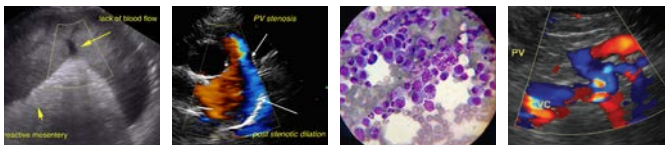
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Griffon Stoops

SPECIES

Canine

BREED

Schnauzer

SEX

Neutered Male

AGE

10 Years

WEIGHT

12.6 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Adrianne Waffle

HOSPITAL NAME

Torch Lake VC

REFERRING VET

Dr. Karen Reabe

INVOICE

42723

DATE

11/16/22

PRESENTING CLINICAL SIGNS

Referral US for weight loss and vomiting. Chronic vomiting undigested food and bile, multiple times a day. Increased urgency of defecating, no diarrhea noted until Monday(hematechezia). Hx of bloody diarrhea in June resolved with metro. Full body rads in October normal
Abnormal PE/Chem/CBC/UA Results: HCT 28.1 MCV 57 MCH 18.5 MCHC 32.5 TP 4.3 Alb 2.0 Glob 2.3 TCHO 111

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is only mildly distended (empty). Visible contents are anechoic. Urinary bladder wall is unable to be fully assessed for pathology without further distension. No visible masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface. If there are urinary signs and/or concern for urinary bladder pathology, reassessment after complete filling is recommended.

The prostate is unable to be well visualized in these images.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. A 1.2 cm cortical cyst is noted in the cranial pole of the right kidney. The right kidney measured 4.87 cm. The left kidney measured 4.17 cm.

Adrenal Glands

The area of the right adrenal gland is examined without evident pathology.

The left adrenal gland is normal in size (0.40 cm at the cranial pole and 0.47 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.

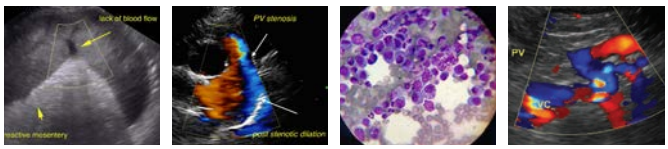
Liver

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

The stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) and layering, except in the cranial abdomen, in the area believed to be pylorus, where the wall looks diffusely thick and hypoechoic with loss of layering suspected. It measures 0.75 cm thick. However, the edge of the bowel mass being



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seen in the area of the pylorus versus true pylorus is possible. 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 (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm), except focally in the mid abdomen, near the Ileocecocolic junction and potentially involving the Ileocecocolic junction, where there is a discrete 4.0 cm long x 1.8 cm thick bowel mass with hypoechoic wall, loss of layering, and some concern for an intussusception at the level of the mass. 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

There is a scant amount of anechoic free fluid and enhanced hyperechoic mesentery and fat in the caudal abdomen, around the urinary bladder and colon, as well as in the mid abdomen around the bowel mass.

A round, hypoechoic, 1.0 cm in diameter mesenteric lymph node is noted, surrounded by enhanced hyperechoic fat.

PRIMARY FINDINGS

- Mid abdominal bowel mass – Concerning for infiltrative neoplasia such as round cell neoplasia, i.e., lymphoma versus adenocarcinoma versus other. There is some concern for an intussusception at the level of the mass as well as focal peritonitis surrounding the mass.

SECONDARY FINDINGS

- Age related kidney changes with a cortical cyst in the right kidney
- Mesenteric lymphadenopathy – Both reactive lymphadenopathy as well as infiltrative neoplasia are differentials and can't be differentiated 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 bowel mass could be considered if patient's coagulation status is appropriate. However, given the concern for possible intussusception as well as the reported GI bleed, exploratory laparotomy for planned excisional biopsy, resection and anastomosis, etc., may be more appropriate if patient is stable for surgery.

In the meantime, submitting a fecal (if not recently evaluated) as well as A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory are recommended as well.

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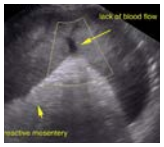
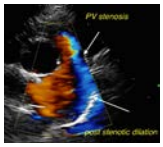
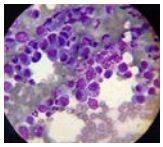
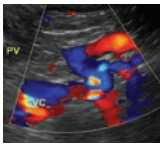

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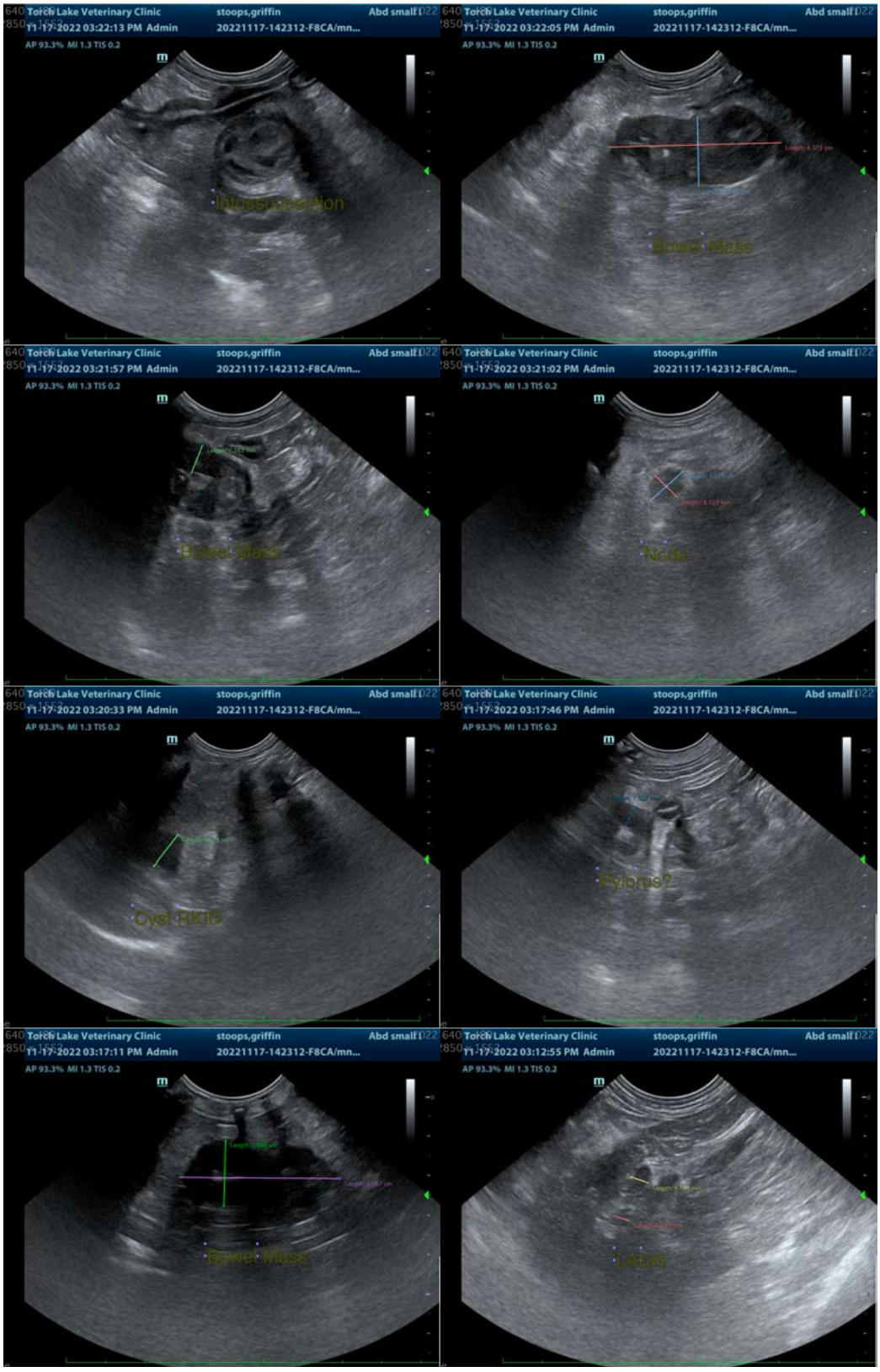

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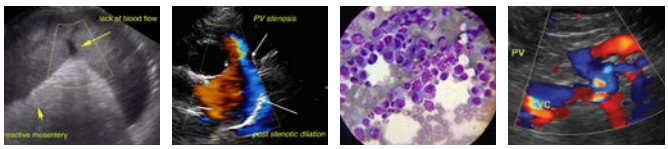

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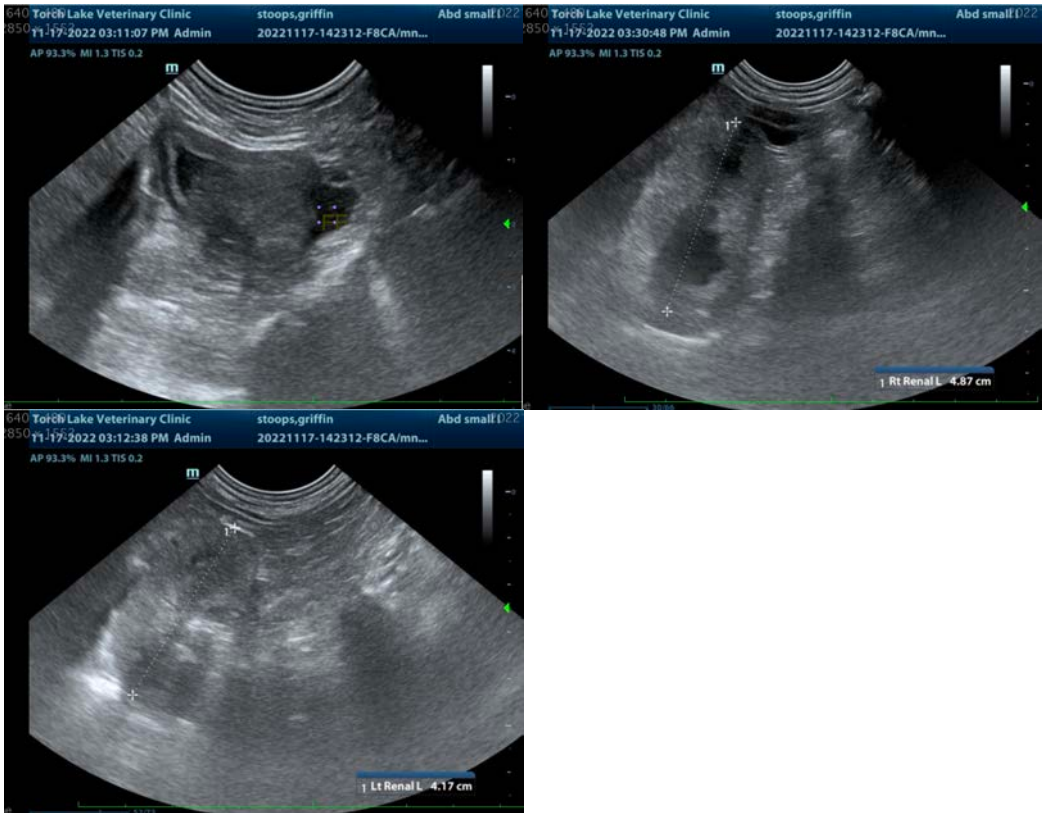

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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