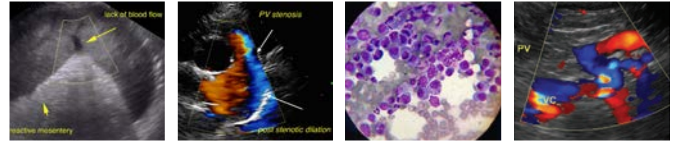


SonoPath.com™
1-800-838-4268 info@sonopath.com

PATIENT

Kyrie-a Brownell

SPECIES

Canine

BREED

Belgian Sheepdog

SEX

Spayed Female

AGE

8 Years

WEIGHT

21.2 kg

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Laura de Cordon

HOSPITAL NAME

Mason Dixon Animal Emergency Hospital

REFERRING VET

Dr. Laura de Cordon

INVOICE

39301

DATE

7/8/22

PRESENTING CLINICAL SIGNS

Intermittent vomiting for the past 2 years. Vomiting several times a day since May 2022. Decreasing appetite and weight loss since May. Syringe feeding for the past 3 weeks. Blood in vomit since 7/7/22. Abnormal PE/Chem/CBC/UA Results: Very dark/melena stool on rectal exam. Gastric pylorus thickening. Thrombocytopenia. Pancreatitis. CBC- platelets 36. Hct 38.7. Phosphorous 6.7.

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 (6.44 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 (6.8 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 area of the right adrenal gland is examined without evident pathology.

The left adrenal gland is normal in size (0.50 cm at the cranial pole and 0.60 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

The spleen is subjectively large 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

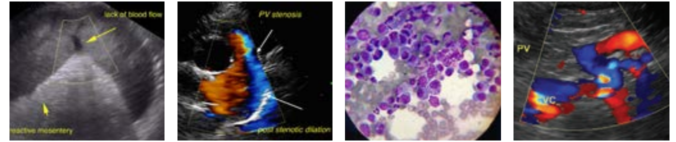
The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

The gallbladder is 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 stomach wall is diffusely thick, measuring up to 2.0 cm in thickness with a diffuse hypoechoic loss of discrete layering.

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.



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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.

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.

Medial to the spleen, 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.

ULTRASONOGRAPHIC 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.

- Aggressive lymph nodes medial to the spleen – most consistent with infiltrative round cell or metastatic neoplasia. A benign aggressive inflammatory response cannot be ruled out without tissue sampling +/- culture.

- Diffusely thick gastric wall with early loss of layering noted – concerning for infiltrative neoplasia such as round cell neoplasia, given the concurrent findings in the abdomen. However, given the chronicity of the vomiting, infiltrative, benign inflammatory disease, edema, etc. cannot be definitively ruled out.

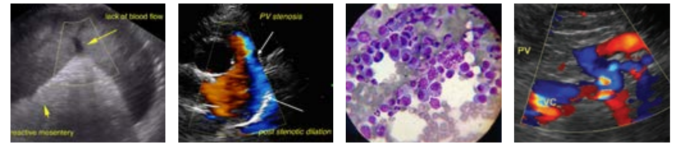
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- 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.

- If platelet clumping is present resulting in an automated platelet count of 36, a manual platelet count is recommended to determine whether or not it is safe to fine needle aspirate that spleen +/- the enlarged lymph nodes and the gastric wall.

- The definitive cause of the reported hematemesis and melena cannot be determined in the face of true thrombocytopenia, as both thrombocytopenia and infiltrative gastric disease could result in that clinical sign. If the thrombocytopenia is true, and this patient cannot be safely aspirated, medical management of the thrombocytopenia with potentially vincristine +/- immunosuppression platelet replacement, etc. should be considered followed by aspiration when it is safe to do so. Another sampling option includes a bone marrow cytology, as that poses less of a risk of hemorrhage and may yield a diagnosis of round cell neoplasia if that is the underlying cause.

- Finally, given the chronicity of the GI signs, a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further



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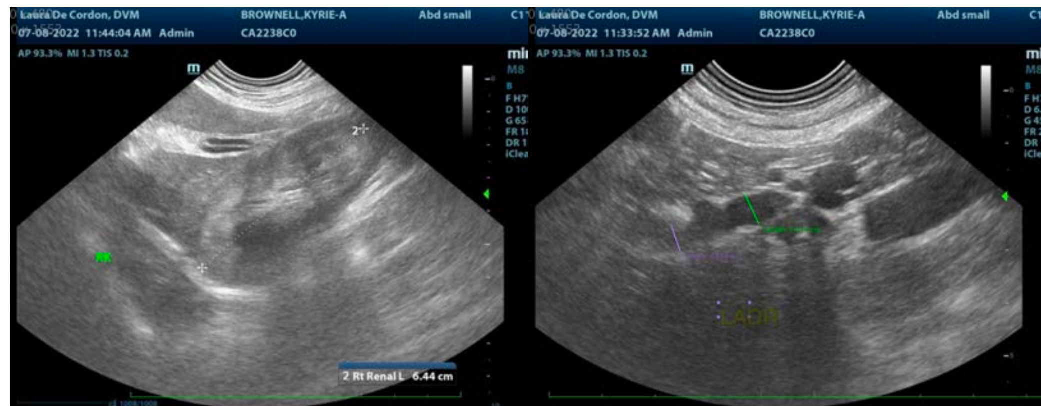
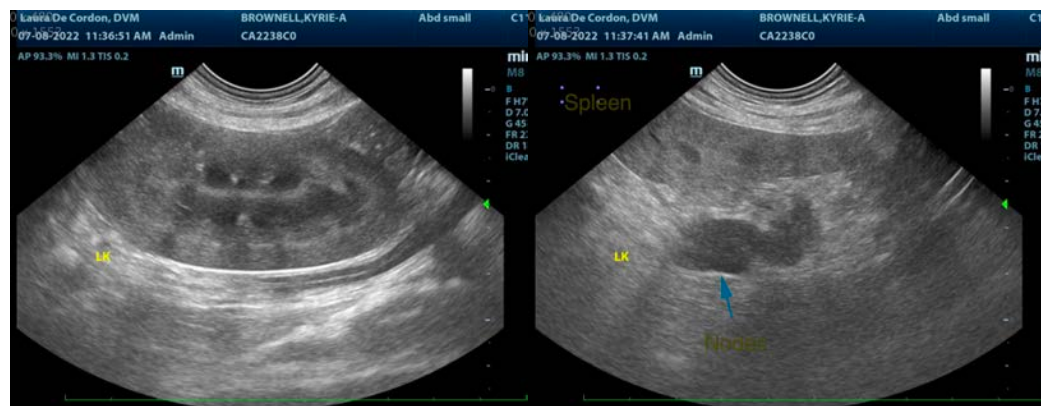
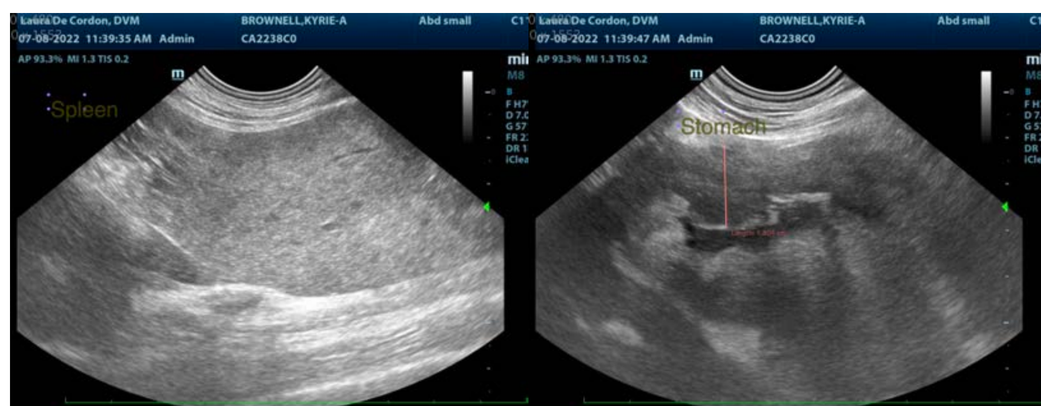
evaluation of GI and pancreatic function.

- A baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.







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