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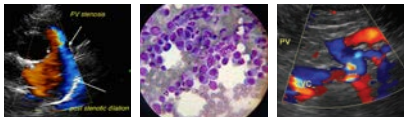

SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
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DATE

6/14/22

PATIENT

Linus Reed

SPECIES

Canine

BREED

Boxer X

SEX

Neutered Male

AGE

6/13/11

WEIGHT

40.6 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Rachel Brilhart RDMS

HOSPITAL NAME

Animal Emergency Hospital

REFERRING VET

Dr. Saubier

INVOICE

38693

PRESENTING CLINICAL SIGNS

06-13-2022 Notes: End of May 20th seen at rDVM for "lazy" eye. acting normally otherwise. Recently has been vomiting after eating, owner thought was eating to fast. Seen rDVM today - recheck left eye - chronic issue. Noted trouble breathing. Full BW - monocytosis, elevated globulins. Referral for continued care. Eye stained - negative. Slightly dehydrated on PE, dyspnea - pulmonary changes, vomited 2x bile-tinged fluid shortly after arriving.

Radiographs: Abdominal - soft tissue mass. Chest - severe diffuse parenchymal changes.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

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.

Prostate (neutered) is normal in size, echotexture and echogenicity for a neutered male.

The right kidney is normal in size (5.06 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 (6.32 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. In the cranial pole of the left kidney, there is a 0.8 cm hypoechoic nodule present, which does not disrupt normal architecture and or capsular contour. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

The right adrenal gland is normal in size (2.72 cm long x 0.80 cm at the cranial pole and 0.79 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 (2.48 cm long x 0.68 cm at the cranial pole and 0.67 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

The spleen is subjectively enlarged in size. Parenchyma contains multifocal poorly defined, hypoechoic nodules of varying sizes that do not disrupt the capsule. Splenic vasculature appear normal.

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.

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 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.

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.

In the cranial abdomen, there is a focal thick loss of layering to the colon, consistent with a mural mass. The wall measures 0.9+ cm thick with complete loss of layering and is hypoechoic in appearance.

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. **Note: see other.

Other

In the mid cranial abdomen, there is a 4.5-5.5 cm heterogeneous, cavitated mass of unknown tissue origin with enhanced hyperechoic fat and mesentery surrounding the mass. Potentials include lymph node primarily. However, bowel and/or pancreas cannot be ruled out.

No free fluid including no pericardial effusion. Pulmonary nodules are suspected.

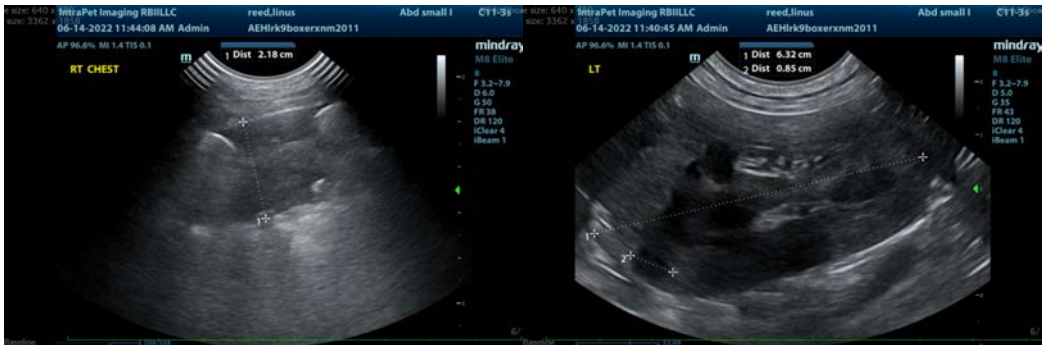
ULTRASONOGRAPHIC FINDINGS

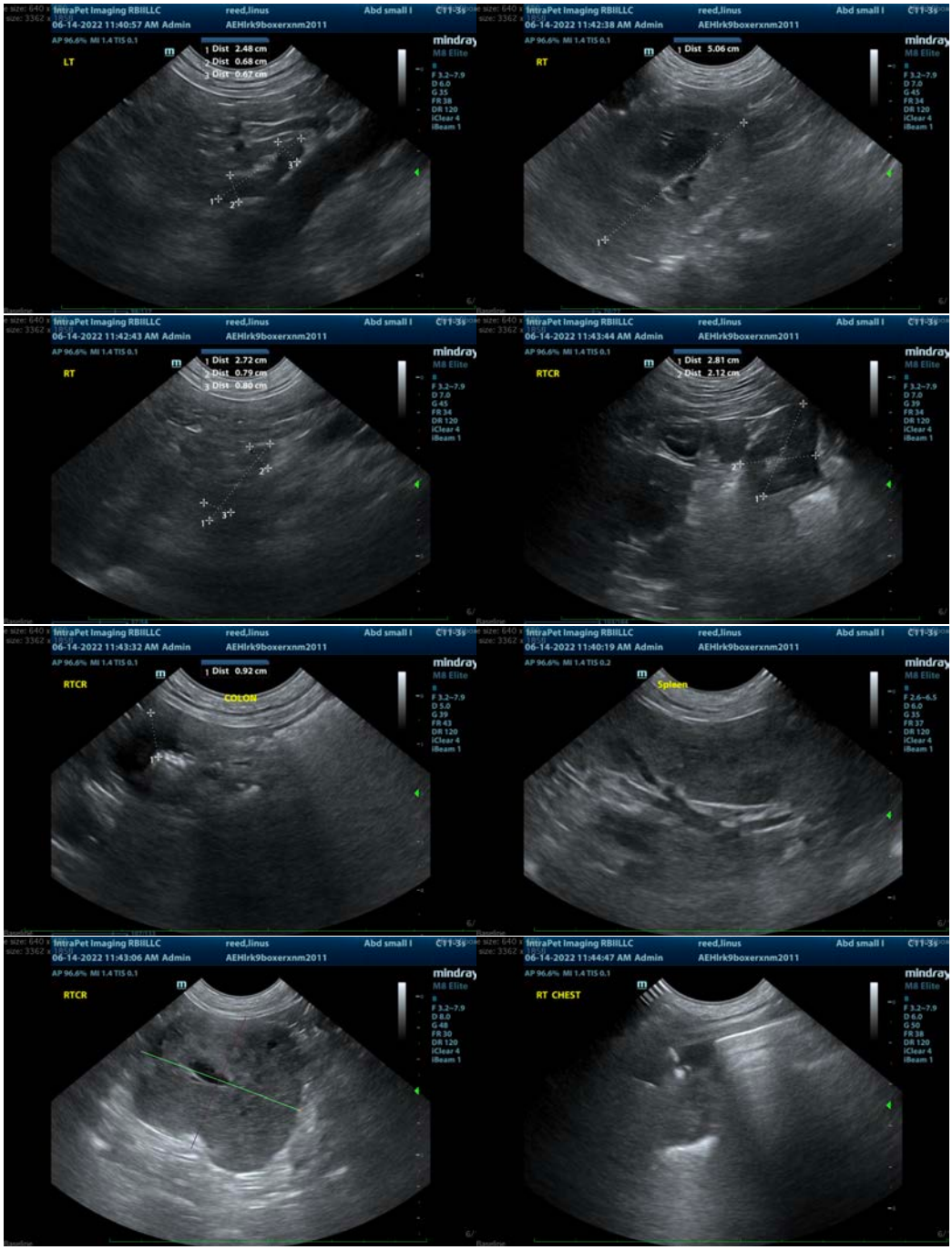
- Multicentric disease affecting the colon, the cranial abdominal mass (likely lymph node, possibly bowel or pancreas), the spleen, and potentially the left kidney, as well as the lung, most consistent with infiltrative round cell neoplasia versus metastatic neoplasia. Benign disease is possible, but considered highly less likely, given the multiple organs affected.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Recommendations include 3-view thoracic radiographs, if not already evaluated, for further evaluation of metastatic disease in the lungs, based on suspicions from these images.

For cytologic diagnosis of the multicentric disease, fine needle aspirate of the cranial abdominal mass/lymph node and/or the colonic mass as well as the spleen recommended, if patient's coagulation status is appropriate.

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Abd small I
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RT CHEST

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
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