



PATIENT

Harlee Love Archer

SPECIES

Canine

BREED

Boston Terrier

SEX

Spayed Female

AGE

9 Years

WEIGHT

14.5

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Lynette Reyes

HOSPITAL NAME

Chain of Lakes Vet

REFERRING VET

Dr. Lynette Reyes

INVOICE

39263

DATE

7/6/22

PRESENTING CLINICAL SIGNS

Pet presented last week for diarrhea for the past 4-5 days. Eating well and no vomiting. Pet has lost 1.5 lbs since last visit in March. On PE, pet's abdomen was distended and cranio organomegaly was present
Abnormal PE/Chem/CBC/UA Results: CBC: PIt: 679 Chem: TP: 4.2 Alb: 2.6 GGT: 28 Calcium: 7.4 Mag: 1.2 PSL: WNL Fecal: neg

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 right kidney is normal in size (4.6 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. A cortical cyst is present.

The left kidney is normal in size (4.0 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 unable to be visualized in these images.

In the area of the left adrenal gland, there is a large, approximately 5.0 cm x 6.0 cm mixed heterogeneous mass believed to be an adrenal mass with complete loss of normal architecture and capsular escape. Vascular invasion is not observed but cannot be definitively ruled out.

Spleen

The 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 focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged with rounded margins. Parenchyma is heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Visible vasculature appears normal.

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 small intestine is diffusely mildly thick with a relatively thick mucosa compared to other layers. Normal wall layering is preserved; however, the mucosa is more echogenic than normal and contains hyperechoic striations perpendicular to the lumen. The lumen of the small intestine is empty with no evidence of obstruction or foreign material.



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The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

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Pancreas

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In the area of the pancreas, in the mid cranial abdomen caudal to the stomach and medial to the duodenum, there is an approximately 4.0 cm undifferentiated mixed heterogeneous, primarily hypoechoic mass of tissue surrounded by free fluid and enhanced hyperechoic clumped fat and mesentery that may be associated with the pancreas versus other.

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There is no evidence of free peritoneal effusion noted in these images.

There is no apparent lymphadenopathy noted in these images. **See pancreas.

PRIMARY FINDINGS

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- Lymphangiectasia - Small bowel findings are most consistent with lacteal dilation. These findings can be observed with protein-losing enteropathies caused by either primary lymphangiectasia or primary infiltrative inflammatory disease with secondary lymphangiectasia. Infiltrative neoplasia is possible but considered less likely. Histopathology is necessary to definitively determine underlying cause.

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- Left adrenal mass – most concerning for adrenal cortical neoplasia such as an adenocarcinoma versus possibly pheochromocytoma. Benign tumor cannot be ruled out, but is considered less likely.

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- Undifferentiated mixed cranial abdominal mass – differentials include severe acute, possibly necrotizing pancreatitis. However, the mild clinical signs are not consistent with this. Therefore, other differentials to consider are an infiltrative pancreatic mass versus bowel or liver mass in the area. Lymph node cannot be ruled out.

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SECONDARY FINDINGS

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- Heterogenous liver – Differentials for hepatic changes include both benign steroid (vacuolar) hepatopathy or extramedullary hematopoiesis as well as infiltrative round cell or metastatic neoplasia.
- 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.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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- This patient's clinical signs and laboratory changes combined with the small bowel changes are all suggestive of lymphangiectasia as a cause for the diarrhea and weight loss. Ideally, biopsies of the GI tract are recommended to definitively diagnosis and therefore manage the infiltrative bowel process. However, given the concurrent changes, immediate recommendations may differ (see below).

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- A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

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- Depending on the level of aggressiveness elected, recommendations for the suspected left adrenal mass and undifferentiated cranial abdominal mass include:

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1. An abdominal CT scan for more definitive tissue of origin identification, identification of vascular invasion from the adrenal mass, etc., followed potentially by surgery, if indicated.

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2. If a less aggressive approach is elected, and clinical signs of adrenal disease are present, then hormone testing could be pursued, at which time a blood pressure and urinalysis are also recommended combined with medical management of potential acute pancreatitis and monitoring of the cranial abdominal mass with color doppler, for changes. If the mass remains, a fine needle aspirate of the mass could be considered if patient's coagulation status is appropriate.

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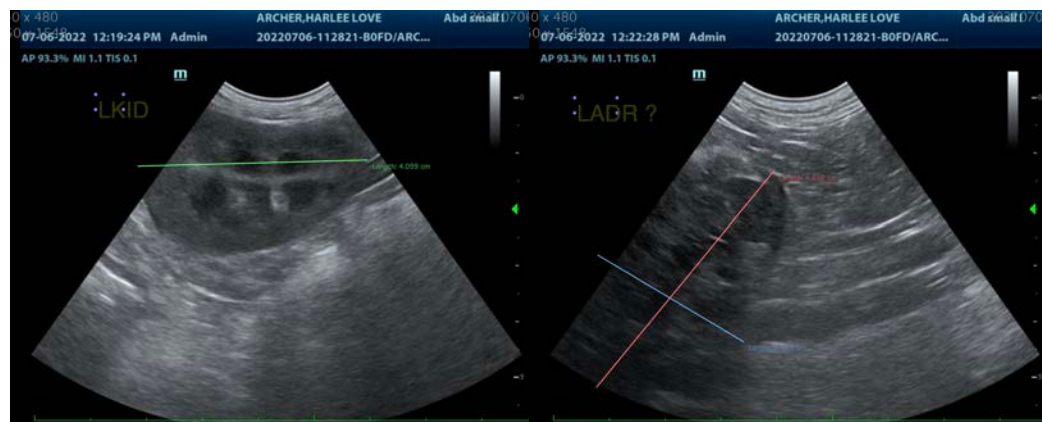
- If the elected focus is on the suspected lymphangiectasia, given the diarrhea and weight loss, empirical therapy with deworming including a 5-day course of Panacur, cobalamin supplementation if indicated based on GI panel, an ultra low-fat diet +/- steroids could be considered.

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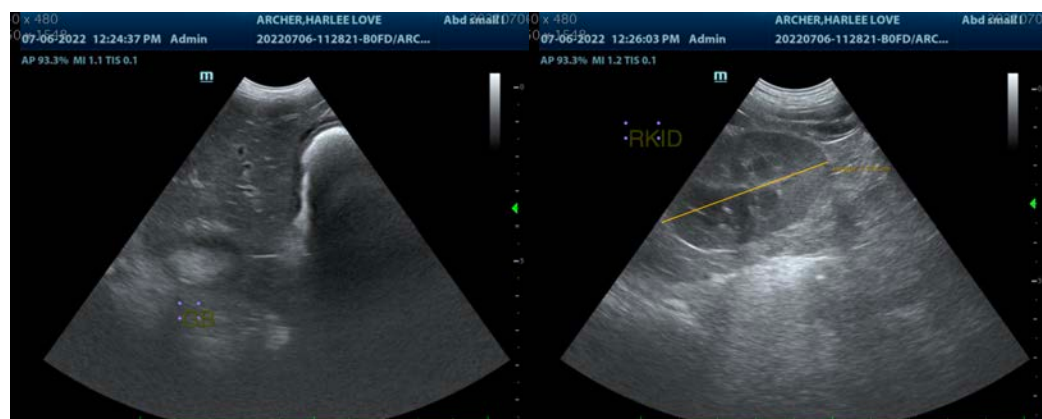


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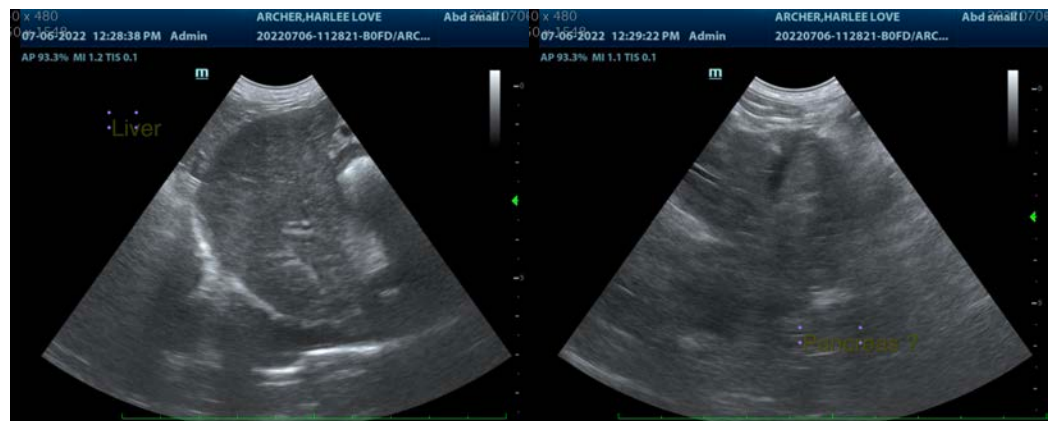
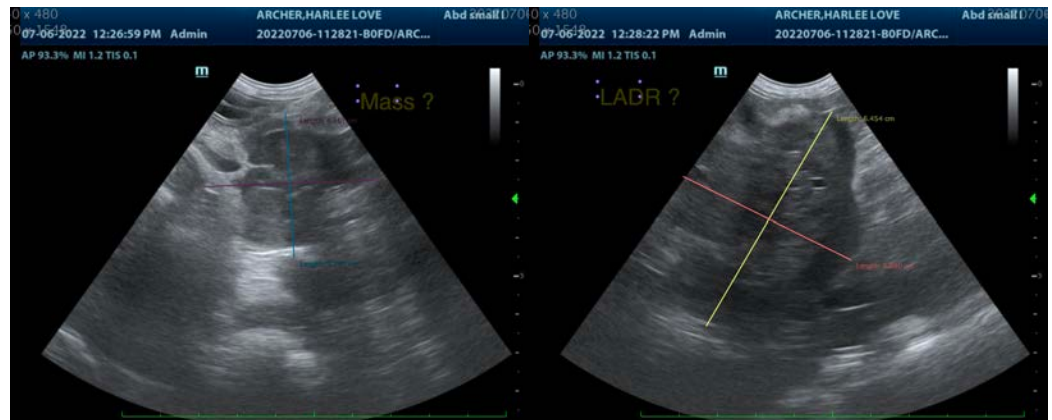
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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.

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