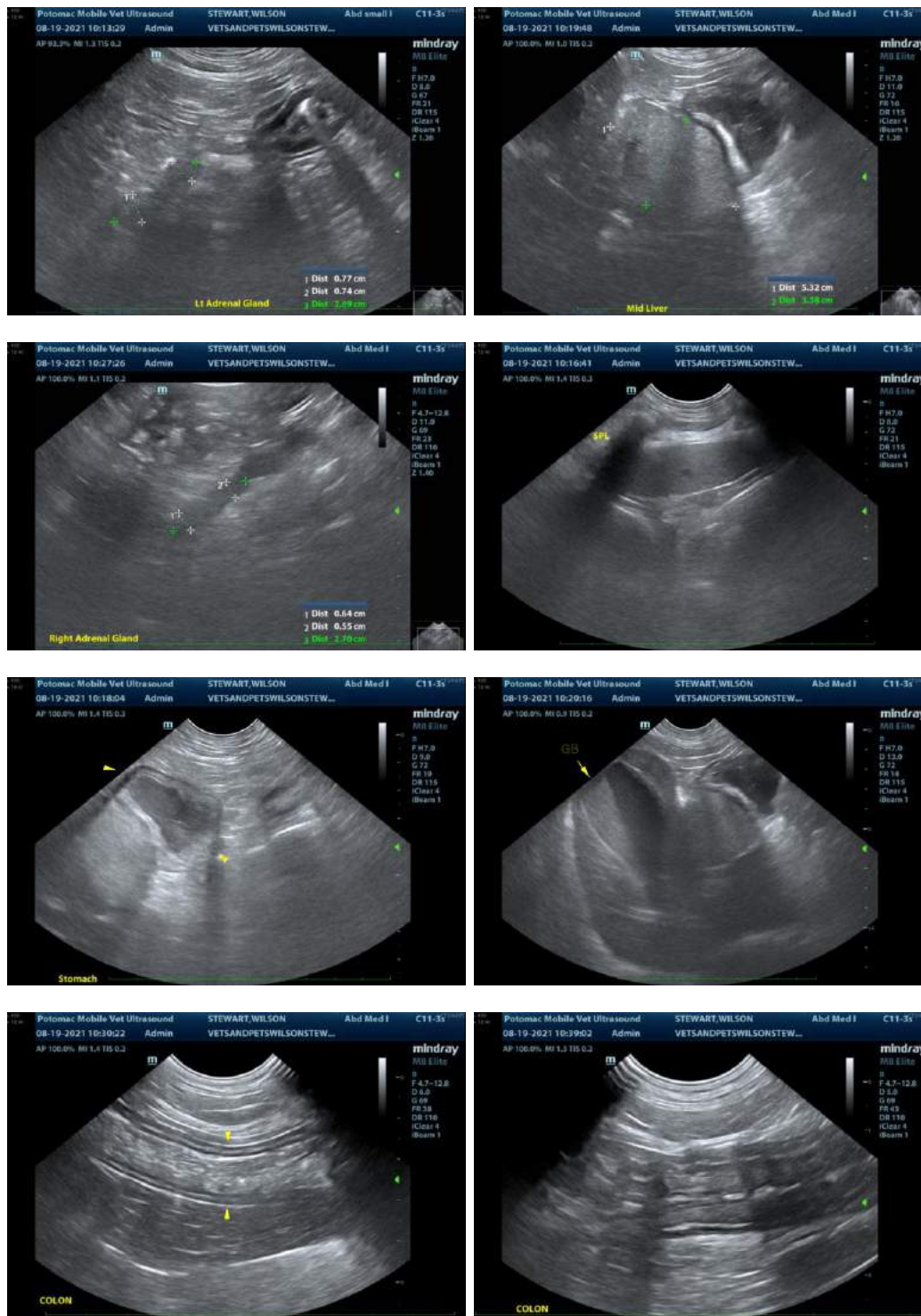
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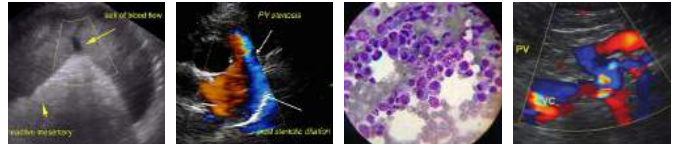
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.



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

Andrea.nicastro@sonopath.com

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