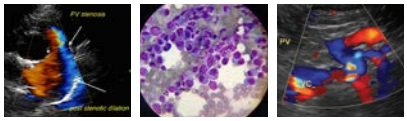
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
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DATE

7/12/22

PATIENT

Tank Marshall

SPECIES

Canine

BREED

Labrador

SEX

Neutered Male

AGE

6/10/14

WEIGHT

89.4 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Rachel Brilhart RDMS

HOSPITAL NAME

Pleasantville Animal Hospital of Fallston

REFERRING VET

Dr. Gounaris

INVOICE

39410

PRESENTING CLINICAL SIGNS

Previously seen at Banfield. Owner reports several months of hematochezia +/- diarrhea. Owner also reports vomiting at least 2 times a week. Decreased appetite and chronic weight loss.
Examined 7/11. Patient BAR, gums slightly pale, BCS 3/9. Rectal revealed abnormal mass of tissue, friable and irregular. Sending out portion for biopsy.

Current Medications: None.
Lab Results: From Banfield June 2022: BUN 49, Creatinine 4.3, Phosph ~8; HCT 33%, WBC ~20k (neutrophilia) (sorry, very difficult to read lab results due to format). 7/11: PCV 30%, TS 7.2.
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 (6.53 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. Small cortical cyst noted.

The left kidney is normal in size (6.56 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. Small cortical cyst noted.

Adrenal Glands

The right adrenal gland is normal in size (2.56 cm long x 1.0 cm at the cranial pole and 0.77 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 (2.8 cm long x 0.68 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.

Spleen

The spleen contains multiple cavitated, cystic masses that disrupt normal capsular contour. The largest measures approximately 11 cm x 13 cm. A second smaller but similar appearing mass measures about 4.0 cm. A third lesion is a small, approximate 1.0 cm hypoechoic nodule.

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 moderately distended with anechoic bile as well as 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 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.

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

There is no evidence of free peritoneal effusion noted in these images. No evidence of pericardial effusion or right auricular mass noted in these images. However, in the right cranial abdomen, there is an enlarged, hypoechoic lymph node noted measuring 1.5-2.0 cm in diameter that is surrounded by enhanced hyperechoic fat.

PRIMARY ULTRASONOGRAPHIC FINDINGS

- Multiple cystic, cavitated splenic masses – most concerning for infiltrative neoplasia such as sarcoma. Benign hematomas cannot be ruled out, but are considered less likely.

- Enlarged lymph node with enhanced fat surrounding it in the cranial abdomen – both reactive and infiltrative neoplasia/metastatic disease are differentials.

SECONDARY FINDINGS

- 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.

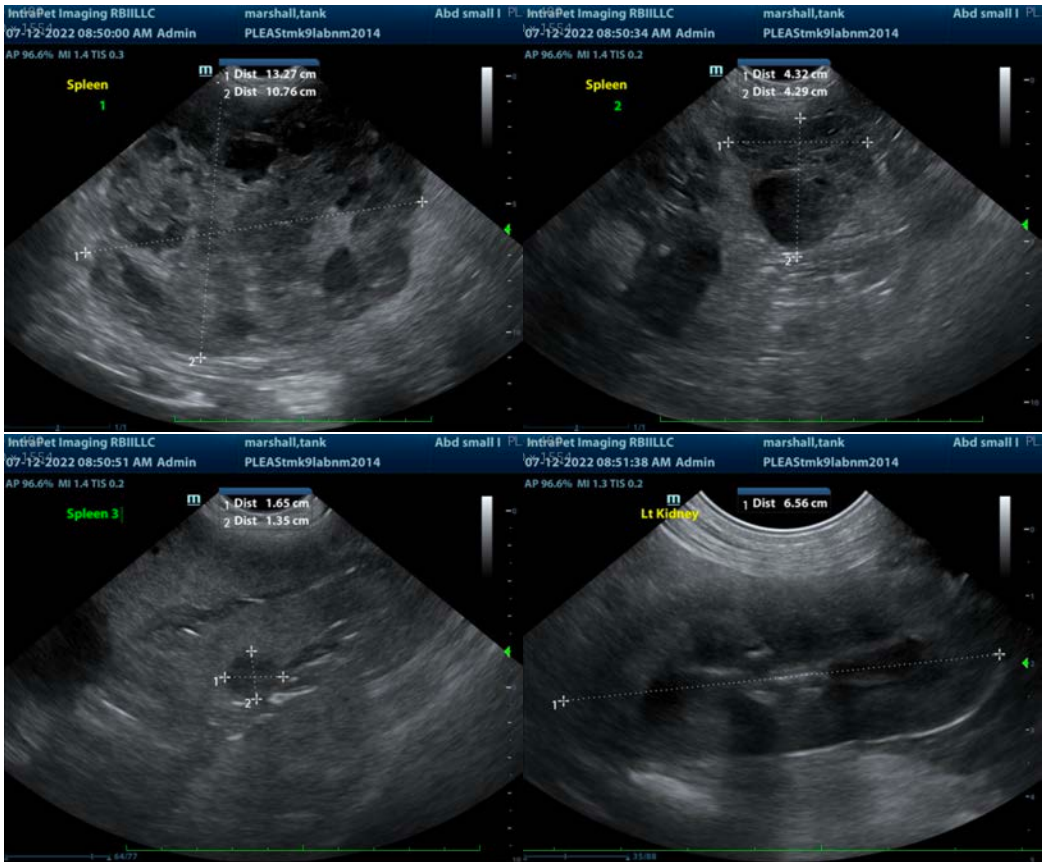
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

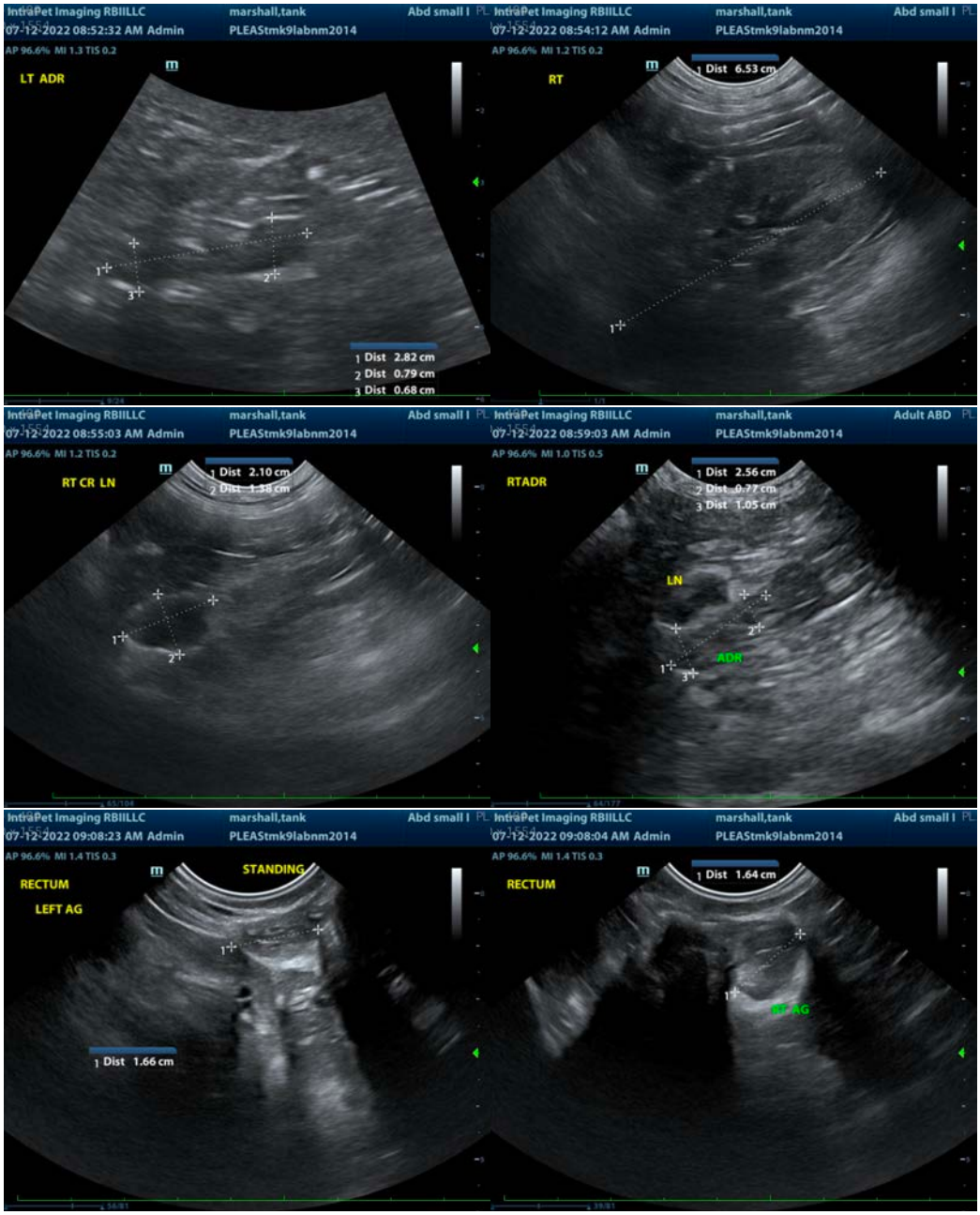
- Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

- Given this patient's reported azotemia, if not already evaluated, urinalysis and, if indicated based on urinalysis results, urine culture are recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

- Given the presence of the cavitated splenic masses, an exploratory laparotomy with planned splenectomy is recommended, regardless of the histologic diagnosis of the splenic masses, given the future risk for hemorrhage, etc. However, in this patient specifically, given the concurrent historical hematochezia and reported rectal mass (of which biopsies are reportedly pending), waiting for pending biopsies results prior to proceeding with splenectomy is recommended, in case further intervention is needed for the rectal/colonic lesions. For example, if a diagnosis is not obtained, a colonoscopy could be considered under the same anesthetic as a splenectomy potentially.

- The abnormal tissue reportedly palpated and biopsied is likely the cause of the hematochezia. However, if it is not determined to be the cause, other diagnostic considerations could include a fecal exam, a fecal enteropathogen PCR panel to Texas A&M GI Laboratory for further evaluation of possible infectious disease, and empirical deworming with a 5 -day course of Panacur +/- diet transition to a higher fiber diet and a probiotic.

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marshall,tank
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AP 96.6% MI 1.3 TIS 0.2
LT ADR
1 Dist 2.82 cm
2 Dist 0.79 cm
3 Dist 0.68 cm
IntraPet Imaging RBIILLC
marshall,tank
Abd small I
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RT
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IntraPet Imaging RBIILLC
marshall,tank
Abd small I
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RT CR LN
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2 Dist 1.38 cm
IntraPet Imaging RBIILLC
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Adult ABD
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RTADR
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2 Dist 0.77 cm
3 Dist 1.05 cm
LN
ADR
IntraPet Imaging RBIILLC
marshall,tank
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AP 96.6% MI 1.4 TIS 0.3
STANDING
RECTUM
LEFT AG
1 Dist 1.66 cm
IntraPet Imaging RBIILLC
marshall,tank
Abd small I
07-12-2022 09:08:04 AM Admin
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AP 96.6% MI 1.4 TIS 0.3
RECTUM
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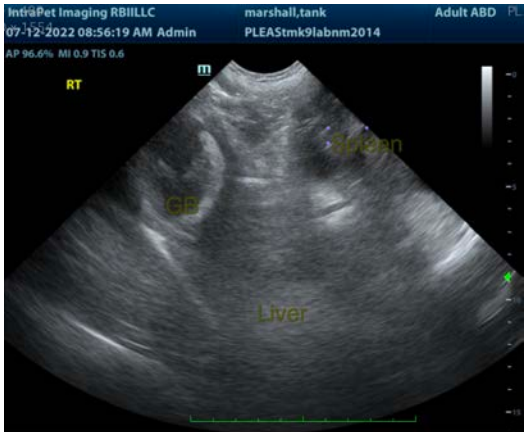
RT AG



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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