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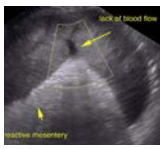
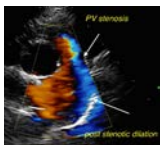
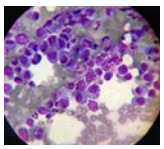
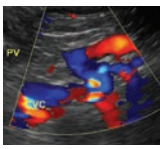

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PATIENT

Zeus Hawkins

SPECIES

Canine

BREED

Boxer x Mastiff

SEX

Neutered Male

AGE

10 Years

WEIGHT

52 kg

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Elyse Hauer

HOSPITAL NAME

Mariposa Vet Hospital

REFERRING VET

Dr. Elyse Hauer

INVOICE

43017

DATE

11/29/22

PRESENTING CLINICAL SIGNS

Presented yesterday with 1 day history of hematemesis, hematochezia, unable to keep food down. On exam was quiet. Started on IV fluids, Cerenia, metronidazole, and sucralfate, sent home for overnight without fluids, back today for ultrasound. Ate dinner last night, kept it down and seemed more settled, fasted since then. Episode of gastroenteritis occurred in the summer 2X and responded to medical management. Patient is up to date on vaccinations including Leptospirosis.

Abnormal PE/Chem/CBC/UA Results: CBC/Biochem/UA/Accuplex – all normal except isosthenuria (has always been a big drinker according to owners). PSL pancreatitis test normal. Lymph notes are palpable/plump but do not feel overly enlarged. Cortisol pending. Fecal test (summer) negative

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.

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

The right kidney is normal in size (5.53 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 (6.01 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 adrenal glands are unable to be well visualized in these images.

Spleen

Spleen is subjectively large in size with normal smooth margins. Parenchyma is normal in echogenicity with a coarse/heterogenous echotexture. 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 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.

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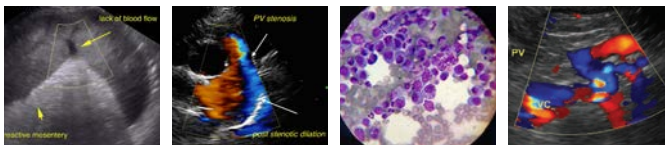

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The visible small intestines are diffusely normal in wall thickness and layering (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). Small intestinal motility appears adequate (1-3 contractions per min). However, in the left mid abdomen, there is a focal loop of bowel with subjectively thick muscularis relative to the mucosa in the part of the bowel where layering is intact. However, this area is adjacent to bowel with thick infiltrative loss of layering measuring 0.75 cm thick. The area with loss of layering is surrounded by enhanced reactive mesentery. 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 no evidence of free peritoneal effusion noted in these images.

There is no apparent lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- Focal left mid abdominal bowel with loss of layering and evidence of an infiltrative process, concerning for infiltrative neoplasia. Benign inflammatory change can't be ruled out but is considered less likely.

- **Coarse splenomegaly –** can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.

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 focally thick bowel with loss of layering, as well as the spleen, could be considered if patient's coagulation status is appropriate. Alternatively, an exploratory laparotomy could be performed for planned mass removal/resection and anastomosis. If surgery is elected, biopsies of the diffuse healthier bowel +/- the stomach should also be considered, given the reported hematemesis and hematochezia. In the meantime, as is reportedly already pending, a baseline cortisol is recommended.

Additionally, to further assess GI function, a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended. Empirical therapeutic recommendations while awaiting further diagnostics/results, etc. include empirical deworming with a 5-day course of Panacur, twice daily antacid i.e., Omeprazole therapy, and Sucralfate, as well as antiemetics if necessary and a probiotic such as Visbiome or Proviable if not already in place.

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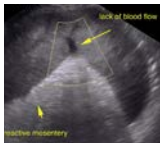
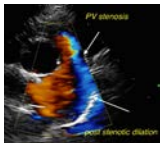
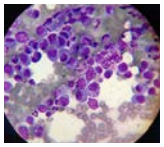
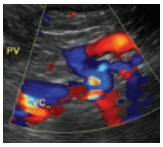

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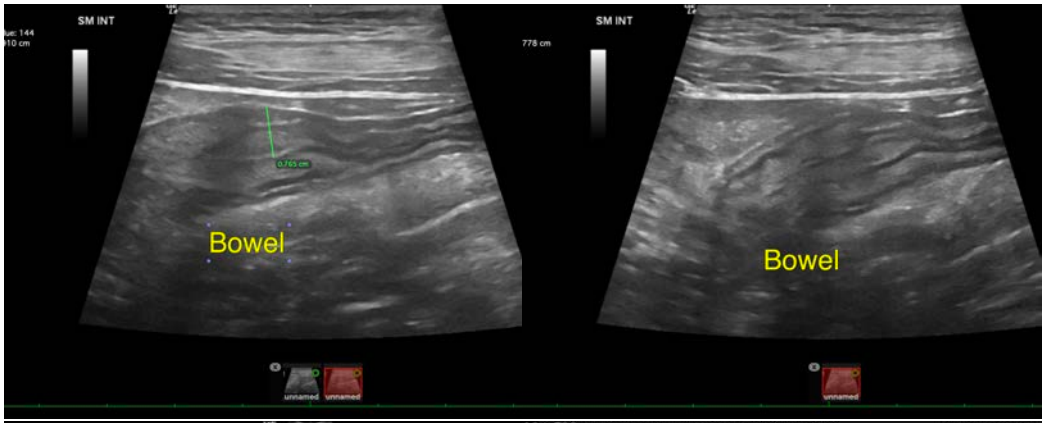

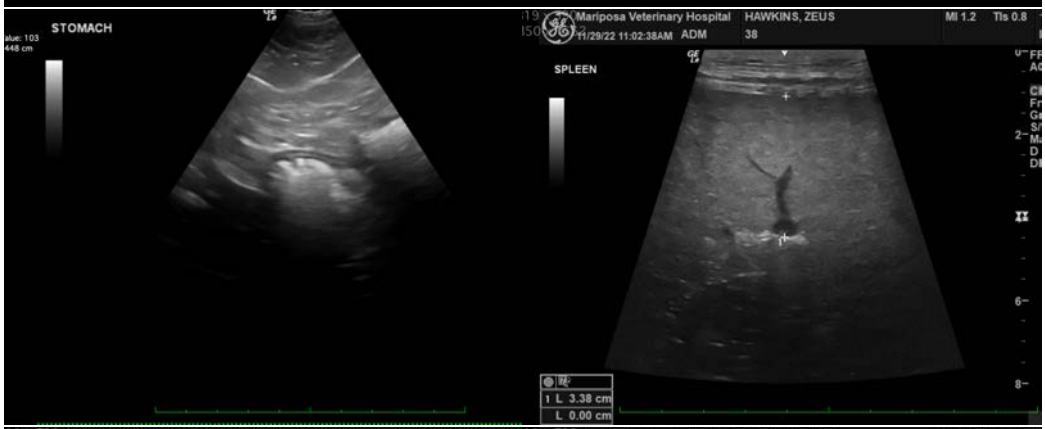

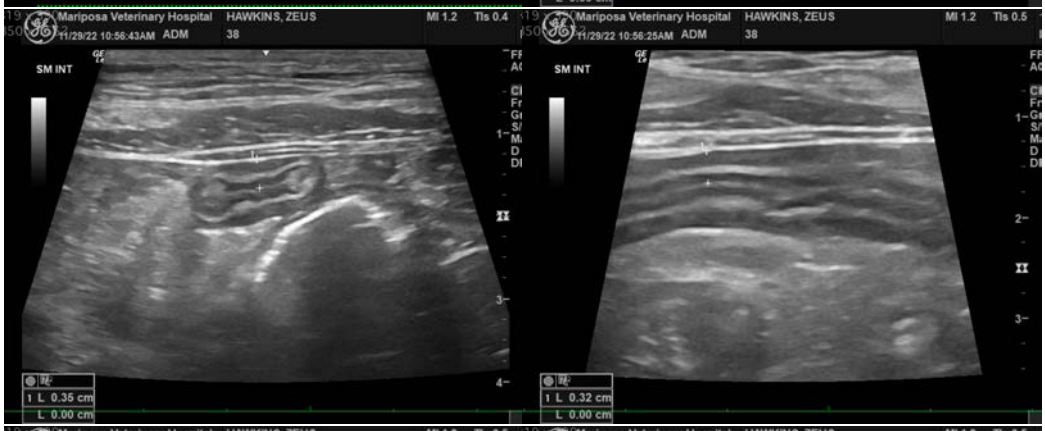

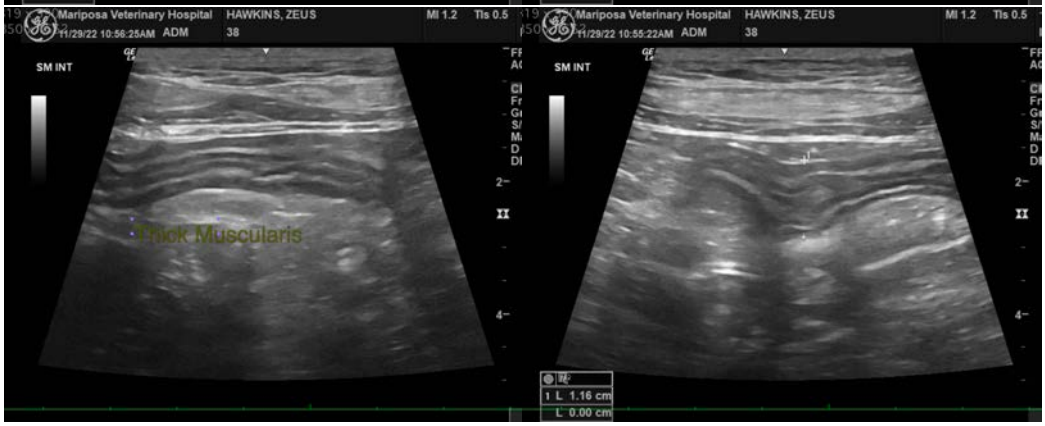

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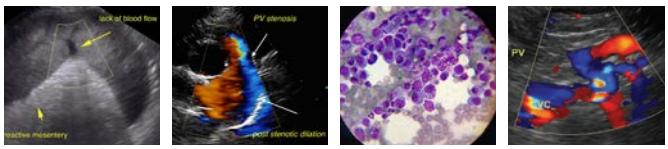

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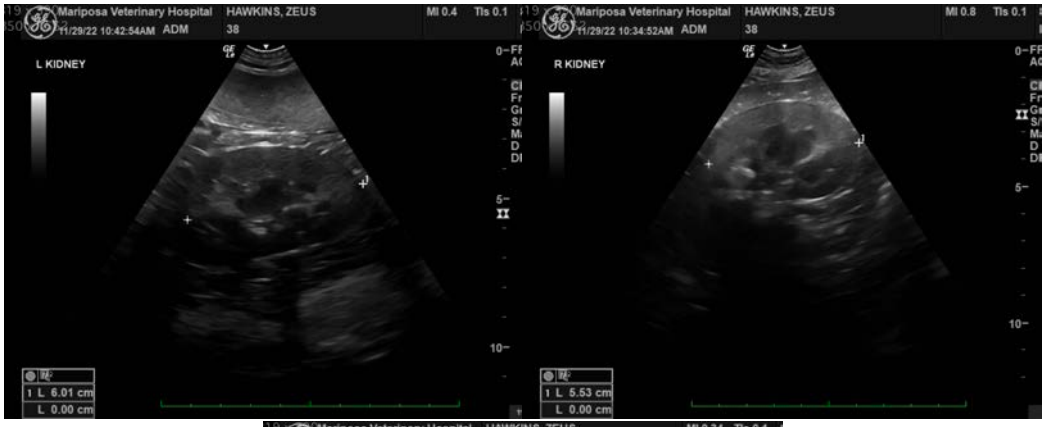

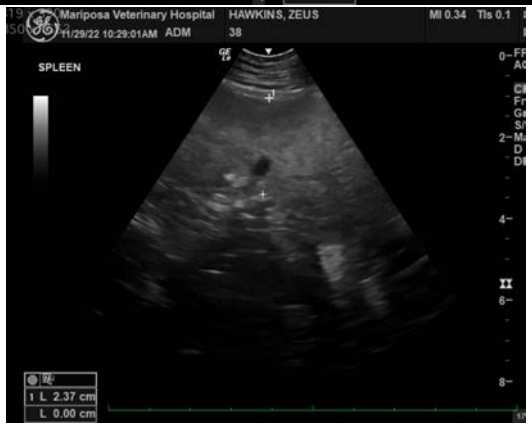

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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