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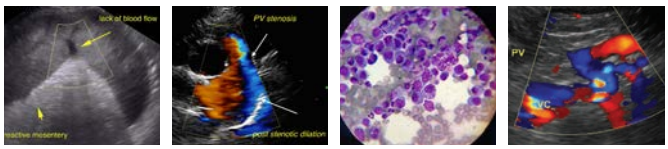
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

**PATIENT**

Henry Mitchell

**SPECIES**

Canine

**BREED**

Golden Retriever

**SEX**

Neutered Male

**AGE**

8 Years 4 Months

**WEIGHT**

106 Pounds

**INTERPRETED BY**

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

**IMAGING PERFORMED BY**

Dr. Callihan/PCMV

**HOSPITAL NAME**

Pacific Crest Mobile

**REFERRING VET**

Dr. Boekenoogen – Nooksack AH

**INVOICE**

43949

**DATE**

11/4/23

## PRESENTING CLINICAL SIGNS

Presented on 1/3/23 for 2 weeks duration vomiting and diarrhea (mucoid, blood streaked); Brief in-house ultrasound reported concern for cystic/mass lesions between bladder and colon, so full diagnostic ultrasound requested.

Abnormal PE/Chem/CBC/UA Results: Chems 1/3/23 normal other than slight elev ALT 162, CBC normal other than slight leukocytosis (neutrophilic) Fecal O&P and Giardia: NEG Abdominal radiographs: nothing overtly amiss to explain clinical signs

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

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

The right kidney is normal in size (7.93 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 (7.83 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 (1.0 cm at the cranial pole and 0.70 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.66 cm at the cranial pole and 0.66 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

### *Spleen*

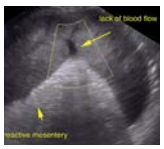
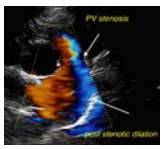
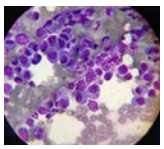
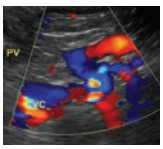
The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

### *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*

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The visible stomach wall is normal in thickness 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.

Diffusely, the visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). However, proximally, the duodenum is thick, measuring 0.70 cm in thickness with a focal mild or early loss of layering suspected. The lumen of the small intestine 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.

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*

There is no evidence of free peritoneal effusion noted in these images.

Sublumbar 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.

## ULTRASONOGRAPHIC FINDINGS

- **Aggressive sublumbar lymph nodes –** most consistent with infiltrative round cell or metastatic neoplasia. A benign aggressive inflammatory response cannot be ruled out without tissue sampling +/- culture.

- **Thick duodenum with early or mild loss of layering –** concerning for infiltrative neoplasia such as lymphoma. A benign inflammatory disease or even aggressive infectious disease can't be definitively ruled out without tissue sampling.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

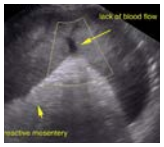
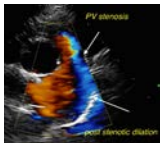
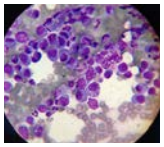
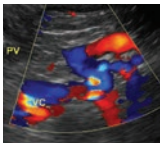
Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

A fine needle aspirate of the enlarged sublumbar lymph nodes is recommended if patient's coagulation status is appropriate.

Pending results, a 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.

A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease.

Ultimately, biopsies of the gastrointestinal tract, being sure to include the upper GI/duodenum as well as the colon may be necessary to definitively diagnose and therefore appropriately manage the suspected infiltrative disease, if a diagnosis is not obtained cytologically from lymph node aspirate.

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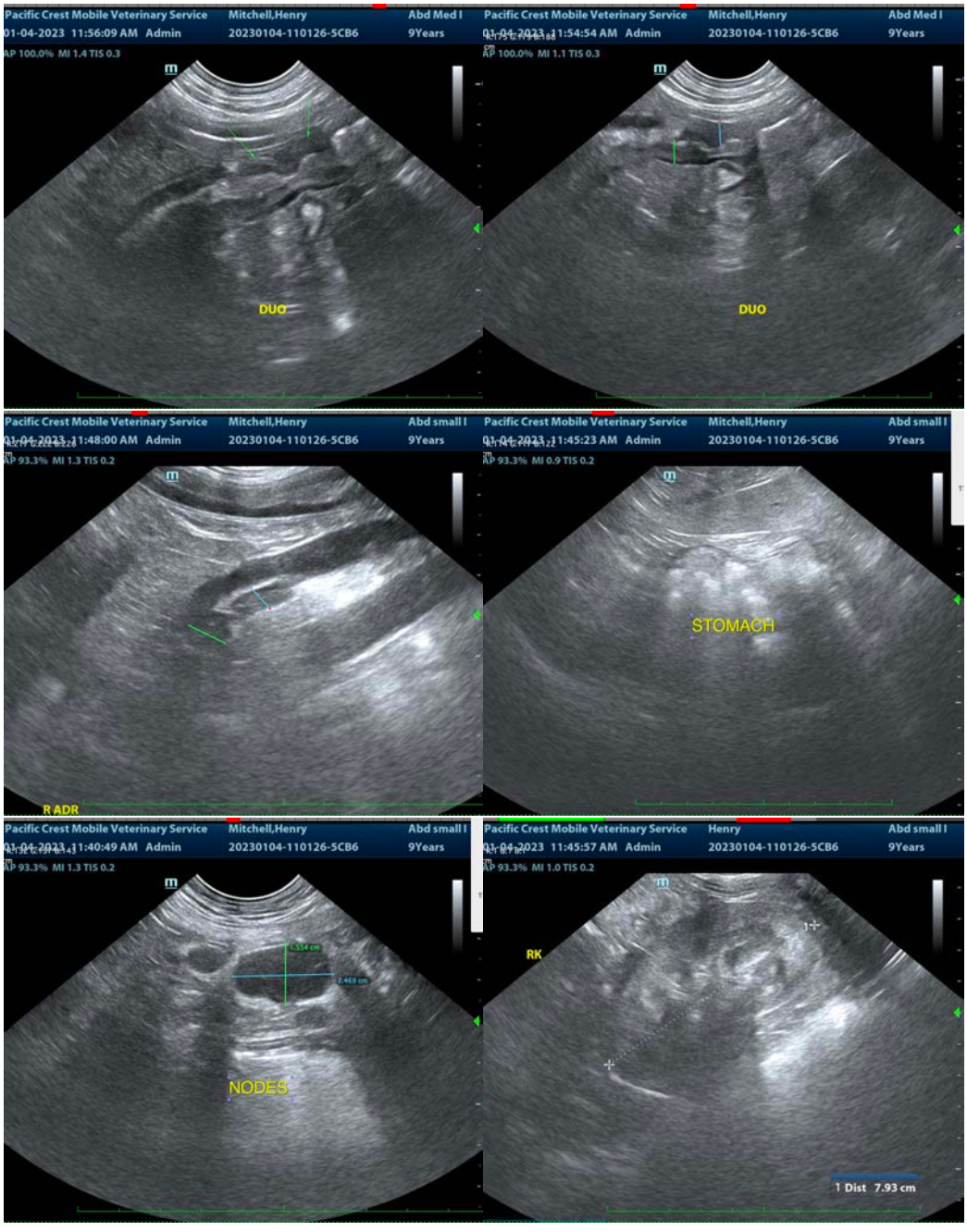
In the meantime, empirical therapeutic recommendations include antiemetics, gastroprotectants, a probiotic such as Visbiome or Proviable, empirical deworming with a 5-day course of Panacur, and potentially, given the hematochezia, an antibiotics such as Metronidazole or Tylosin.



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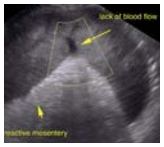
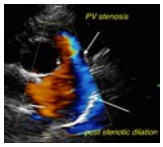
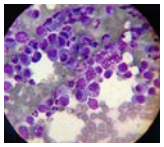
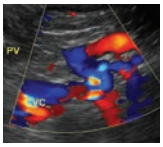

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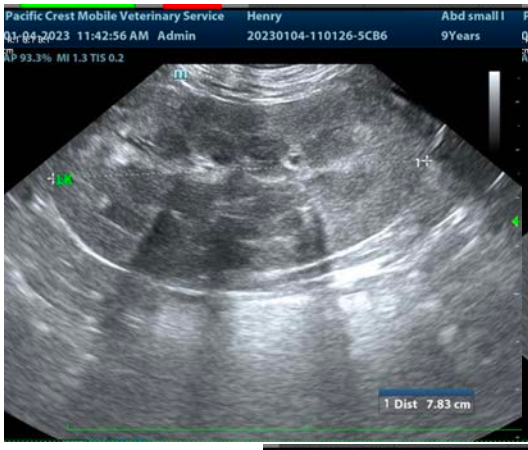


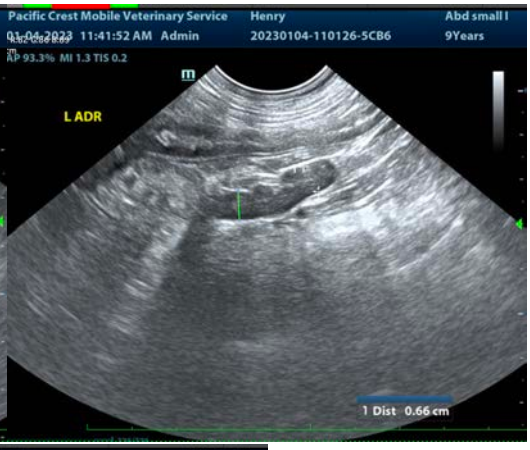


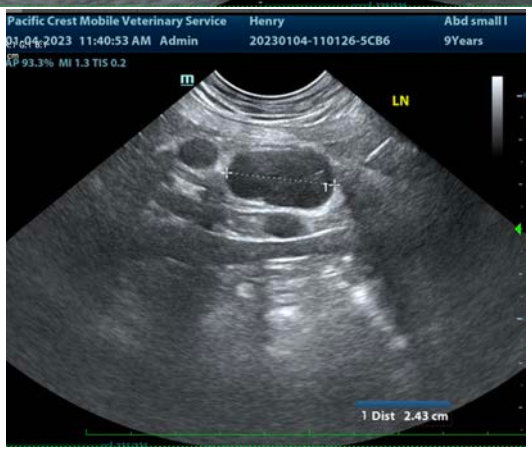


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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