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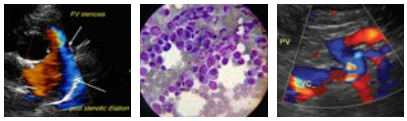
IntraPet.com

SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
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**DATE**

7/28/22

**PATIENT**

Shiloh Moylan

**SPECIES**

Canine

**BREED**

Rottweiler

**SEX**

Neutered Male

**AGE**

4/1/14

**WEIGHT**

93.8 Pounds

**INTERPRETED BY**

Beth Johnson, DVM DACVIM

**IMAGING PERFORMED BY**

Andi Parkinson RDMS

**HOSPITAL NAME**

Belvedere Vet Center

**REFERRING VET**

Dr. Molinelli

**INVOICE**

39943

## PRESENTING CLINICAL SIGNS

ADR, limping left front. Pe no abdominal pain, painful left scapula and dorsal humerus no obvious swelling at area and limp had improved. back pain T10-L3, no not eating and blood work of concern of neutrophilia and eosinophila and elevated cpl

Current Medications: Clavamox 375mg and Rimadyl which have been discontinued due to anorexia.
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.

The area of the prostate is examined without evident pathology.

The right kidney is normal in size (7.61 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 (7.2 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*

The right adrenal gland is normal in size (1.9 cm long x 0.75 cm at the cranial pole and 0.58 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 (3.35 cm long x 0.78 cm at the cranial pole and 0.87 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

### *Spleen*

Spleen is markedly enlarged in size with a swollen and scalloped/undulating capsular contour. Multifocal coalescing nodules are noted throughout the parenchyma. Splenic vasculature appears normal. Enhanced hyperechoic surrounding fat is noted.

### *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.

The gallbladder is non-distended in size. The wall appears mildly thick/edematous with a characteristic “halo” sign. 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 moderately fluid distended 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.

Mid abdominal lymph nodes are enlarged with swollen irregular capsular contour and loss of normal length to width ratio (rounded in shape). Nodes are hypoechoic with loss of normal parenchymal detail.

No evidence of pericardial effusion or heart base lesions.

## PRIMARY FINDINGS

- **Honeycomb Spleen –** This finding is strongly suggestive of infiltrative disease such as round cell neoplasia. Benign disease cannot be ruled out but is considered less likely.
- **Hypoechoic hepatomegaly** – This appearance is consistent with an acute hepatopathy or acute cholangiohepatitis. Infiltrative neoplasia (round cell neoplasia) should also be considered.
- **Aggressive mid abdominal lymph nodes –** most consistent with infiltrative round cell or metastatic neoplasia. A benign aggressive inflammatory response cannot be ruled out without tissue sampling +/- culture.

## SECONDARY FINDINGS

- Edematous gallbladder wall/halo sign

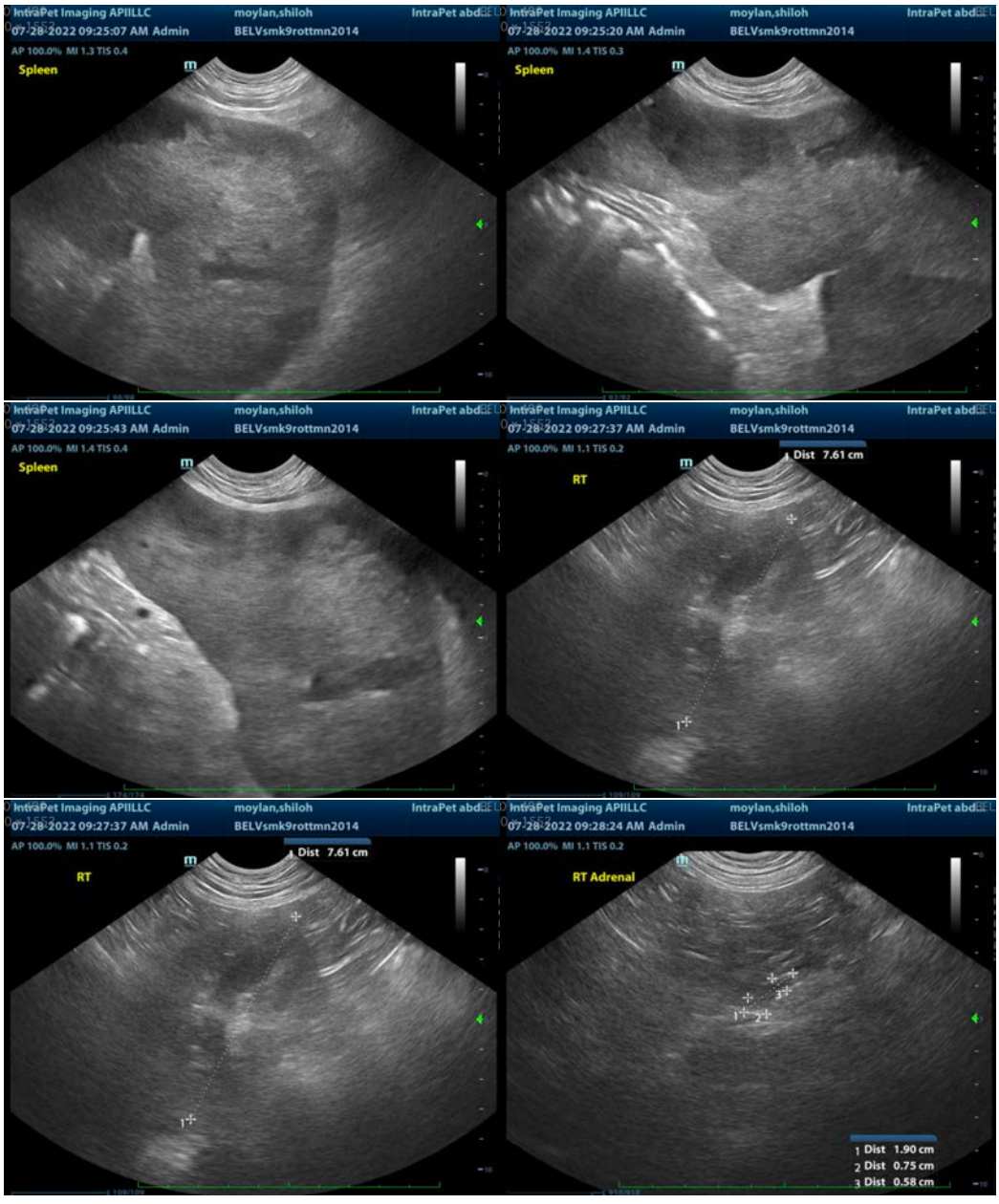
## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

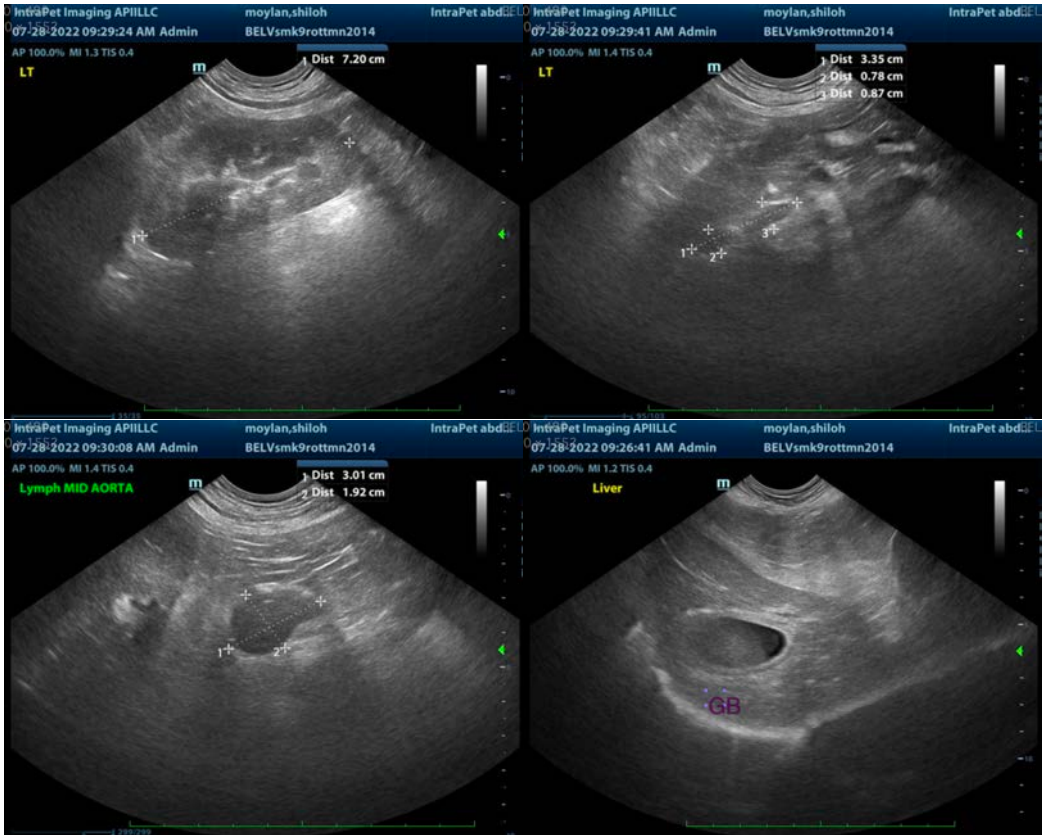
The top differential, given the combination of clinical signs, is infiltrative neoplasia, possibly round cell neoplasia, with mast cell tumor and lymphoma being top differentials, given the concurrently reported eosinophilia, although other cancers can also cause paraneoplastic eosinophilia. Recommendations include:

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.

Fine needle aspirate of the spleen +/- liver and enlarged lymph node, if patient's coagulation status is appropriate.

Pre-medication with diphenhydramine is recommended.






**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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