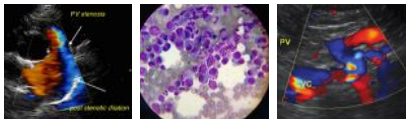
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
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DATE

2/27/23

PATIENT

Sammy Adkins

SPECIES

Canine

BREED

Dachshund

SEX

Neutered Male

AGE

2/27/07

WEIGHT

7 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Alexander AH

REFERRING VET

Dr. Alexander

INVOICE

21303

PRESENTING CLINICAL SIGNS

History: Bloody diarrhea for 1 month--some response to metro and proviable. Frequency--getting O at night. No V. Eating chicken and rice currently. Prev on Fresh Pet food. BW WNL. Fecal Neg

Current Medications: Metro and Proviable. Started R/C GI diet today--O has been feeding chicken and rice
Lab Results: BW WNL, Fecal NOS
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Rachel Brilhart, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with occasional echogenic non-shadowing debris, most consistent with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can also present with echogenic debris. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. The left kidney measures 4.01 cm. A chronic infarct is observed in the left kidney. The right kidney measures 6.21 cm. A large cortical cyst is note din the caudal pole of the right kidney, measuring 2.7 cm x 3.7 cm in size. Mild pyelectasia is noted in the right kidney, measuring 0.36 cm in the sagittal view.

Adrenal Glands

Adrenal glands are largely normal in size, shape and contour. Some parenchymal heterogenicity is present without concerning capsular distortion. These changes are likely normal for this age but should be monitored if there is any suspicion of adrenal disease. The left adrenal gland measures 1.86 cm long x 0.74 cm at cranial pole and 0.67 cm at caudal pole. The right adrenal gland measures 2.0 cm long x 0.59 cm at cranial pole and 0.72 cm at caudal pole.

Spleen

Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). A 2.7 cm x 2.3 cm mixed heterogenous, partially cavitated, primarily hypoechoic mass in the mid body of the spleen, resulting in a capsular bulge. 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 moderately distended with anechoic bile as well as moderate suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

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 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.

The visible colon is normal in wall thickness and layering. Contents are consistent with liquid soft stool to liquid stool in the colon.

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. There is no apparent lymphadenopathy.

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

Primary Findings

- Heterogenous splenic mass. This could represent infiltrative neoplasia, such as round cell neoplasia vs sarcoma vs other. However, benign cysts, hematomas, extramedullary hematopoiesis, etc. can mimic neoplasia and cannot be diagnosed or differentiated without tissue sampling.

Secondary Findings

- Moderate gallbladder debris - Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

- Age-related kidney changes with a large cortical cyst and mild pyelectasia in the right kidney.

- Urinary bladder debris

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the presence of the splenic mass, 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.

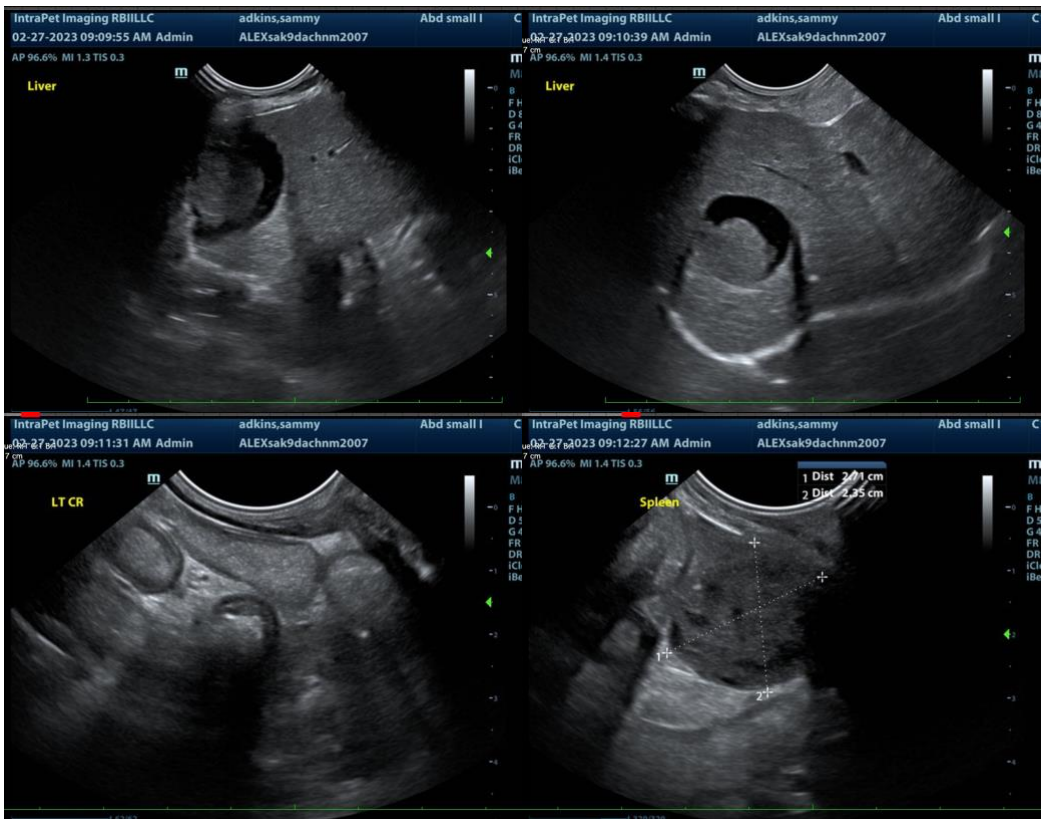
A fine needle aspirate of the splenic mass could be considered if patients coagulation status is appropriate.

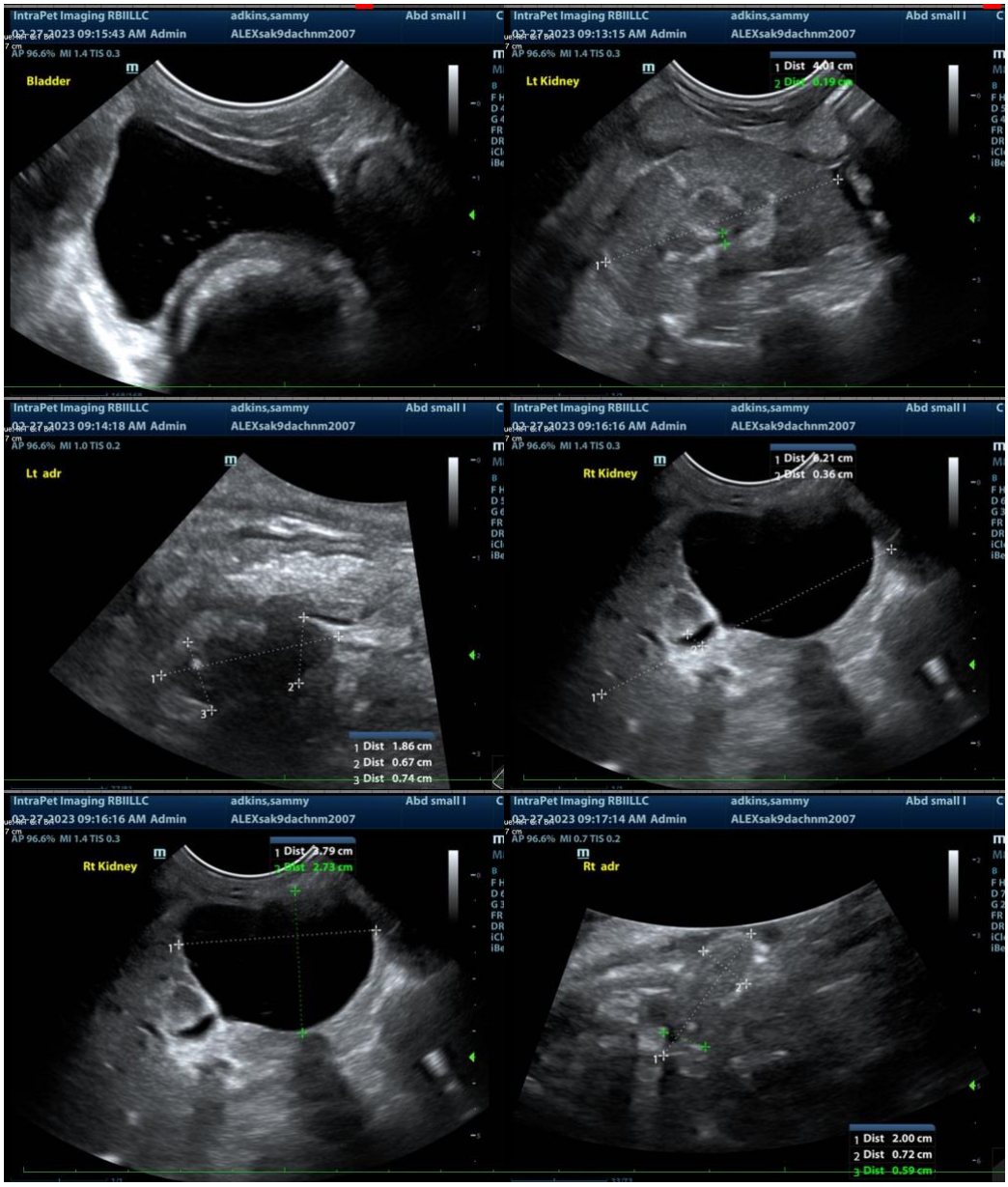
However, while significant, the splenic mass may or may not be related to the presenting complaint of hematochezia, therefore, additional recommendations include If this is an acute episode, recommendations include an overall general metabolic evaluation (CBC, chemistry panel with electrolytes, coagulation panel, urinalysis and fecal exam if not recently evaluated) followed by supportive/symptomatic medical management of clinical signs (possibly HGE) including anti-emetics, gastroprotectants (including sucralfate), a probiotic (such as Visbiome or Proviable), empirical deworming with a 5-day course of Panacur, +/- metronidazole or Tylosin and if tolerated a short term course of a bland, easy to digest or possibly fiber responsive diet.

If, however, there is any chronicity, then in addition to the above, further evaluation is warranted beginning with:

- A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.
- A baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.
- A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease.

Ultimately, if clinical signs persist, and a diagnosis is not reached, further evaluation of the GI tract via upper and lower endoscopy for visualization and biopsies may be warranted.

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Bladder
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Lt adr
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Rt Kidney
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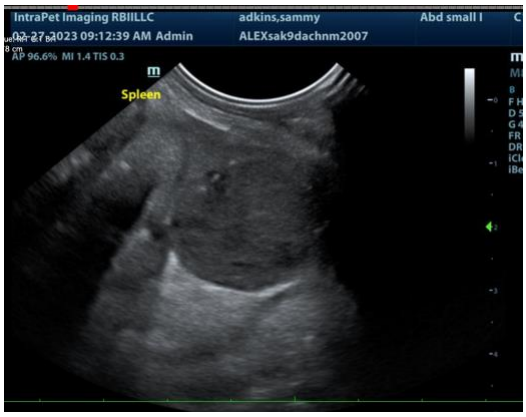
2 Dist 0.72 cm
3 Dist 0.59 cm



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