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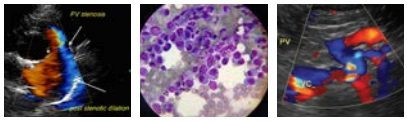

SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
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DATE

2/2/23

PATIENT

Captain Jack Venker

SPECIES

Canine

BREED

Mixed

SEX

Neutered Male

AGE

2/2/10

WEIGHT

40.9 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Animal Emergency Hospital

REFERRING VET

Dr. Kalwa

INVOICE

44675

PRESENTING CLINICAL SIGNS

rDVM records: - 8/6/22 1. Full bloodwork 2. 4dx negative 3. T4 wnl - 12/12/22: 1. Previous vomiting, improved 2. Limited exam 3. CBC/CHEM/LYTES: HCT 37%, WBC 25k, Neutrophilia 23k, PLT high, BUN low Glob high, Na high (liver/ kidney wnl) 3. Xrays: improvement gas pattern compared to 12/11/22 4. Plan to monitor at home, feed bland diet, proviable, Rx Metro in not improving. Notes: PC: vomiting, shaking, ADR, lethargy Last night vomited 2x, shaking, ADR O went to work last night (Mr works overnight) Panting overnight, urinated in house- never done O came home from work this morning drank a lot then vomited a large amount, keeps panting not moving Episode just like this in december- see records above- O states he resolved quickly after first episode 2 weeks ago shaking, ADR, but fine O very concerned something wrong inside Owned 1 year- rescued Seemed healthy until december Picky eater? Will eat people food- sometimes needs entycing for food No obvious* weight loss- but compared record - previously 46 lb--> 41 lb No PU/PD- wnl. O has 7 dogs O concious of Gi signs- had previously switched pet to sensitive diet food- canned since eating less - unsure name, usually eats well Does get people food but O has been staying away from this Hx of other dog in house with pancreatitis Not a toy eater

Current Medications: None yet aside from Buprenorphine.
Lab Results: See attached.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Requested by DVM.
Imaging Performed By: Andi Parkinson, RDMS

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 area of the prostate is examined without evident prostatic pathology.

The right kidney is normal in size (6.11 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 (6.25 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 unable to be fully visualized in these images, but the area is examined without evident adrenal pathology.

The left adrenal gland is normal in size (3.01 cm long x 0.51 cm at the cranial pole and 0.71 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

Spleen is largely normal in appearance (shape, echotexture and echogenicity); however, it is volume contracted. Hydration status assessment is recommended.

Liver
Liver is subjectively enlarged (swollen contour). Mild parenchymal remodeling with diffusely mildly coarse architecture and increased portal markings is present. No focal nodules or masses 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 very echogenic reverberation artifact from intraluminal gas. There is no evidence of obstruction, foreign material or infiltrative disease; however, complete visualization of far wall is partially inhibited by gas. Pyloric outflow tract appears patent.

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 mid abdomen, there is what appears to be a loop of jejunum with concentric thick hypoechoic wall and loss of layering. The wall measures 0.67 cm in thickness. Wall integrity is questionable, given the lack of ability to trace the serosa, and a large amount of very enhanced/hyperechoic mesentery fat clumped around the bowel mass in addition to other loops of jejunum that almost appear to be stacked or adhered to one another. A scant amount of anechoic free fluid is also noted around the bowel mass.

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
A scant amount of anechoic free fluid is noted, and very enhanced hyperechoic mesentery clumped around the bowel mass.

There is no apparent lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- Mid abdominal/jejunal bowel mass with evidence of a focal peritonitis and potentially adhesions or stacking of adjacent bowel loops and some concern for perforation, given the appearance of the wall. Infiltrative neoplasia such as round cell neoplasia (i.e., lymphoma) is a concern, versus other infiltrative neoplasia such as adenocarcinoma, etc. Benign disease is possible but considered less likely. A perforating foreign body could potentially result in these changes with a marked inflammatory effect in the wall, but given the loss of layering and the severity, that is considered far less likely.

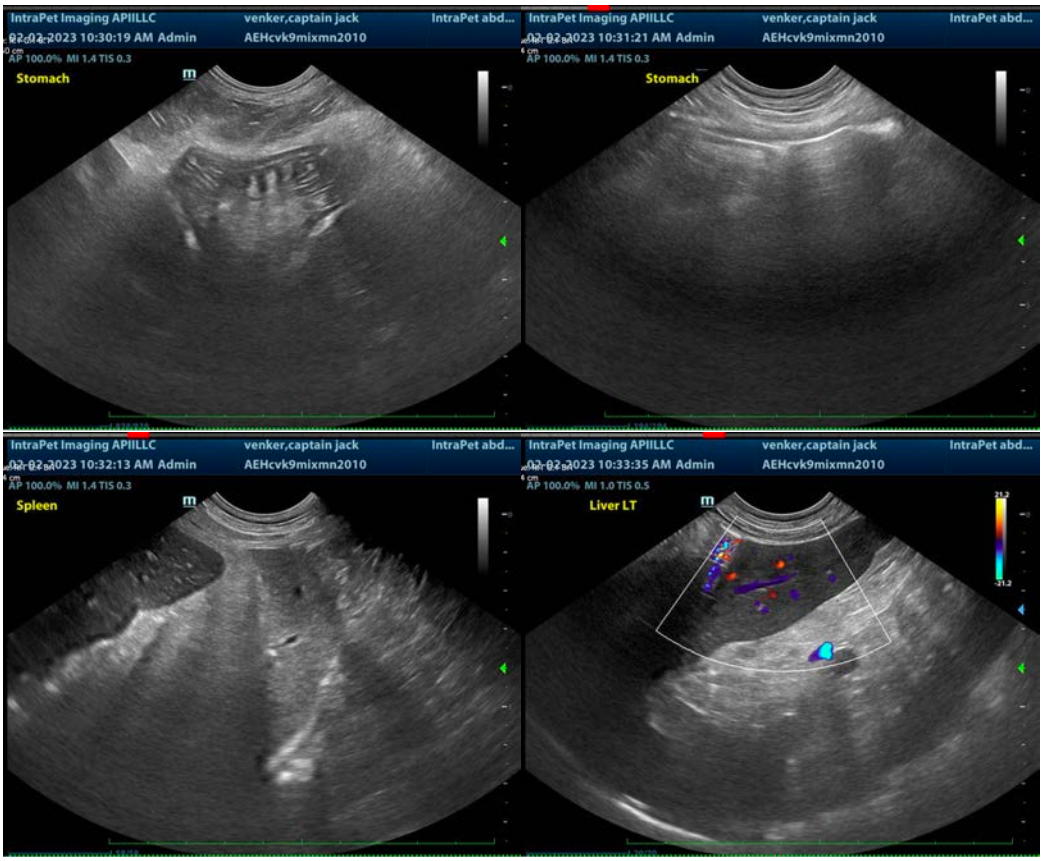
- **Hypoechoic hepatomegaly** – This appearance is consistent with an acute hepatopathy or acute cholangiohepatitis. Infiltrative neoplasia (round cell neoplasia) should also be considered.

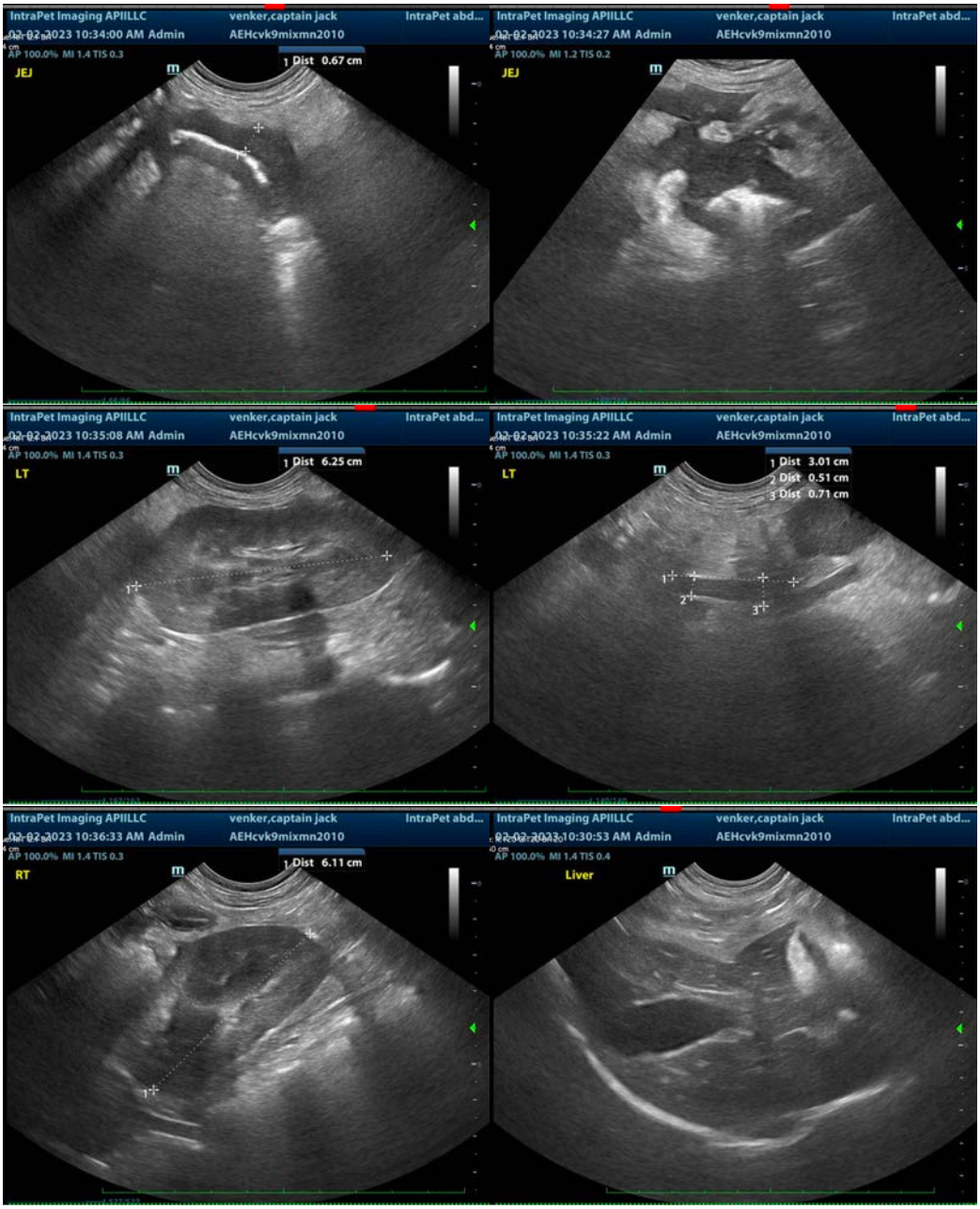
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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.

Once patient is stable enough to undergo surgery, an exploratory laparotomy for planned bowel mass resection is recommended as soon as possible.

If a pre-surgical diagnosis changes the plan, a fine needle aspirate of the liver could be considered to look for evidence of lymphoma if patient's coagulation status is appropriate.

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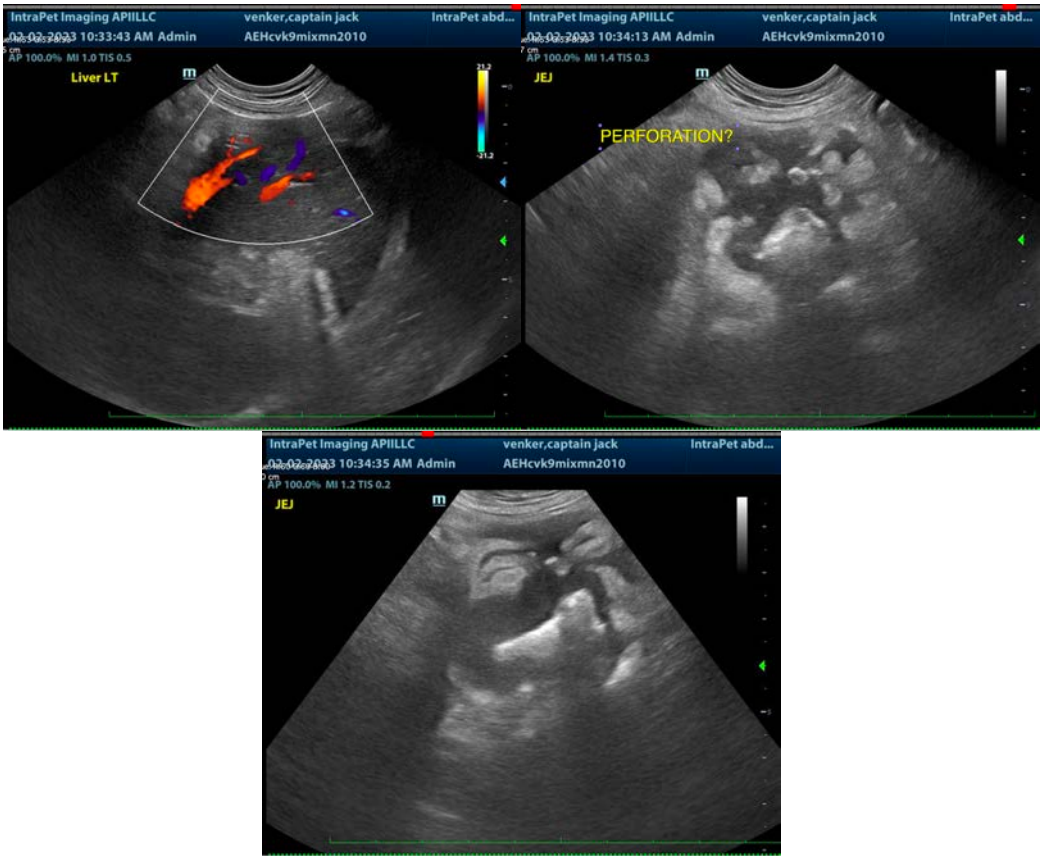
Liver



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