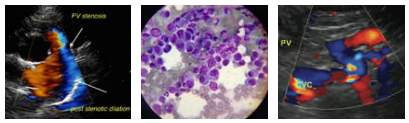
IMAGING PERFORMED BY

IntraPet.com



SonoPath
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**DATE**
7/1/22

**PATIENT**
Skye Fogg

**SPECIES**
Canine

**BREED**
Pitbull Mix

**SEX**
Spayed Female

**AGE**
5/28/17

**WEIGHT**
49.5 lbs

**INTERPRETED BY**
Beth Johnson, DVM DACVIM

**HOSPITAL NAME**
Swan Creek VC

**REFERRING VET**
Dr. O'Connor

**INVOICE**
31411

## PRESENTING CLINICAL SIGNS

First seen 5/27/2022 for 2 week history of vomiting/diarrhea/decreased appetite. CBC/chem unremarkable, xray NVL (motion artifact). Symptomatic treatment. Returned 6/9/2022, temporary improvement but recurrence of symptoms, xray decreased serosal detail, SNAP cPL abnormal, CBC normal. Symptomatic treatment. Returned 6/21/2022, again temporary improvement but recurrence of symptoms. Symptomatic treatment. Returned 6/30/2022, anorexia x 2 days, has lost 6.5 lbs since first visit.
Current Medications: Currently started 6/30/2022: Cerenia 48 mg SID
Entyce 2.2 mls (66 mg) SID PRN. Previously on: Cerenia 48 mg SID
Famotidine 20 mg BID, Diagel, Metronidazole 250 mg BID, Proviable forte.
Lab Results: See attached.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: IV Torb.
Stat Report: Not 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.

Left kidney is normal is size (5.78 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 (6.47 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 (2.39 cm long, 0.62 cm at cranial pole and 0.65 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (2.14 cm long, 0.7 cm at cranial pole and 0.86 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

### *Spleen*

Spleen is generally normal in size and shape with a smooth capsular contour. Parenchyma is diffusely nodular in appearance characterized by small discrete hypoechoic nodules. Splenic vasculature appears normal.

### *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.

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 intestine demonstrates areas of thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. 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 (< 0.2 cm) 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 a scant amount of anechoic free fluid noted primarily around the spleen. Lymph nodes are enlarged with swollen irregular capsular contour and loss of normal length to width ratio (rounded in shape). Mesenteric and cranial abdominal nodes are hypoechoic with loss of normal parenchymal detail.

No appreciable pericardial effusion is noted in these images.

## ULTRASONOGRAPHIC FINDINGS

- **Aggressive lymph nodes –** most consistent with infiltrative round cell or metastatic neoplasia. A benign aggressive inflammatory response cannot be ruled out without tissue sampling +/- culture. This is a diffuse finding involving the mesenteric and cranial abdominal lymph nodes.

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

- **Splenic micronodular hyperplasia pattern–** This nodular change is often associated with benign aging nodular hyperplasia. Infiltrative neoplasia, however, including both early hemangiosarcoma as well as round cell neoplasia cannot be ruled out.

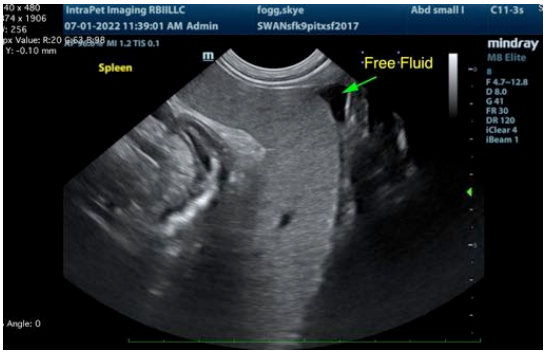
- **Inflammatory bowel disease pattern (IBD) -** This finding has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

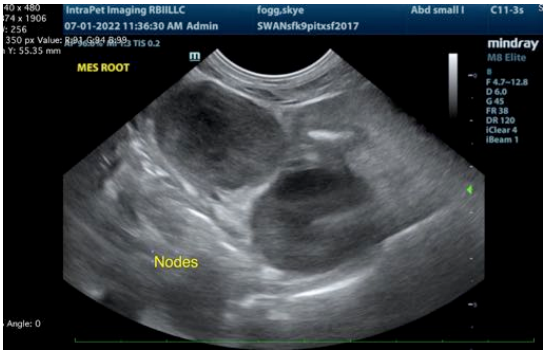
Top differential for this patient is infiltrative round cell neoplasia such as lymphoma versus other. Recommendations include a FNA of the enlarged lymph nodes if the patient's coagulation status is appropriate.

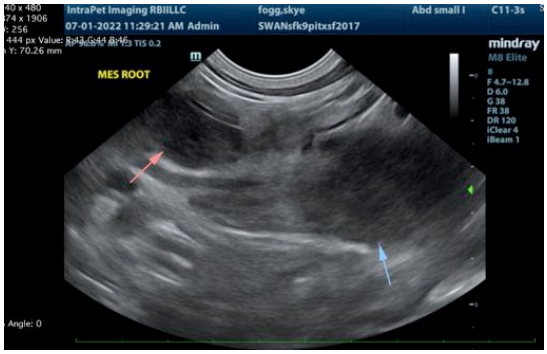
Hepatic and splenic involvement cannot be ruled out. Therefore, if a cytologic diagnosis is not obtained from lymph node cytology FNA of the liver and/or spleen can be considered if the patient's coagulation status is appropriate.

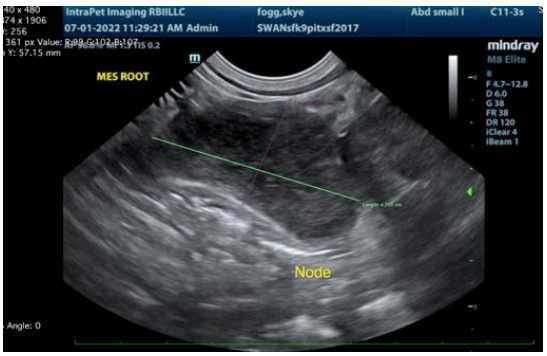
Ultimately if a diagnosis is not obtained cytological biopsies of the GI tract are recommended to definitively diagnose and therefore manage the suspected infiltrative bowel involvement.

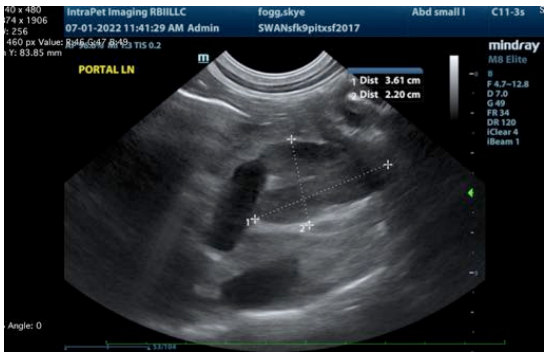




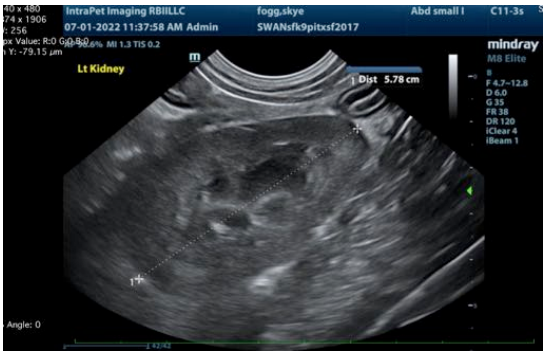


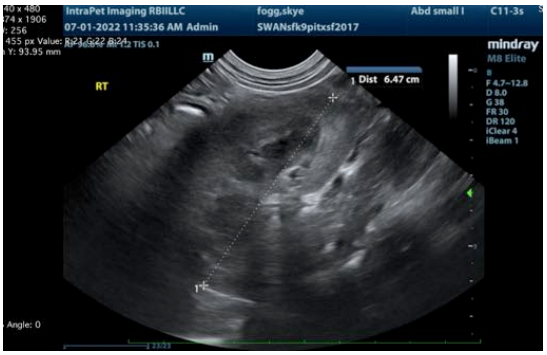














**The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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**

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