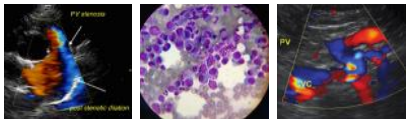
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

**DATE**

2/21/23

**PATIENT**

Blue Kahoe

**SPECIES**

Canine

**BREED**

Pitbull

**SEX**

Neutered Male

**AGE**

6/11/21

**WEIGHT**

62.5 Pounds

**INTERPRETED BY**

Beth Johnson, DVM DACVIM

**HOSPITAL NAME**

Animal Emergency Hospital

**REFERRING VET**

Dr. Nacke-Horney

**INVOICE**

21228

## PRESENTING CLINICAL SIGNS

History: Ate diaper 2 weeks ago - size 2 ate about 3/4 of it - owner woke up around 3 and found the mess in the hallway, monitored him overnight then presented to homeward bound in the AM - induce vomiting, took rads unsure of foreign material in the GI tract, did an enema, took another rad and started anti-inflammatory By sat was moving slow, whimpering, struggling to move up the steps - typically a very active dog Monday took back to homeward bound and tried to recreate what was going on - patient was not reactive- sent home with gabapentin for concerns for joint pain Tuesday: had a horrible night - started amantidine Thursday: slowing down with eating Friday: didn't want to go outside to go to the bathroom Talked to another vet - recommended holding feeding then start slow small meals and then slowly increased - stopped wanting to eat and pain kept getting worse Presented to greenbrier yesterday - did rads, PE was non-reactive but then exhibited behavior describe - did famotidine, gaba, and methocarb - gave inj of buprenorphine - had another bad night overnight, was whining and panting heavily and shaking Saw by Greenbrier today was having extreme Gave no meds over the weekend. Owner noted that when getting to him eat started shaking behavior within 20 mins Has had food issues. Presented to Homeward Bound 2/7: - Presented after ingestion of a diaper - Induced vomiting with Clevor drops - Tx: injection of metoclopramide - Owner declined Sq fluids Client communication 2/11: whining after jumping off the bed - owner declined drop off exam but expressed concerns about obstruction, patient is not having vomiting or diarrhea - recommended monitoring for lameness. Presented to Homeward Bound 2/13: - Painful - reactive when the owner push his tail - had some blood int he stool yesterday when he defecated out piece of diaper - Rads: concern for colonic foreign material - gave an enema - Bw: NSF - Sent home with gabapentin 300 mg and carprofen 100 mg Client communication 2/17: patient is very painful despite pain management - appears painful during defecation - prescribed amantidine 100 mg 1 tab q12 Presented to Greenbrier 2/20: - Second opinion - Painful on rectal - Rads: empty stomach, no obvious FB observed, no obvious obstructive pattern, spine appears normal - Administered buprenorphine inj - Recommended restarting gabapentin - added on methocarbamol 500 mg 1 tab q12 and famotidine 20 mg 1 tab q12 - if not responding consider US Presented to Greenbrier 2/21: - Recheck due to have a horrible night - was whimpering and panting - Discussed concerns for spinal vs musculoskeletal vs abdominal - We unable to obtain 4dx

Current Medications: See above.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: IV Ace and Buprenex.
Stat Report: STAT requested.
Imaging Performed By: Rachel Brilhart, RDMS.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

Urinary bladder is adequately 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 pathology.

Left kidney is normal is size (6.99 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.

Right kidney is normal is 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.

### *Adrenal Glands*

Left adrenal gland is normal in size (2.54 cm long x 0.61 cm at cranial pole and 0.66 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (3.39 cm long x 0.7 cm at cranial pole and 0.82 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

### *Spleen*

Spleen is subjectively large in size with a mildly swollen but smooth capsule. Parenchyma is normal and homogenous in echogenicity and echotexture. No focal nodules or masses are observed. Splenic vasculature appears normal.

### *Liver*

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.

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 empty with no evidence of obstruction, foreign material or infiltrative disease.  Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering. 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 and layering. Contents are consistent with normal formed feces and gas.

### *Pancreas*

The observed pancreas appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

### *Free Abdomen*

There is no evidence of peritoneal effusion.

In the caudal abdomen, near the trifurcation, there is a large 3.5 cm+ x 5.8 cm+ irregular heterogenous primarily hypoechoic mass consistent, possibly, with lymph nodes.

### *Other*

There is no evidence of heart base or pericardial pathology noted in these images at this time. If cardiac function evaluation is desired, a full echocardiogram is recommended.

## ULTRASONOGRAPHIC FINDINGS

- Hypersplenism – 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.

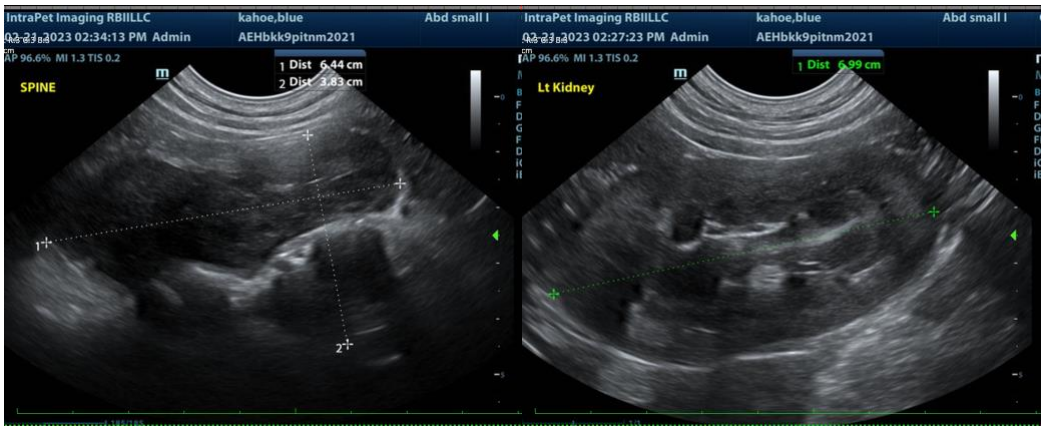
- Large heterogenous hypoechoic caudal abdominal mass, most consistent with medial iliac or sublumbar lymph nodes, in which case, an aggressive process, such as an infiltrative round cell or metastatic neoplasia or a benign, but aggressive inflammatory response is suspected.

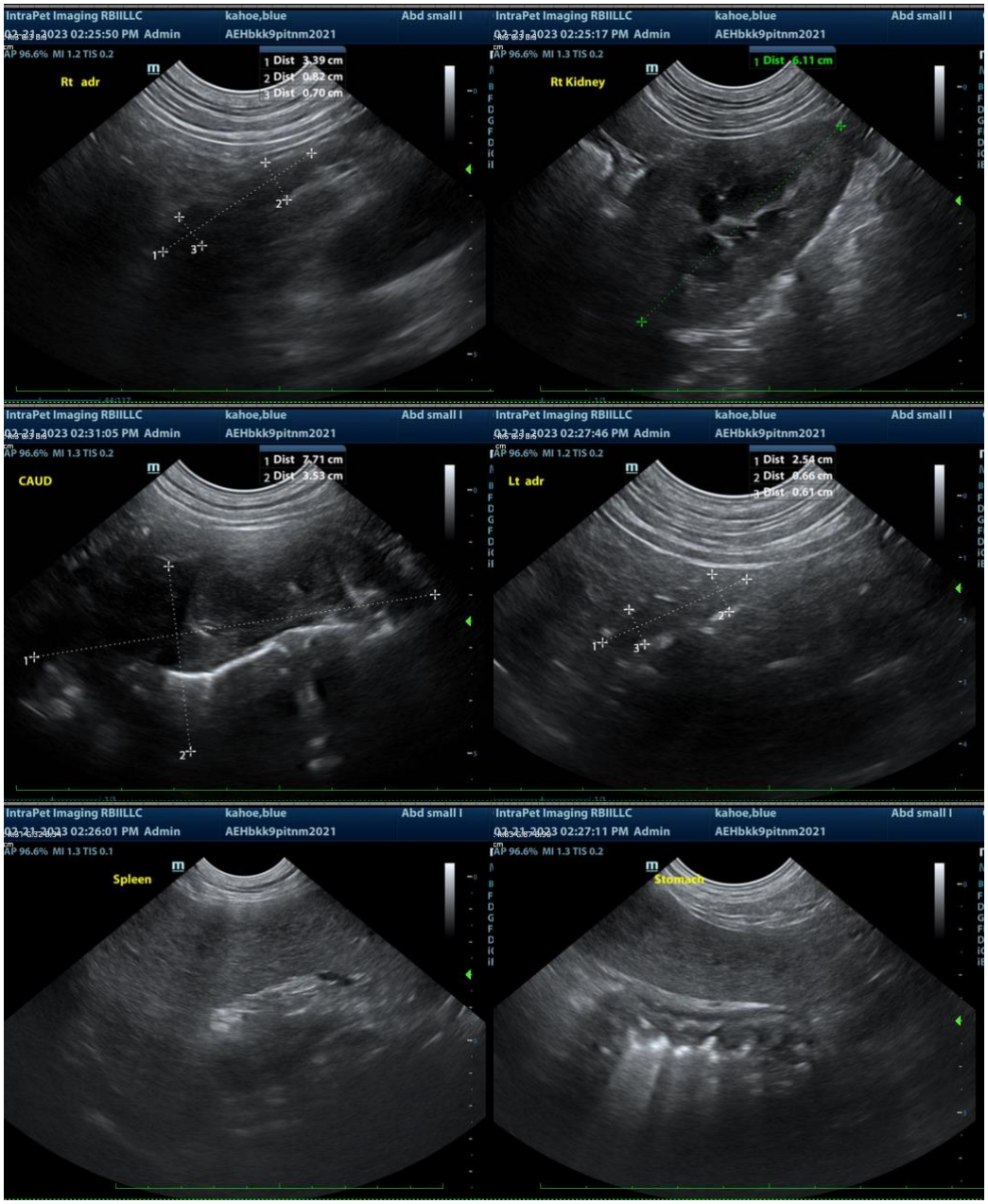
## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

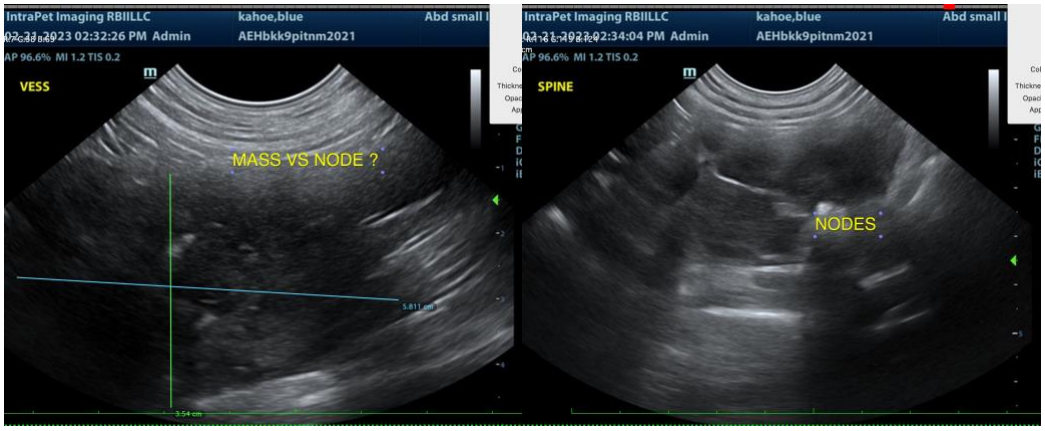
If not recently evaluated, three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

A fine needle aspirate of the caudal abdominal mass/enlarged lymph nodes is recommended if patients coagulation status is appropriate, for both cytology, as well as culture and sensitivity, if indicated based on cytology results.

Additionally, if not recently evaluated, a thorough rectal/anal gland and perianal exam is recommended to look for evidence of a primary disease. If a diagnosis is not obtained cytologically, or a primary disease located, advanced imaging, such as a caudal abdominal/pelvic CT scan may be warranted.




IntraPet Imaging RBIILLC
kahoe,blue
Abd small I
AEHbkk9pitnm2021
Rt adr
1 Dist 3.39 cm
2 Dist 0.82 cm
3 Dist 0.70 cm
IntraPet Imaging RBIILLC
kahoe,blue
Abd small I
AEHbkk9pitnm2021
Rt Kidney
1 Dist 6.11 cm
IntraPet Imaging RBIILLC
kahoe,blue
Abd small I
AEHbkk9pitnm2021
CAUD
1 Dist 7.71 cm
2 Dist 3.53 cm
IntraPet Imaging RBIILLC
kahoe,blue
Abd small I
AEHbkk9pitnm2021
Lt adr
1 Dist 2.54 cm
2 Dist 0.66 cm
3 Dist 0.61 cm
IntraPet Imaging RBIILLC
kahoe,blue
Abd small I
AEHbkk9pitnm2021
Spleen
IntraPet Imaging RBIILLC
kahoe,blue
Abd small I
AEHbkk9pitnm2021
Stomach




**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