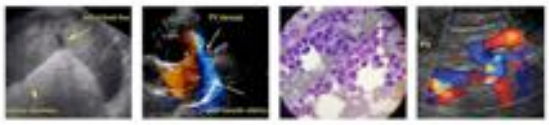

PATIENT

Daisy Carrera

SPECIES

Canine

BREED

Labrador Retriever

SEX

Spayed Female

AGE

11 years

WEIGHT

84 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT

HOSPITAL NAME

Fairgrounds AH

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PRESENTING CLINICAL SIGNS

Presented on 27 JUN for lethargy, reduced appetite, polydipsia, ~7% dehydrated, QAR Unremarkable chemistry, cPLI negative; stress luekogram Supportive symptomatic tx for pancreatitis/gastroenteritis – metronidazole, maropitant PT represented on 30 JUN for continued clinical signs and minimal improvement PT was examined, assessed as stable with mild cranial abd pain and was given more maropitant and additional rx of omeprazole 40mg PO q24hrs + id low fat for over the weekend. PT to return if not improving on Tuesday. PT represented on 5 JUL for progressive lethargy, anorexia and lack of interest in treats or special human foods PT assessed as not nauseous, adequate hydration (O's have been syringe feeding bone broth and pedialiyte all weekend), increased lethargy and pain in cranial abdomen Recommended hospitalization for supportive care and ADB US to get an answer as rads performed last week were read out as WNL. In hospital tx: IVF 2x's maintenance, maropitant inj, fentanyl CRI and place fentanyl transdermal patch ABD US performed with abnormal duodenal thickness and loss of layers and severe, generalized mesenteric lymphomegaly; other findings considered less concerning – hepatic and splenic changes

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 (7.15 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 (6.69 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 (0.66 cm at cranial pole and 0.86 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.69 cm at cranial pole and 0.95 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

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). No masses are observed. Several small less than 1.0 cm diameter with hypoechoic non-capsular, disrupting nodules are noted. Splenic vasculature appears normal.

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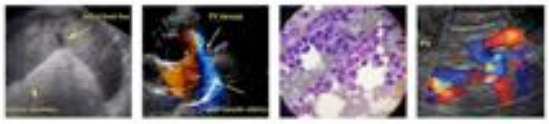

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Liver

Liver is subjectively enlarged with irregular margins. Parenchyma is heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. 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 intestines other than the duodenum are normal in wall thickness and layering. 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 duodenum is diffusely thick and slightly corrugated surrounded by enhanced hyperechoic fat with a focal area that exhibits complete loss of normal layering/loss of mural detail. This measures approximately 1.0 cm thick and is diffusely hypoechoic.

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.

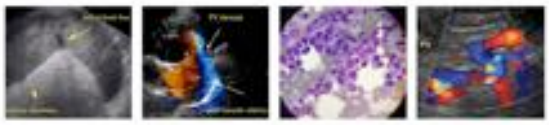
Free Abdomen

There is no evidence of peritoneal effusion noted in these images. Diffuse lymphadenopathy is appreciated and mesenteric lymph nodes are swollen irregular capsular contour and loss of normal length to width ratio (rounded in shape). Nodes are hypoechoic with loss of normal parenchymal detail.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS:

- Focal, thick loss of normal layering in the duodenum. This is most consistent with infiltrative neoplasia such as lymphoma versus other. In addition to suspected enteritis/focal peritonitis given the enhanced fat and corrugation to bowel.
- 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.



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SECONDARY FINDINGS:

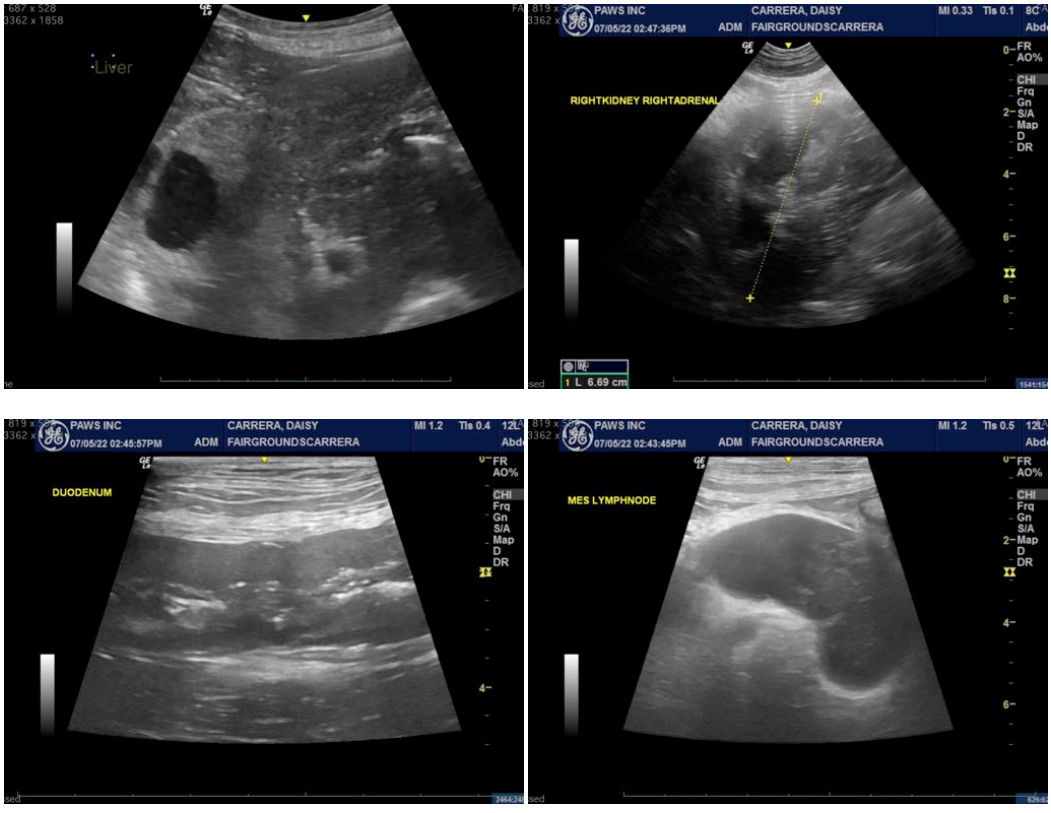
- Liver Nodular Hyperplasia Pattern – These changes are most consistent with benign processes such as nodular hyperplasia, steroid (vacuolar) hepatopathy, extramedullary hematopoiesis or possibly chronic inflammatory disease and less commonly infiltrative round cell or metastatic neoplasia.
- **Hypoechoic splenic nodule** – likely represents a benign lesion such as a cyst, hematoma, nodular hyperplasia, extramedullary hematopoiesis, etc., however, infiltrative neoplasia can mimic benign lesions and cannot be ruled out (while considered highly less likely).

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.

FNA of the enlarged mesenteric lymph nodes is recommended if patient's coagulation status is appropriate.

If diagnosis of round cell neoplasia is not obtained via cytology biopsies of the focal duodenal thickening may be necessary to definitively diagnose and therefore manage the infiltrative disease.



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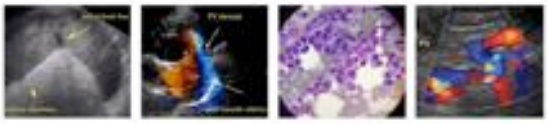

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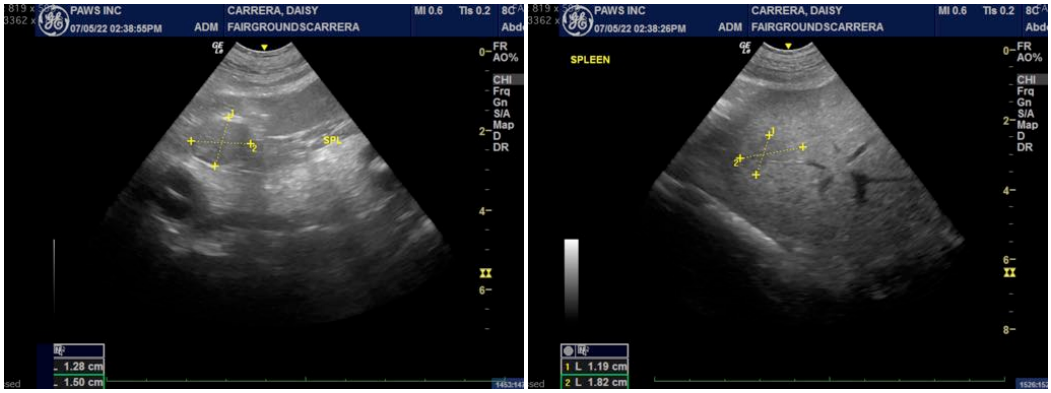

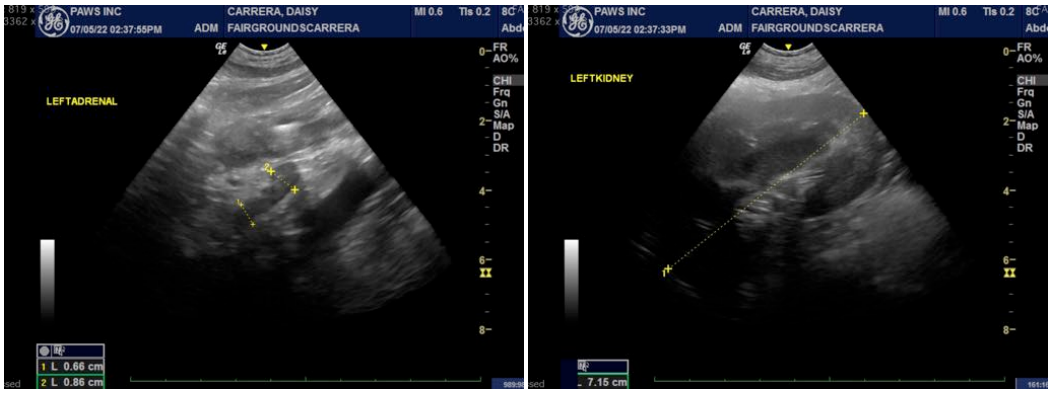

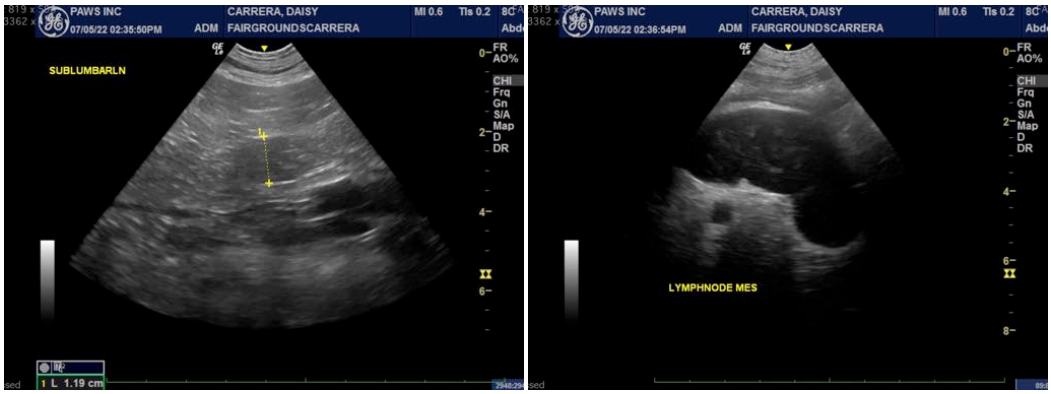

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

Beth.Johnson@SonoPath.com