

**DATE**

2/16/22

PRESENTING CLINICAL SIGNS

Weight loss over last 4 weeks. Presented 1/26 for leaking stool and some blood in stool. Appetite a little off and a few skin issues. No constipation palpated then but may have been. Was on carprofen, gabapentin dasuquin for ortho. Was put on metronidazole, Higher fiber GI Biome diet and probiotic. Seen about a week later for vomiting and not eating. No more leakage of stool. Obstipation was palpated and relieved over a 2 day period with IVF, lactulose and enemas. Was changed to low residue I/D diet and sent with lactulose to use if stools got firm or metro if too loose. Did well for a few days and stools a little on the loose side. Some recurrence of rectal leakage but none for the last 48 hours. Seen today for inappetence x 24 hours. No V. Non painful abdomen. All along the rectum distal colon has palpated oddly - good tone but ventral 1/2 seemed thickened or more firm/calloused. Tiny bumps on it. No constipation today.

PATIENT

Stella Salinas

SPECIES

Canine

BREED

English Bulldog

SEX

Spayed Female

Current Medications: Carprofen discontinued 48 hours ago. Provable SID. Gabapentin 100mg bid-tid PRN. Gave cerenia / pepcid today and sent home PO. Dasuquin.

Lab Results: ALT 145 last week and mild mature neutrophilia.

Radiographs: Rads last week constipated, then after relieved and repeated today. No recurrent constipation today. Gas in colon.

Date of Previous IntraPet Ultrasound: No previous.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

Imaging Performed By: Rachel Brillhart, RDMS.

AGE

2012

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**Urinary System**

Urinary bladder is moderately distended with anechoic contents. It has normal uniform wall thickness (< 0.2 cm). No masses or cystoliths are observed.

WEIGHT

42.8 lbs

Left kidney is normal in size (5.15 cm), shape and echogenicity. It has smooth peripheral margination and appropriate corticomedullary distinction. There is no pyelectasia noted. No mineral is observed.

INTERPRETED BYBeth Johnson, DVM
DACVIM

Right kidney is normal in size (5.42 cm), shape and echogenicity. It has smooth peripheral margination and appropriate corticomedullary distinction. There is no pyelectasia noted. No mineral is observed.

HOSPITAL NAME

Rolling Hills AH

Adrenal Glands

Left adrenal gland is normal in size (2.82 x 0.72 cm at cranial pole and 0.83 cm at caudal pole) and subjectively plump in appearance. Corticomedullary structure is unremarkable.

REFERRING VET

Dr. Gividen

Right adrenal gland is normal in size (2.77 cm x 1.03 cm at cranial pole and 1.08 cm at caudal pole) and subjectively plump in appearance. Corticomedullary structure is unremarkable.

INVOICE

96106

Spleen

Spleen is subjectively normal in size with normal smooth margins. Parenchyma is normal in echogenicity and echotexture. No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

Liver is subjectively normal in size. Margins are sharp and smooth. It has normal homogenous echotexture and normal echogenicity. No focal lesions are observed. Visible vasculature appears normal. Gallbladder is mildly distended with anechoic contents. The wall is smooth without visible thickening. There is no evidence of common bile duct dilation.

Gastrointestinal

The visible gastric wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm). The stomach is empty.

The small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). There are no luminal contents noted within small intestines.

Colon is diffusely thick and measured 0.42 cm with a maintenance of normal layering still visible. The wall of the cecum is thick, hypoechoic and measured 0.49 cm with less visible layering/early loss of normal layering suspected.

Pancreas

The pancreatic parenchyma is slightly hypoechoic to the surrounding tissue and coarse in architecture. The visible capsule is smooth and normal in contour. There is no visible pancreatic duct dilation. there was no evidence of active peri-pancreatic inflammation.

Free Abdomen

The medial iliac lymph nodes are noted and are mildly enlarged and normal in shape.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS:

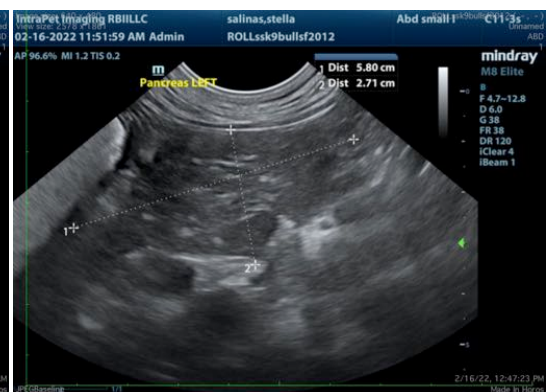
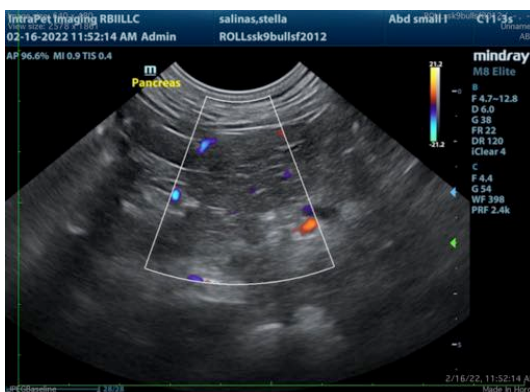
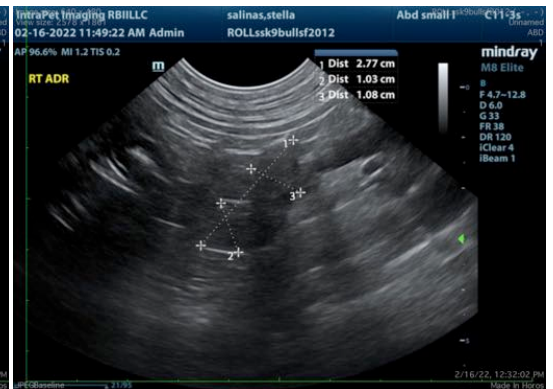
- Thick colonic and cecal wall. Differentials are vast and include infectious, parasitic, ulcerative, granulomatous, other benign inflammatory disease as well as some concern for infiltrative neoplasia such as lymphoma given the less visible normal layering in the cecum.
- Suspected reactive medial iliac lymphadenopathy; however, infiltrative neoplasia of the lymph nodes cannot be ruled out.

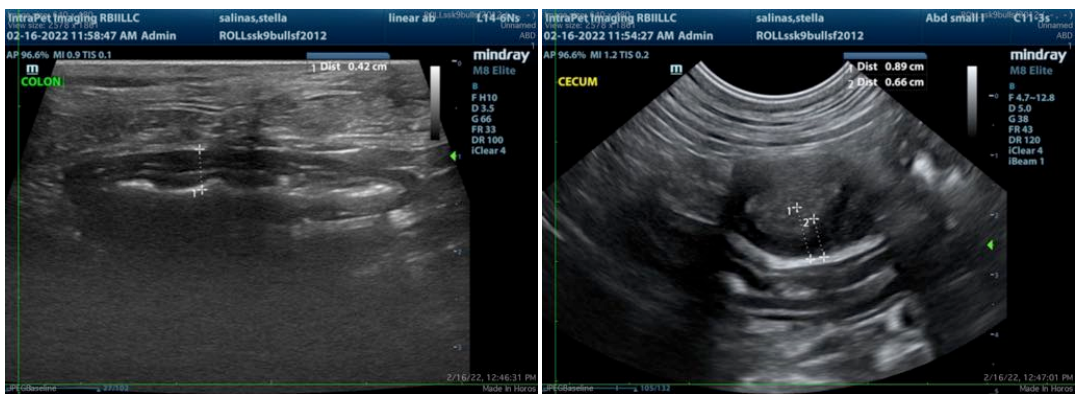
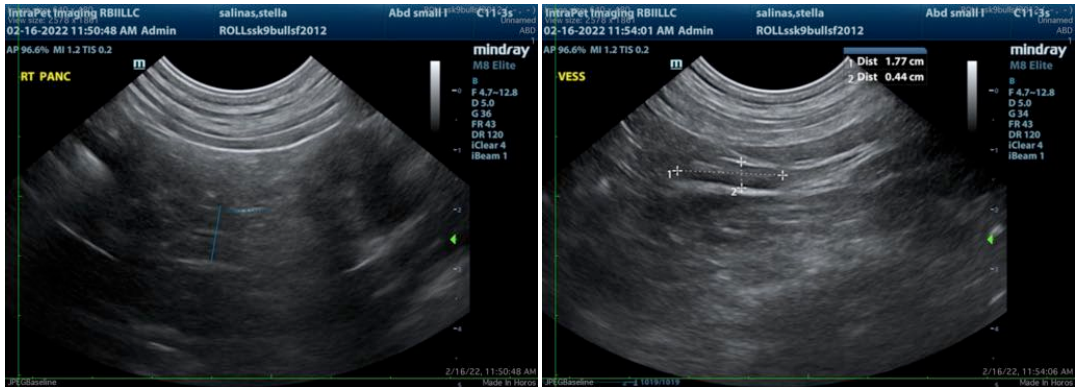
SECONDARY FINDINGS:

- Bilateral adrenomegaly – consistent with adrenal hyperplasia secondary to pituitary depending hyperadrenocorticism vs normal variant.
- Prominent coarse pancreas. Rule outs for which include normal anatomic variant versus mild, chronic smoldering pancreatitis . Likely of little clinical consequence.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Recommendations for this patient include colonoscopy with visualization /assessment/biopsies of the rectum, colon and cecum if possible. Prior to colonoscopy however fecal exam followed by empirical deworming with a 5-day course of Panacur despite fecal results is recommended. If clinical signs of hyperadrenocorticism are present testing for hyperadrenocorticism with a low dose Dexamethasone suppression test could be considered. However, this is considered a likely non-significant finding at this point with the primary concern being the large bowel changes.





The information and recommendations provided are based on the images presented by the referring veterinarian. 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