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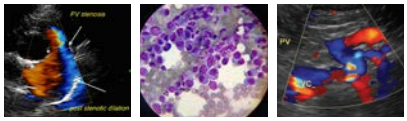

SonoPath
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DATE

1/18/22

PATIENT

Cooper Frey

SPECIES

Canine

BREED

Jack Russell Terier

SEX

Neutered Male

AGE

10/14/08

WEIGHT

14.9 Pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Stephanie Pearce
RDCS, RVT

HOSPITAL NAME

Hickory Vet Hospital

REFERRING VET

Dr. McNesby

INVOICE

34365

PRESENTING CLINICAL SIGNS

History: Patient presented on 1/5/2022 for decreased appetite, pica, and licking excessively (carpet, furniture, etc). Marked weight loss (2.5 lbs in past month). Physical exam revealed BCS of 3, mm pale pink/white.
Labwork - chemistries normal, regenerative anemia (Hct 15.6%), fecal neg. Treated with Doxycycline and Prednisone. Hct initially rebounded to 16.9%, but recheck Hct on 1/14/22 showed decreased Hct to 13.7%. Clinically, patient is better (eating better) since on Prednisone.

Current Medications: Prednisone 7.5 mg BID, Doxycycline 50 mg BID, Probiotic (Mycequin).
Lab Results: Attached separately.
Date of Previous IntraPet Ultrasound: No previous IntraPet scans.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is moderately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Prostate (neutered) is normal in size, echotexture and echogenicity for a neutered male.

Right kidney is normal in size (4.67 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.

Left kidney is normal in size (4.38 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

Right adrenal gland is normal in size (1.67 cm long x 0.33 cm at the cranial pole and 0.37 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Left adrenal gland is normal in size (1.58 cm long x 0.54 cm at the cranial pole and 1.0 cm at the caudal pole), shape and contour. The caudal pole is near the upper end of normal range. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively hypovolemic/small in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

Hyperechoic hepatomegaly – most consistent with benign steroid (endocrine) hepatopathy or reactive or idiopathic hepatopathy. Infiltrative neoplasia such as round cell neoplasia is also possible, but considered less likely.

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 stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) and layering. The lumen of the stomach is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). 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. in the mid abdomen, there is a focal area of thickened bowel measuring 0.7 cm thick with concentric loss of normal layering and a hypoechoic appearance to the wall. This section measures 3.4 cm in length.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

Pancreatic parenchyma is appropriately isoechoic to surrounding tissue. Visible capsule is smooth and normal in contour. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

A very scant amount of anechoic free fluid is noted in the caudal abdomen. There is no apparent lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

- Mid abdominal small bowel mass – most concerning for infiltrative neoplasia such as round cell neoplasia or carcinoma.
- Hyperechoic hepatomegaly canine – most consistent with benign steroid (endocrine) hepatopathy or reactive or idiopathic hepatopathy. Infiltrative neoplasia such as round cell neoplasia is also possible, but considered less likely.
- Mildly enlarged left adrenal caudal pole – of unknown clinical significance.
- Small spleen – suggestive of hypovolemia.
- Very scant amount of anechoic free fluid in the caudal abdomen.

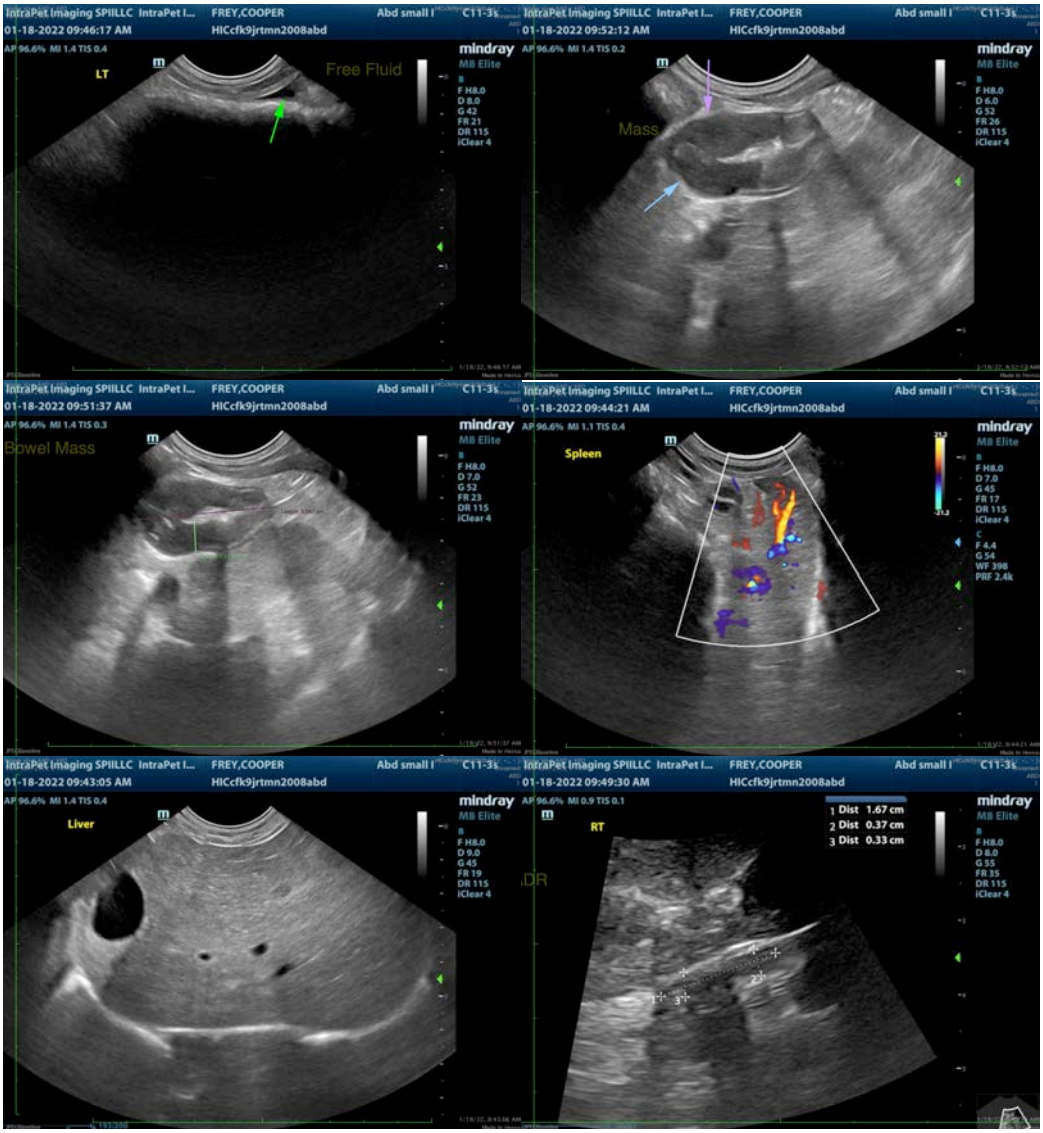
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

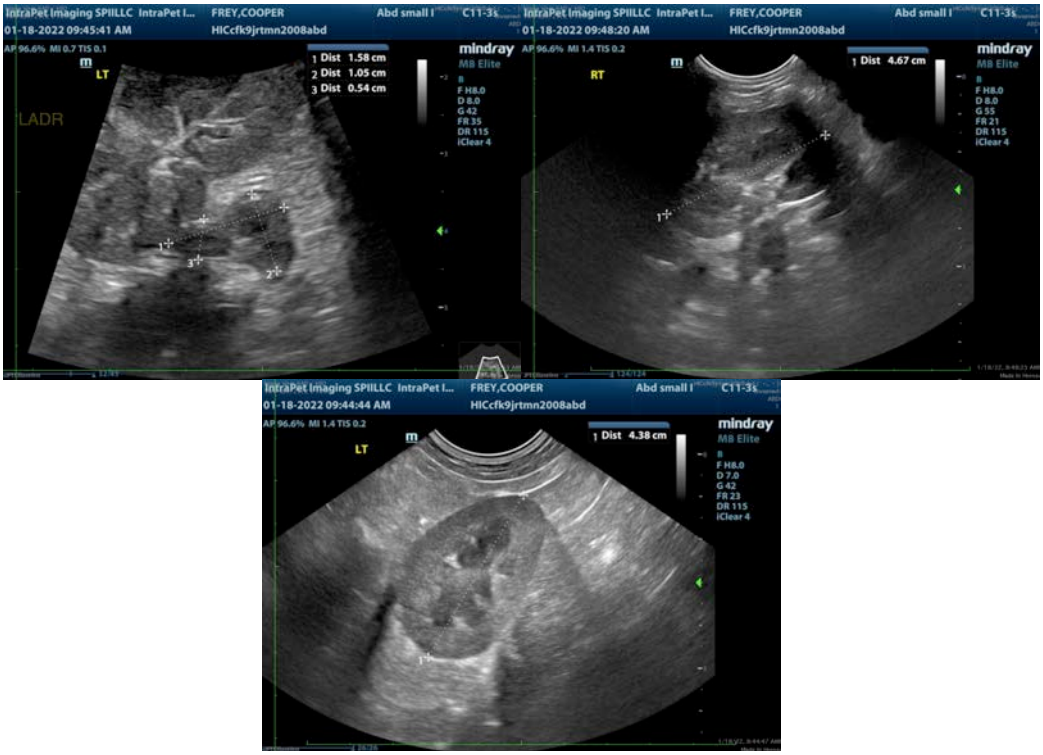
Recommendations include 3-view thoracic radiographs to further assess cardiopulmonary status and look for evidence of metastatic disease if not already performed.

Given this patient's progressive anemia, there is a concern for GI blood loss at the level of the mass, or autoimmune hemolysis secondary to infiltrative neoplasia, and therefore the recommendations are to stabilize the patient with a packed red blood cell or whole blood transfusion and then proceed to surgery for an exicisonal biopsy and resection and anastomosis of the bowel mass. If surgery is not possible, a fine needle aspirate of the thickened bowel wall could be considered if patient's coagulation status is appropriate, to rule out round cell neoplasia that may be able to be managed medically with chemotherapy.

A fine needle aspirate of the liver could be considered if patient's coagulation status is appropriate. However, the liver changes are likely response to previous steroid administration.

Further adrenocortical testing cannot be accurately performed while the patient is receiving steroids. However, if the future after the bowel mass and anemia are managed, if clinical signs of hyperadrenocorticism are present such as polyuria, polydipsia, polyphagia, panting, etc., adrenocortical testing with a low-dose Dexamethasone suppression test may be warranted.





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.

Beth Johnson, DVM, DACVIM
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