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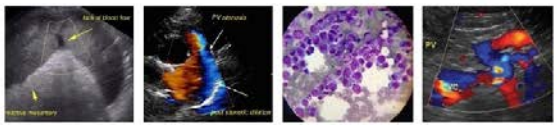


THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Juneau Robbins

SPECIES

Canine

BREED

American Eskimo

SEX

Neutered Male

AGE

6 Years

WEIGHT

17 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

BPH Stoney Creek

REFERRING VET

Dr. Mellish

INVOICE

44617

DATE

1/30/23

PRESENTING CLINICAL SIGNS

Patient was transferred to our clinic 01/28 Originally presented for hunched posture, painful abdomen, panting, straining to urinate Original hospital placed urinary catheter, drained bladder and transferred here Patients urinary catheter fell out during transport. While patient has been in our hospital, has had multiple 10-30 minute episode of acute, severe pain. Holding head low during these episodes and holding breath for 5-10 seconds between whining. Patient is screaming when being touched anywhere but especially painful in the abdomen. Patient has been urinating well on his own. Current Medications Convenia, Baytril, Hydromorphone

Abnormal PE/Chem/CBC/UA Results: 01/28 blood work: CREA 196, UREA 13.5, ALBUMIN 41, ALKP 235, RETIC-HGB 21.7, WBC 33.72, NEUT 29.09, MONO 1.71, MPV 15.9, PDW 19.5, PCT 0.52 01/28 urinalysis: WBC >50/HPF, RBC >50/HPF, STruvite 1-5/HPF 01/29 blood work: ALKP 299, MCV 61.4, RETIC-HGB 19.3, WBC 33.91, NEUT 29.74, MONO 1.41, MPV 14.9, PDW 20.5

Rad findings: CONCLUSIONS: 1. A definite cause for this animal's neck pain is not identified on this study. Occult intervertebral disc disease or other spinal disease such as inflammation or less likely neoplasm are not excluded. 2. Loss of serosal detail is noted in the central aspect of the abdomen and may indicate urine leakage. Differential diagnoses to consider include hemorrhage, emerging peritonitis or mesenteric neoplastic seeding. 3. A soft tissue mass lesion is strongly suspected to of the caudal sublumbar space and dorsal aspect of the pelvic canal. This may indicate sublumbar lymphadenopathy (reactive versus metastatic neoplastic) and may indicate pathology in the drainage area of these lymph nodes. This being indicative for a soft tissue opaque neoplastic mass lesion such as a fibrosarcoma or focal inflammation should remain differential diagnoses.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately to mildly over distended with anechoic contents as well as echogenic suspended debris. At the level of the trigone, there is an approximately 1.5 cm in diameter echogenic, non-shadowing density that appears not to be attached to the wall, but a polyp or mass attached to the wall cannot be definitively ruled out. No cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are otherwise normal in thickness with a smooth mucosal surface.

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

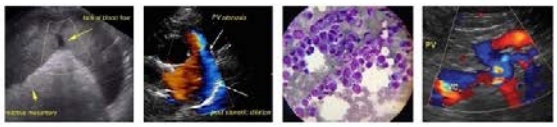
The right kidney is normal in size (5.6 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal in size (5.12 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

The right adrenal gland is normal in size (1.46 cm long x 1.1 cm at the cranial pole and 0.59 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (1.72 cm long x 0.67 cm at the cranial pole and 0.40 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.



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Spleen

The spleen is subjectively normal 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

The 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.

The 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 empty with 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.

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

Pancreas

The 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

In the mid to caudal abdomen, there is markedly hyperechoic enhanced mesentery, making visualization and differentiation of organs within that area difficult. There is also a small to moderate amount of mildly echogenic free fluid throughout the abdomen, primarily in the caudal abdomen. There is no visible evidence of sublumbar lymphadenopathy or sublumbar mass present in these images at this time.

ULTRASONOGRAPHIC FINDINGS

- Urinary bladder debris with a suspect mucus, blood clot, or other cellular debris causing a non-shadowing density at the level of the trigone. However, a polyp or even infiltrative neoplasia cannot be definitively ruled out.
- The free fluid present has a slightly echogenic appearance, concerning for a cellular fluid.
- The markedly enhanced mesentery fat is suggestive of an inflammatory change of unknown origin.

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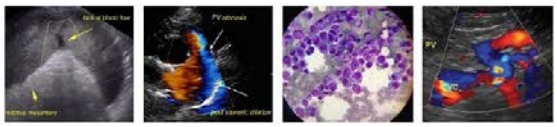

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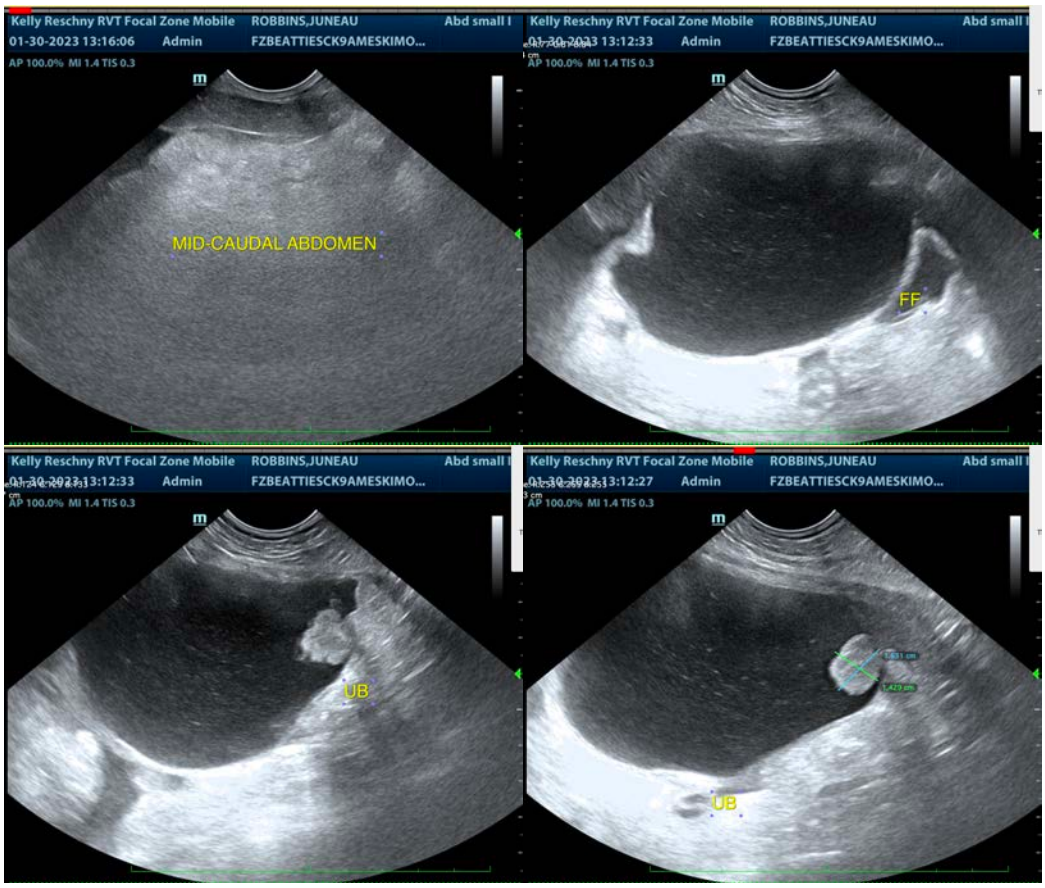
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Overall, the marked degree of pain described in this patient is atypical with abdominal pain and more consistent with neurologic and/or even orthopedic pain. However, given the marked inflammatory change found in this abdomen, abdominal pain is highly likely. Unfortunately, a source of the inflammatory change is not able to be definitively visualized.

Sampling of the free abdominal fluid for both cytology as well as culture and sensitivity is recommended if not already evaluated. Given the appearance of the fluid combined with this patient's pain description, ruling out a septic abdomen as soon as possible is recommended.

Urinalysis and urine culture, if indicated based on urinalysis results, are recommended. Submission of urine to look for BRAF gene mutation, which is associated with urinary bladder cancer, could be considered. Other diagnostic options include traumatic catheterization, fine needle aspirate (with small risk of tumor seeding/trailing) or cystoscopy for further sampling.

Given lack of visualization/identification of the reported sublumbar pathology combined with the lack of definitive tissue origin of the marked inflammatory change, pending fluid analysis results, next diagnostic steps to consider could include an abdominal and pelvic CT scan.



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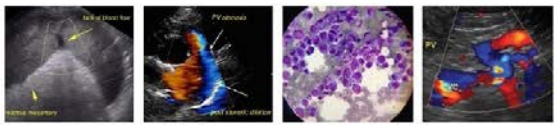

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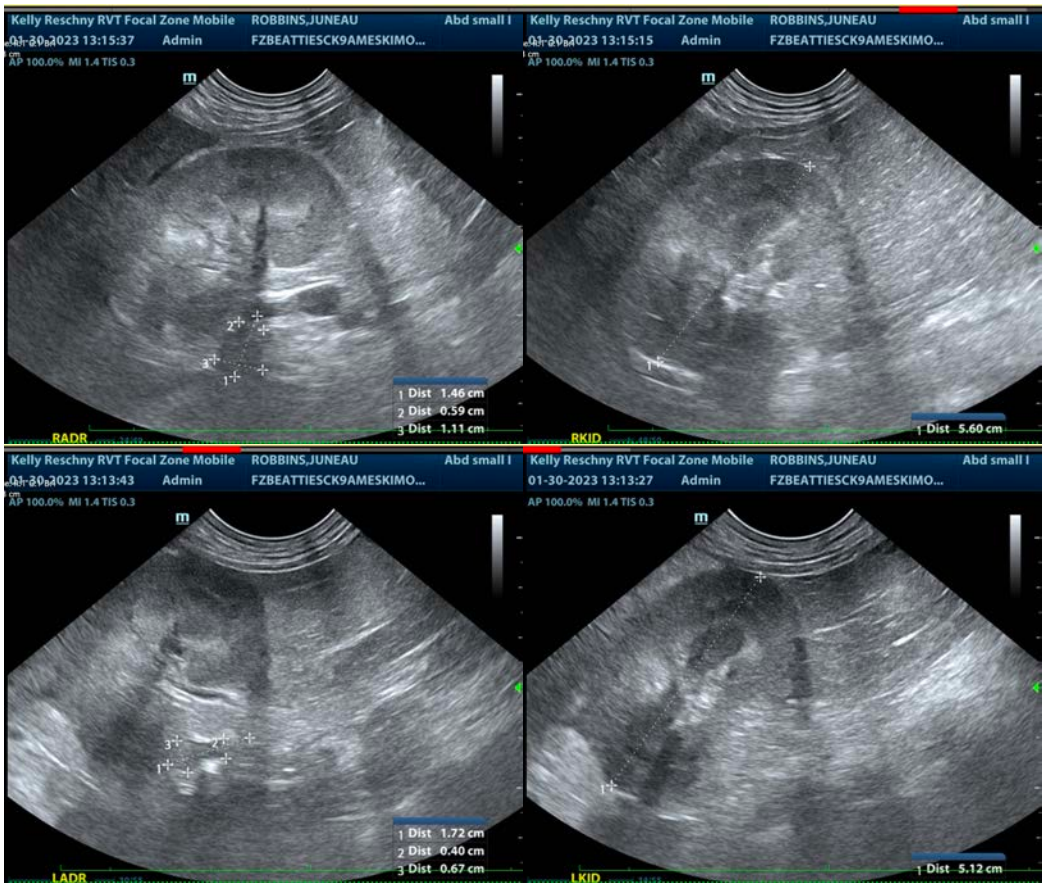

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM
Beth.Johnson@sonopath.com