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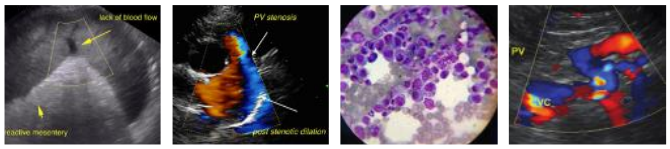


SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Penelope Jones

SPECIES
Canine

BREED
Shih Tzu

SEX
Spayed Female

AGE
17 Years

WEIGHT
8 Pounds

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Elaina Petrone

HOSPITAL NAME
Long Brach AH

REFERRING VET
Elaina Petrone

INVOICE
20736

DATE
1/23/23

PRESENTING CLINICAL SIGNS

History: 17 yo FS Shih tzu, under the care of an oncologist for multicentric lymphoma. Also mammary mass-per oncologist consistent with neoplasia on cytology. Owner and oncologist have been monitoring the mass and report it is stable in size. Recently losing weight, referred for AUS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with occasional echogenic non-shadowing debris, most consistent with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can also present with echogenic debris. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Left kidney is not well visualized in these images.

Right kidney is normal is size (4.29 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

Left adrenal gland is not well visualized in these images.

Right adrenal gland is normal in size (1.0 cm at cranial pole and 0.67 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large in size with a swollen and scalloped/undulating capsular contour. Multifocal coalescing nodules are noted throughout the parenchyma. Splenic vasculature appears normal. Enhanced hyperechoic surrounding fat is noted.

Liver

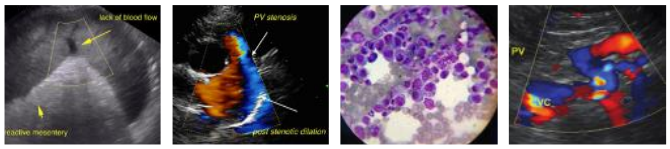
Liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are diffusely normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease. Focally, in the mid abdomen, there is one bowel loop that is focally, mildly bigger than the other, measuring 0.5 cm thick with normal intact layering maintained.



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The visible colon is normal in wall thickness and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The observed pancreas appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

The mesenteric lymph nodes are enlarged with swollen irregular capsular contour and loss of normal length to width ratio (rounded in shape). Nodes are hypoechoic with loss of normal parenchymal detail. A very scant amount of anechoic free fluid is noted around the enlarged lymph nodes.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Honeycomb Spleen – This finding is strongly suggestive of infiltrative disease such as round cell neoplasia. Benign disease cannot be ruled out but is considered less likely.
- Aggressive mesenteric lymph nodes – most consistent with infiltrative round cell or metastatic neoplasia. A benign aggressive inflammatory response cannot be ruled out without tissue sampling +/- culture.
- A possible focal mid abdominal small bowel thickening without loss of layering. This could represent normal patient variant or given the focal change, compared to the remainder of the bowel, could be suggestive of emerging neoplasia and can't be differentiated without tissue sampling.

Secondary Findings

- Urinary bladder debris

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

A fine needle aspirate of the enlarged abdominal lymph nodes could be considered if patient coagulation status is appropriate, as could a fine needle aspirate of the spleen. However, given patient history, infiltrative neoplasia/metastatic disease is considered highly likely.

If not recently evaluated, Urinalysis and, if indicated based on urinalysis results, urine culture are recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

Given the suspicion of possible small bowel involvement, further evaluation of possible malabsorption that could potentially be managed medically, could be investigated via gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

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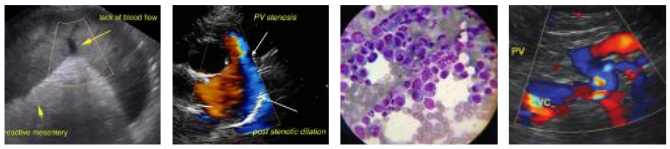

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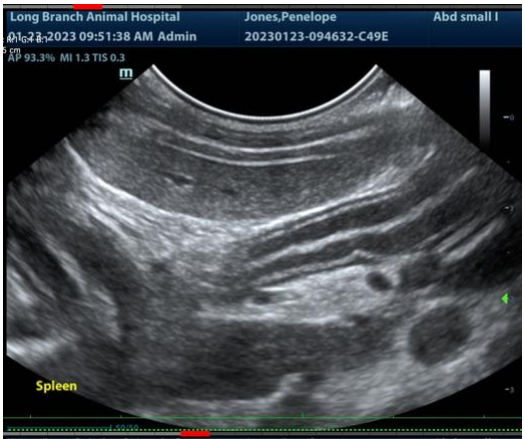

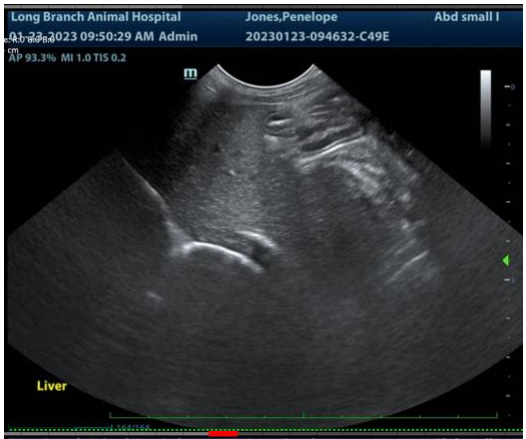

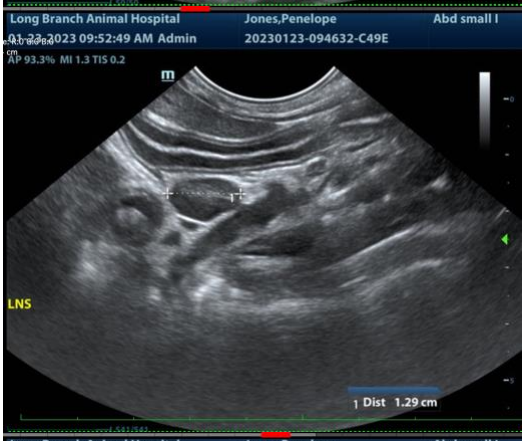

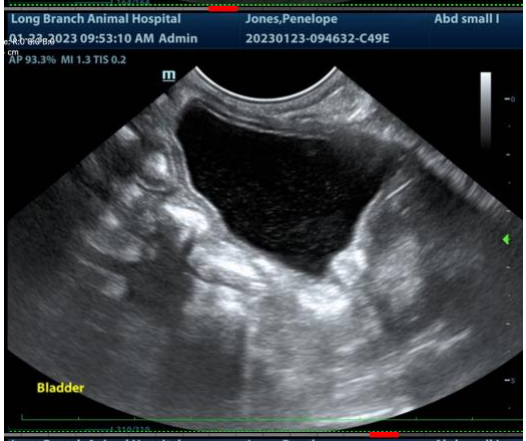

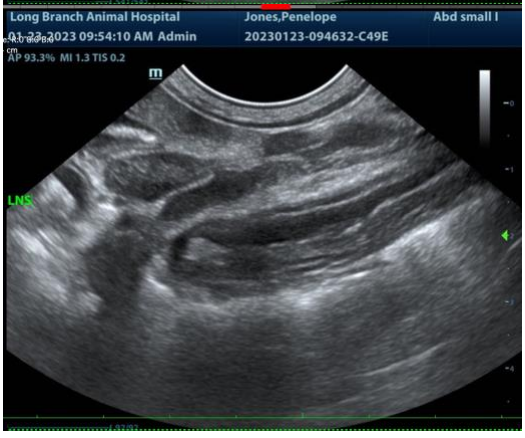

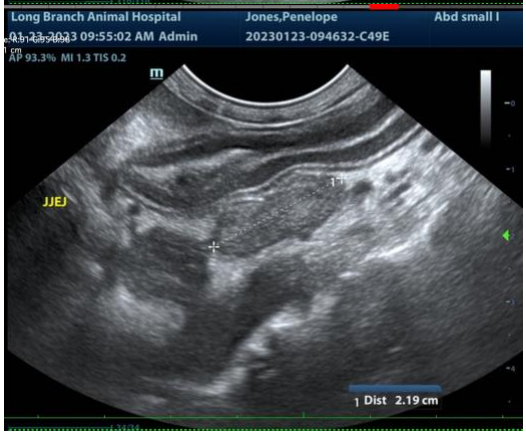

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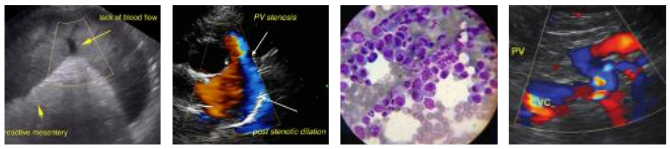

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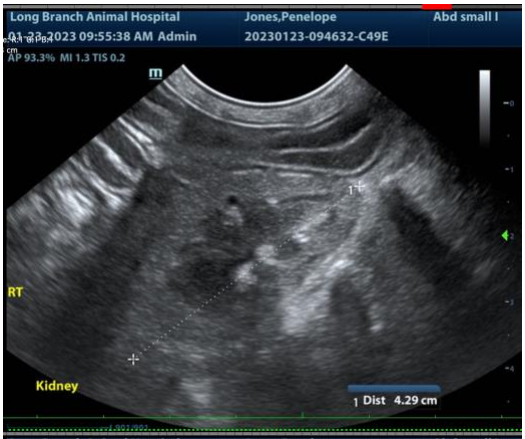

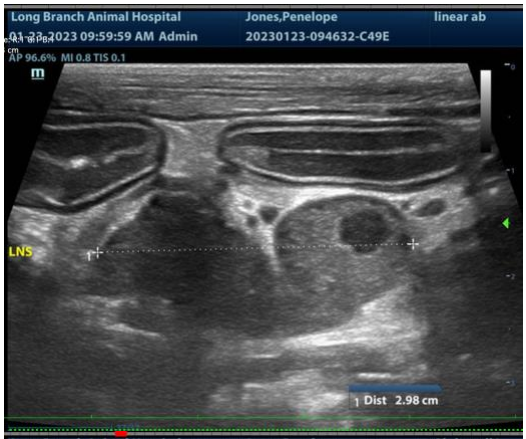

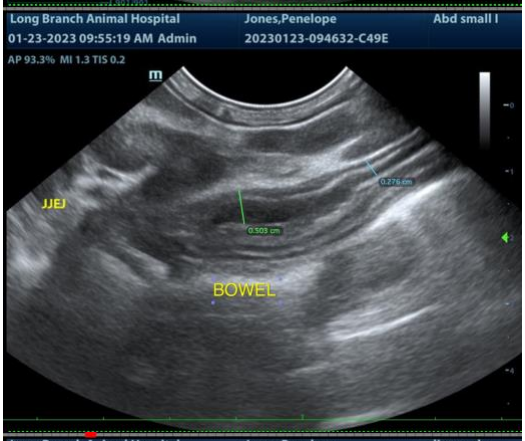

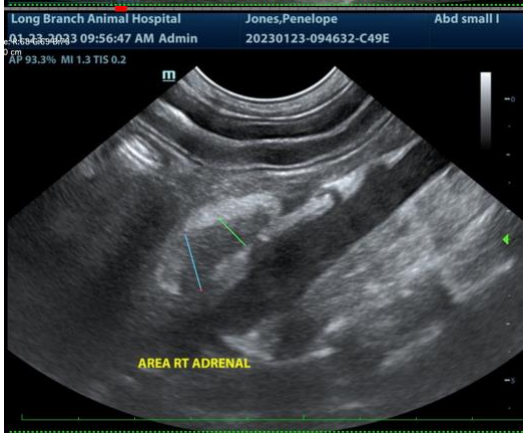

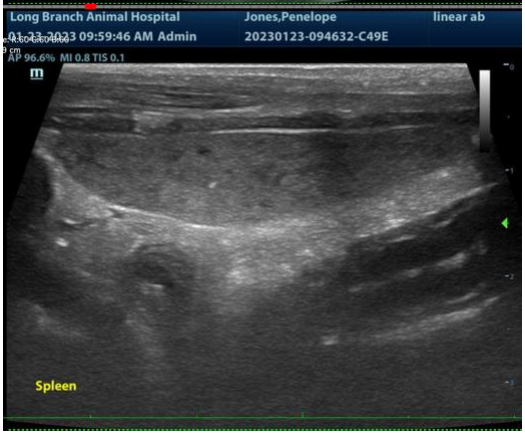

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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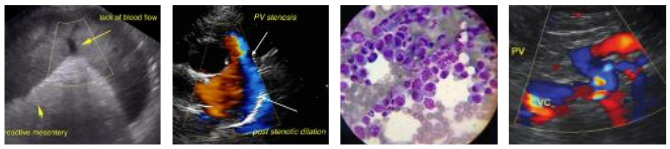

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