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Clinical Sonography & Telecytology
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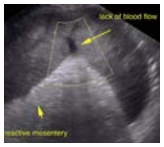
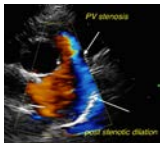
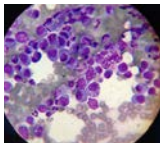
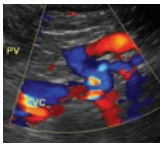

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1-800-838-4268 info@sonopath.com

PATIENT
Max Wechtler

SPECIES
Canine

BREED
Labrador Retriever X

SEX
Neutered Male

AGE
11 Years

WEIGHT
N/A

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Kelly Vazquez

HOSPITAL NAME
Midland Park VH

REFERRING VET
Dr. John Shokoff

INVOICE
41884

DATE
10/6/22

PRESENTING CLINICAL SIGNS

Chronic/intermittent diarrhea. Responsive to metronidazole, but recurs when off med. Negative fecal. Current med: metronidazole 500mgs BID

Abnormal PE/Chem/CBC/UA Results: Alk. Phos. 769.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is subjectively overdistended 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 (5.9 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 (6.2 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 (2.9 cm long x 1.4 cm at the cranial pole and 0.90 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 (2.4 cm long x 0.61 cm at the cranial pole and 0.73 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.

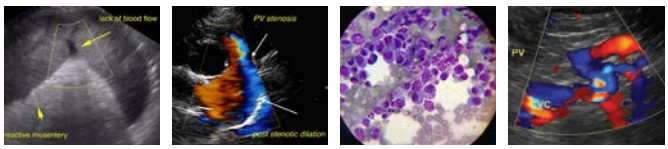
Liver

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. Multifocal discrete 1-1.5 cm round, hyperechoic nodules noted throughout the parenchyma. 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.



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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), except for a focal loop of bowel medial to the spleen that has a thick hypoechoic wall measuring 0.64 cm and exhibits loss of layering. The bowel loop is surrounded by enhanced hyperechoic fat. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction or foreign material.

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

Pancreas

Pancreas is prominent in size with swollen irregular contour. Parenchyma is heterogenous characterized by hyperechoic tissue remodeling intermixed with ill-defined hypoechoic nodules. 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.

There is no apparent lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- **Focal small bowel thickening with loss of layering** – Concerning for infiltrative neoplasia, such as round cell neoplasia, carcinoma, versus other. A benign focal inflammatory lesion is possible but considered less likely, given the loss of layering appreciated.
- **Pancreatic nodular hyperplasia –** Infiltrative neoplasia cannot be ruled out but is considered less likely.
- **Liver nodules –** Differentials for a discrete liver nodule include primarily benign changes such as nodular hyperplasia, fibrosis of an old hematoma, granuloma, etc.; however, while considered less likely, primary hepatic neoplasia, infiltrative round cell neoplasia and metastatic disease can mimic benign lesions and cannot be definitively ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

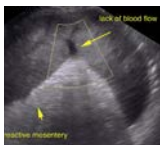
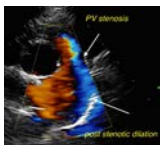
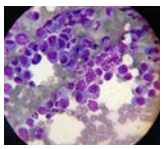
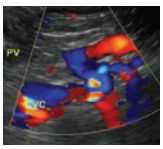
Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

Given the pancreatic and bowel changes combined with chronic diarrhea, 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 fine needle aspirate of the liver and the thickened bowel (if the bowel can safely be reached) are recommended if patient's coagulation status is appropriate. If a diagnosis cannot be obtained cytologically, then an exploratory laparotomy with planned biopsy. Resection and anastomosis of the focally thick bowel loop may be necessary to definitively diagnose and therefore manage the suspected infiltrative bowel disease.

Additionally, given this patient's response to Metronidazole, potentially before more invasive steps, a fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease.

In the meantime, empirical therapies could include a transition from Metronidazole to Tylosin for a subjectively safer long-term option with plans to treat with Tylosin for 6-8 weeks. Probiotics such as

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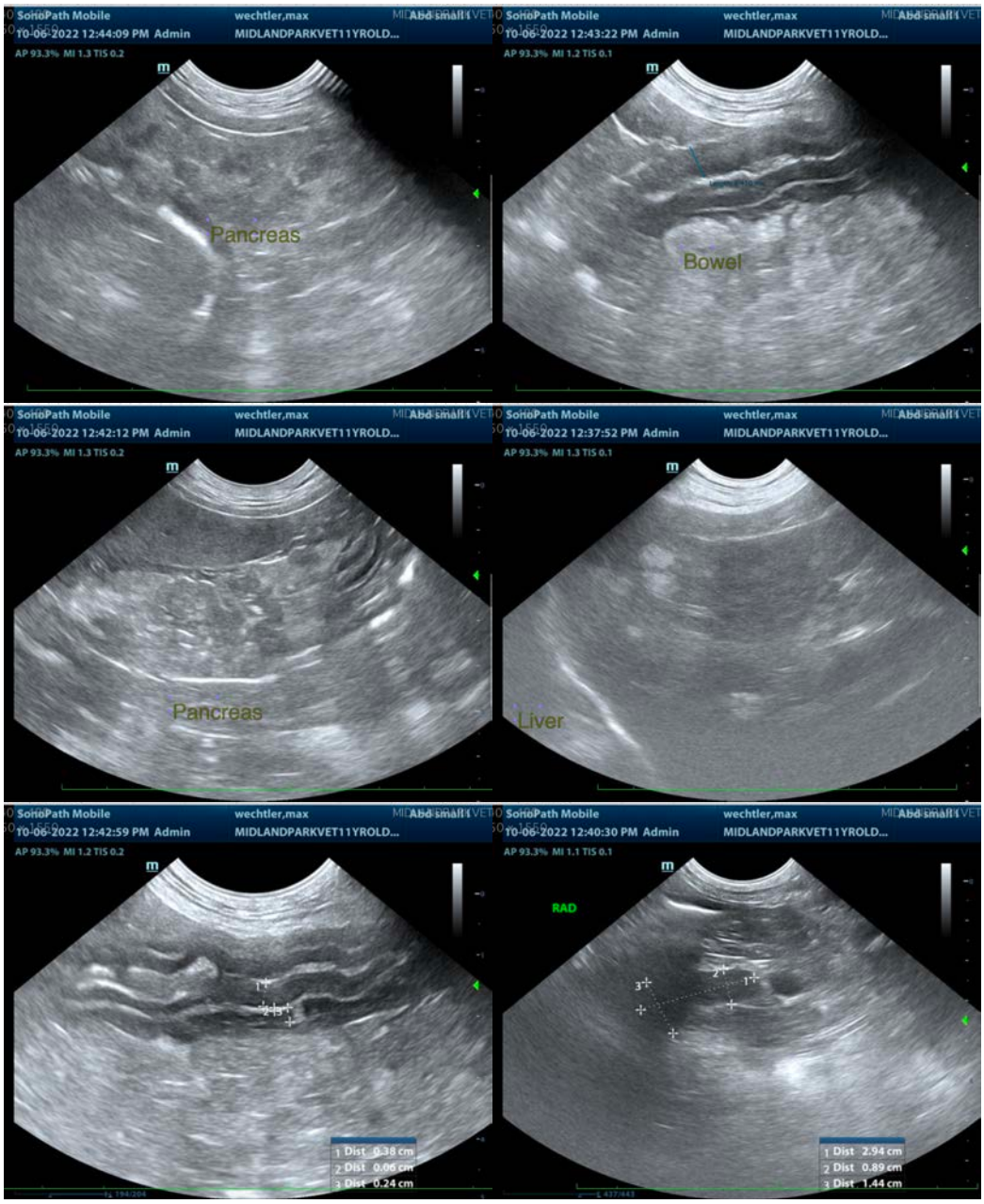
Proviable or Visbiome and a transition to a hydrolyzed protein diet can all be considered to help alleviate clinical signs in the meantime. Empirical deworming with a 5-day course of Panacur is also recommended.



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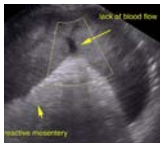
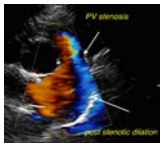
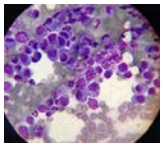
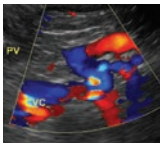

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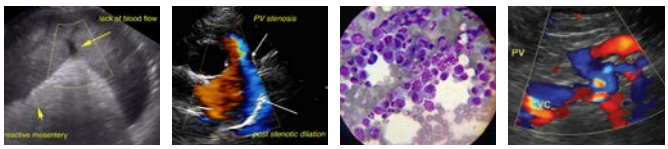

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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