



PATIENT

Melody Joy

SPECIES

Canine

BREED

Border Collie X

SEX

Spayed Female

AGE

13

WEIGHT

26 kg

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Evan Bell

HOSPITAL NAME

Cedarview AH

REFERRING VET

Dr. Kim Holzman

INVOICE

44697

DATE

2/1/23

PRESENTING CLINICAL SIGNS

Recent history of PuPd (x several months), Decreasing mobility over past several weeks and abdominal pain. Has aged dramatically over past several months. Chronic (over many years) intermittent diarrhea. Dramatic improvement on NSAID. Can make it through night without urinating and mobility has improved. Much brighter

Abnormal PE/Chem/CBC/UA Results: Sodium to potassium ratio of 27:1, mild increase in potassium to 5.5 ALK mildly increased USG 1.015, pH 6.5, trace protein Chest rads - unremarkable Severe abdominal pain throughout abdomen, no palpable masses, Slight increase in lung sounds diffusely, otherwise exam findings unremarkable.

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 right kidney is normal in size (7.3 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 or infarcts observed. Non-obstructive areas of mineralization/nephroliths are noted.

The left kidney is normal in size (6.9 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 or infarcts observed. Non-obstructive areas of mineralization/nephroliths are noted.

Adrenal Glands

The right adrenal gland is normal in size (0.94 cm at the cranial pole and 0.68 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 (0.82 cm at the cranial pole and 0.99 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large in size with subtly scalloped or undulating capsular contour. Parenchyma is normal in echogenicity with a mildly coarse/heterogenous echotexture. No focal nodules or masses are observed. Splenic vasculature appears normal. However, the head of the spleen is hypoechoic, beginning at a well demarcated line. I don't see good blood flow in that area, so an infarcted part of the spleen is possible. That particular area is surrounded by enhanced hyperechoic mesenteric fat.

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.



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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.

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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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Diffusely, 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. Focally, in the jejunum, there is a 1.5 cm heterogeneous intramural mass that is at least partially pressing down and occluding the lumen (i.e., partially obstructive). That mass is also surrounded by enhanced hyperechoic mesenteric fat.

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

Pancreas

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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.

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Free Abdomen

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

There is no apparent lymphadenopathy noted in these images.

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Evan Bell

ULTRASONOGRAPHIC FINDINGS

- **Intramural small bowel/jejunal mass surrounded by changes consistent with a focal peritonitis** – Differentials include leiomyoma versus leiomyosarcoma, versus infiltrative round cell neoplasia, or less likely carcinoma, sarcoma, other. A benign inflammatory lesion is possible but considered much less likely.
- **Scalloped spleen** – can be associated with benign or malignant infiltrative disease. Common causes include a reactive spleen secondary to immune stimulus or early infiltrative round cell neoplasia such as lymphoma or mast cell tumor. A small area of infarcted spleen is also suspected.
- Non-obstructive nephroliths bilaterally

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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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.

Fine needle aspirates of the bowel mass and spleen could be considered if patient's coagulation status is appropriate, or alternatively, depending on patient stability and owner wishes, given the visibly partially obstructive nature of the bowel mass, an exploratory laparotomy for planned mass removal, resection and anastomosis, +/- splenectomy could be considered.



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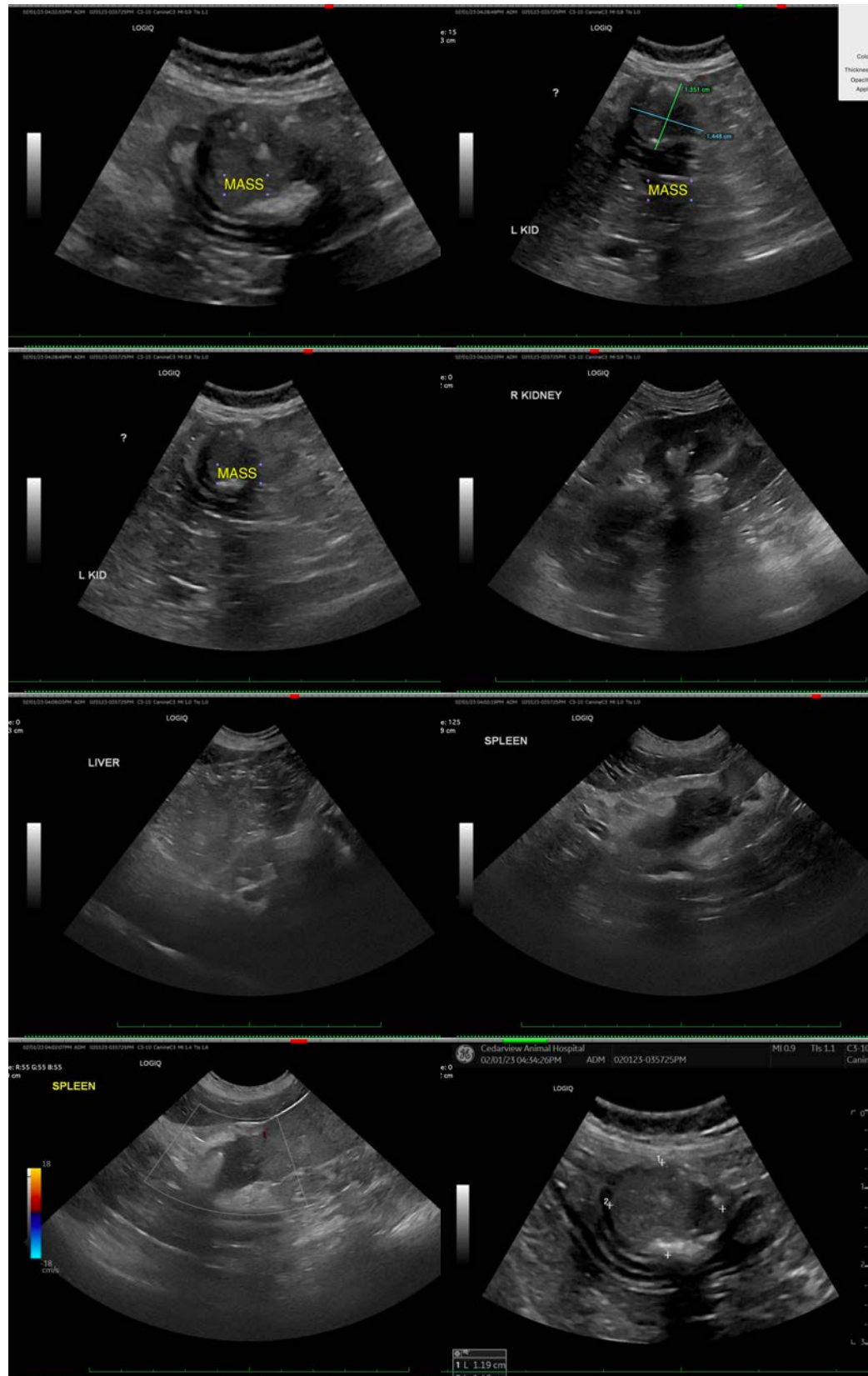
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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