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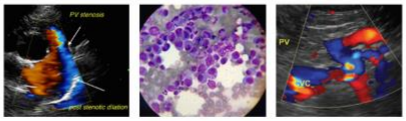

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Clinical Sonography & Telecytology
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PATIENT

Flash Oakley 278063

SPECIES

Canine

BREED

Dachshund

SEX

Intact Male

AGE

3 years

WEIGHT

6.4 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. Jochman

INVOICE

11566

DATE

9.1.22

PRESENTING CLINICAL SIGNS

History: Presented for vomiting. 10 days ago Flash started out appearing off- lethargic. On 8/25 he was started on prednisone and gabapentin due to concern for back/neck pain. BW showed low ALT and low albumin. On 8/29 he ate breakfast but started vomiting water. Prednisone was stopped on 8/30. Continued anorexia and lethargy. Polydipsic no polyuria. No coughing or respiratory changes at home. No diarrhea at home

Abnormal PE/Chem/CBC/UA Results: BW from 8/25: CBC - Neu 8.528 (H), Mono 2.516 (H), nRBCs 3 (H), PLTS 456 (H); otherwise WNL --> Stress leukogram Chem - TP 7.9 (H), Alb 1.9 (L), Globs 6.0 (H), ALT 13 (L); otherwise WNL 9/1: Chem: Glu 116 (N), BUN 135 (H), Creat 6.5 (H), Phos 21.4 (H), Cal 7.6 (L), Na 139 (L), Cl 89 (L), TP 9.8 (H), Alb 1.9 (L), Glob 8 (H), ALT 56 (N), AST 67 (H), tbili 0.4 (H), Cholesterol 126 (L), CK 687 (H) CBC: WBC 16.2 (H), Neut 11756 (H), PLT 271 (N) --> Stress leuk UPC: 10.4 (H) (!!!) --> Concern for glomerular disease

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** is 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 enlarged (2.19 cm in width) with a slightly irregular shape. Parenchyma is heterogenous with at least one hyperechoic nodule measuring 0.37 cm in diameter. The prostatic urethra is not overtly dilated.

The **left kidney** is normal size (4.99 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. The cortex is hyperechoic. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The **right kidney** is normal size (5.07 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

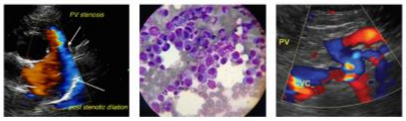
The **left adrenal gland** is normal size (0.48 cm at cranial pole) (0.51 cm at caudal pole); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The **right adrenal gland** is normal size (0.43 cm at cranial pole) (0.49 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.

Spleen

The **spleen** is normal in size (1.03 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



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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. A scant amount of echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The **gastric lumen is** not distended. The gastric wall is mildly thickened (up to 0.66 cm) with questionable retention of the normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. An approximately 4.50 to 5.00 cm segment of jejunum is severely thickened (up to 0.94 cm) with loss of the normal layering pattern and a mass effect. Adjacent to this segment, a 1.12 x 0.97 cm focal nodular thickening is observed in within the jejunal wall. The remaining small intestinal segments are normal in thickness with a normal layering pattern. The ileocecal colic junction is normal. A segment of proximal descending colonic wall is thickened (up to 0.41 cm) with questionable loss of the normal layering pattern. There is no evidence of an obstructive pattern.

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. Numerous enlarged, hypoechoic, rounded **lymph nodes** are observed throughout the abdomen, the largest measuring 4.57 cm in length. A few of the nodes are slightly heterogenous in appearance. Surrounding mesentery is hyperechoic.

Other

The testicles are subjectively normal in size, the left measuring 2.50 x 1.63 cm; the right 2.33 x 1.52 cm, with normal shape and homogenous parenchyma. No obvious pathology is observed.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The severe abdominal lymphadenopathy is concerning for infiltrative neoplasia (i.e., round cell tumor) with a lower possibility of severe lymphadenitis (i.e., pyogranulomatous).
- The jejunal mass effect and focal nodular jejunal lesion are both concerning for infiltrative neoplasia (i.e., round cell tumor).
- The gastric and colonic wall changes could be consistent with emerging neoplasia, inflammatory disease, or less likely, hypertrophy.
- The bilateral renal changes in conjunction with the azotemia are consistent with chronic interstitial nephrosis/nephritis.
- The trace ascites is likely secondary to bowel and/or lymph node pathology.

Secondary Findings

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- The prostate changes are consistent with benign prostatic hyperplasia. Concurrent bacterial prostatitis should be a consideration, particularly if there is evidence of a urinary tract infection on the urinalysis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

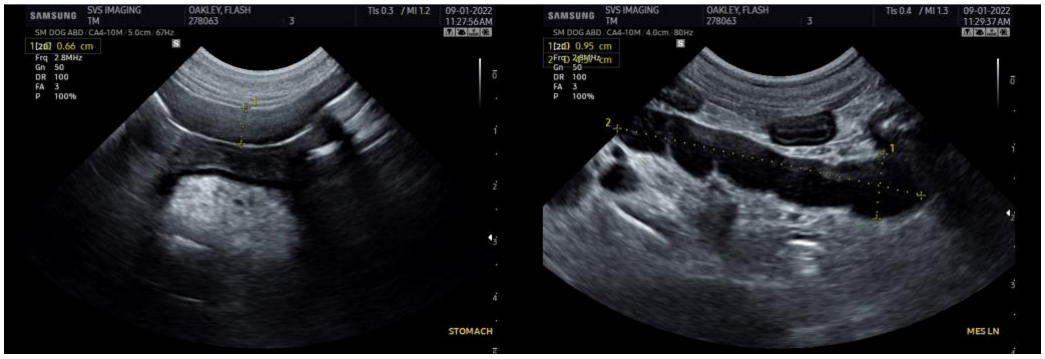
Thoracic radiographs are recommended to assess for occult disease in the chest.

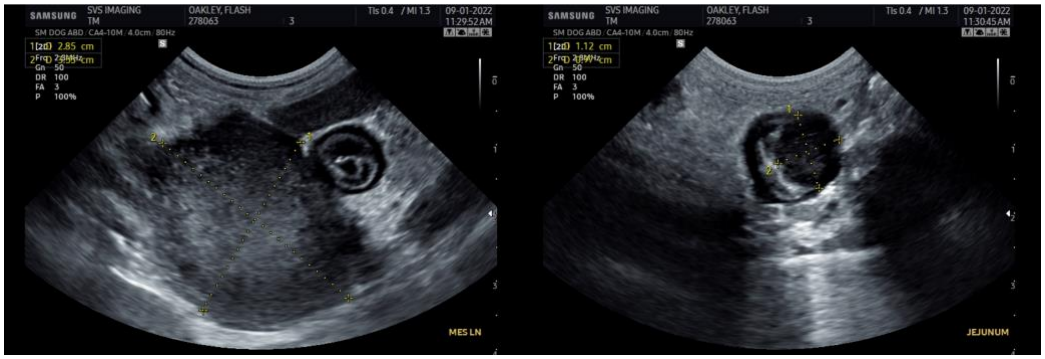
Fine-needle aspirates of the enlarged abdominal lymph nodes and jejunal mass effect are recommended if clotting status is appropriate. Twenty-five gauge-needles should be used. If cytology results are inconclusive, surgical biopsies may be necessary to get a definitive diagnosis.

Also consider a malabsorption panel including serum cobalamin and folate, TLI and PLI.

Regarding the patient's azotemia, consider the following:

1. Urinalysis and urine culture and sensitivity
2. Baseline blood pressure measurement, UPC (if proteinuria is present in the absence of infection)
3. IV fluid diuresis and supportive care.





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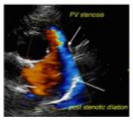
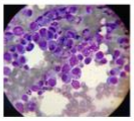
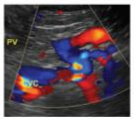

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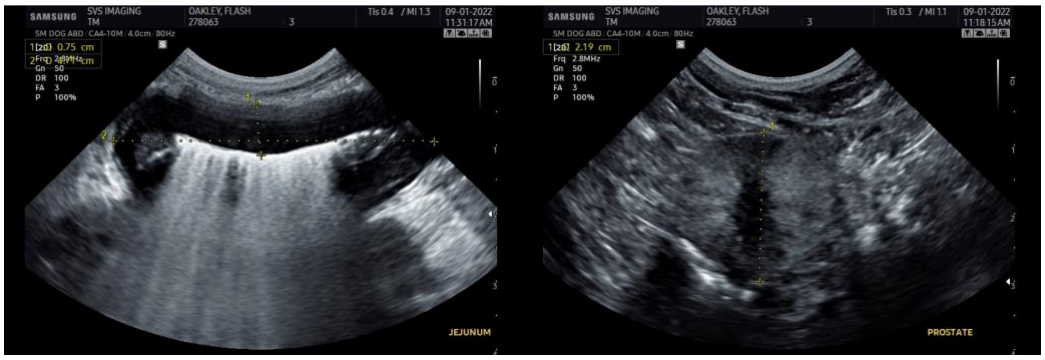

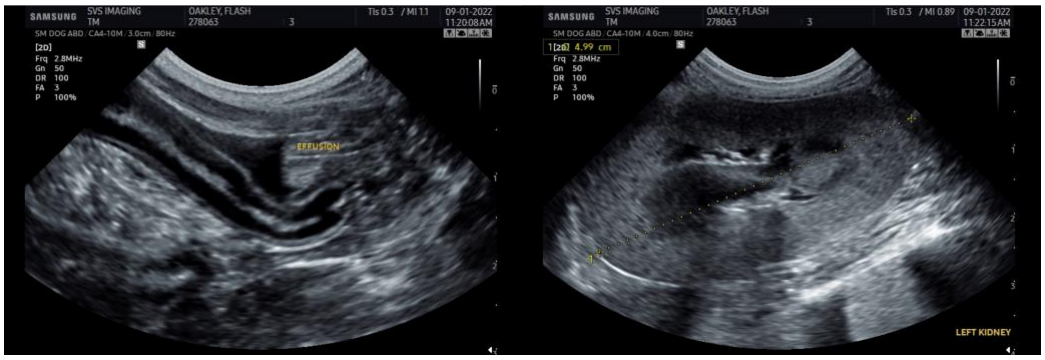

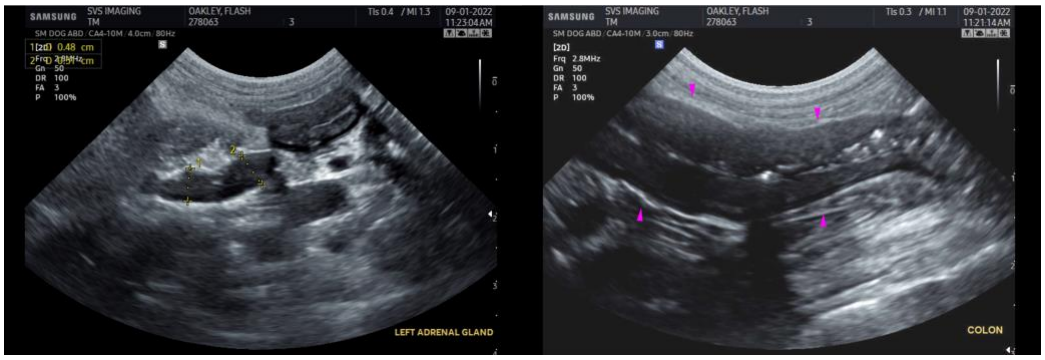

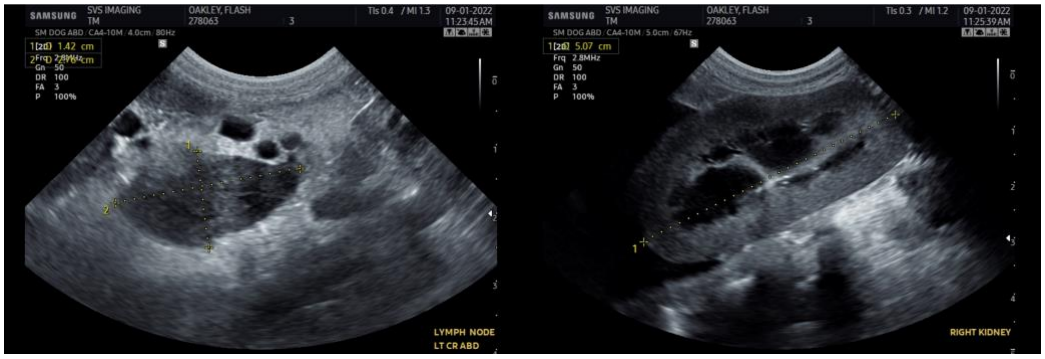

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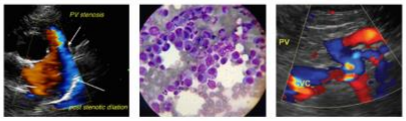

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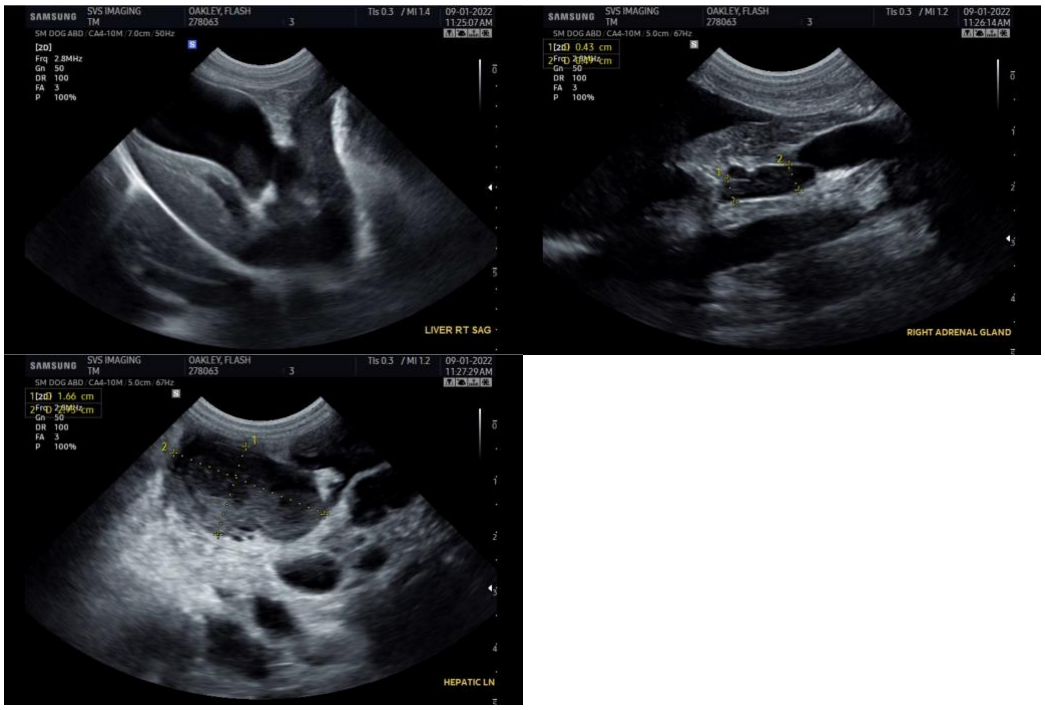

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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