**DATE PRESENTING CLINICAL SIGNS**

8/24/22 Suspected MCT, cytology not definitive, planned surgery, however, patient has been having on/off diarrhea, inappetence, vomiting over past 2 weeks; mild weight loss; recent hair coat changes.

**PATIENT**

Chessie Mahle Current Medications: Diphenhydramine, famotidine.  
Lab Results: Most recent 7/22/22- SDMA 16 (0-14), Crea 1.5 (0.5-1.5), BUN/UREA 17 (9-31), USG 1.057, resting cortisol 1.0. ACTM Stim pre 1.2, post 12.7.

**SPECIES**

Canine Date of Previous IntraPet Ultrasound: No previous.  
Sedation: Not required to complete full diagnostic ultrasound.  
Stat Report: Not requested.

**BREED**

Labrador

**SEX**

Spayed Female

**AGE**

7/22/14

**WEIGHT**

66.1 Pounds

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

**IMAGING PERFORMED BY**

Rachel Brillhart RDMS

**HOSPITAL NAME**

Frederick Road VH

**REFERRING VET**

Dr. Beyer

**INVOICE**

40709

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN****Urinary System**

Urinary bladder is only mildly distended (empty). Visible contents are anechoic. Urinary bladder wall is unable to be fully assessed for pathology without further distension. No visible masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface. If there are urinary signs and/or concern for urinary bladder pathology, reassessment after complete filling is recommended.

The right kidney is normal in size (6.52 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 (6.27 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 (2.5 cm long x 0.79 cm at the cranial pole and 0.55 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 (1.96 cm long x 0.65 cm at the cranial pole and 0.62 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

**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**

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 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 intestine demonstrates areas of mildly thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. The lumen is empty with no evidence of obstruction or foreign material.

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 heart base tumors or nodules present in these images.

The mesenteric and medial iliac lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

## **ULTRASONOGRAPHIC FINDINGS**

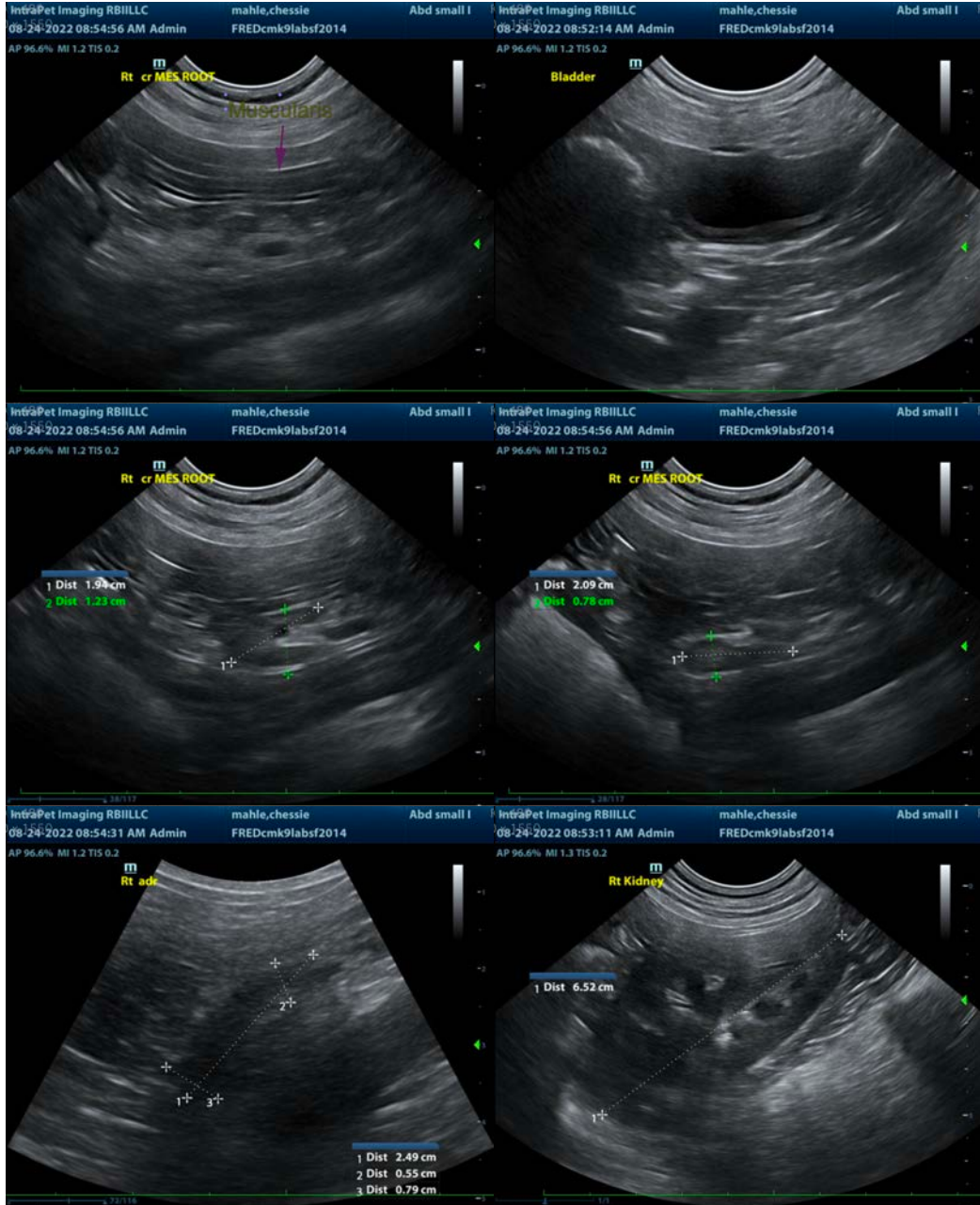
- **Inflammatory bowel disease (IBD) pattern** – Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No aggressive lymphadenopathy, loss of layering, etc. is noted to make lymphoma more probable, but lymphoma cannot be definitively ruled out without tissue sampling.
- **Reactive mesenteric and medial iliac lymph nodes** – infiltrative neoplastic disease cannot be ruled out but is considered less likely.

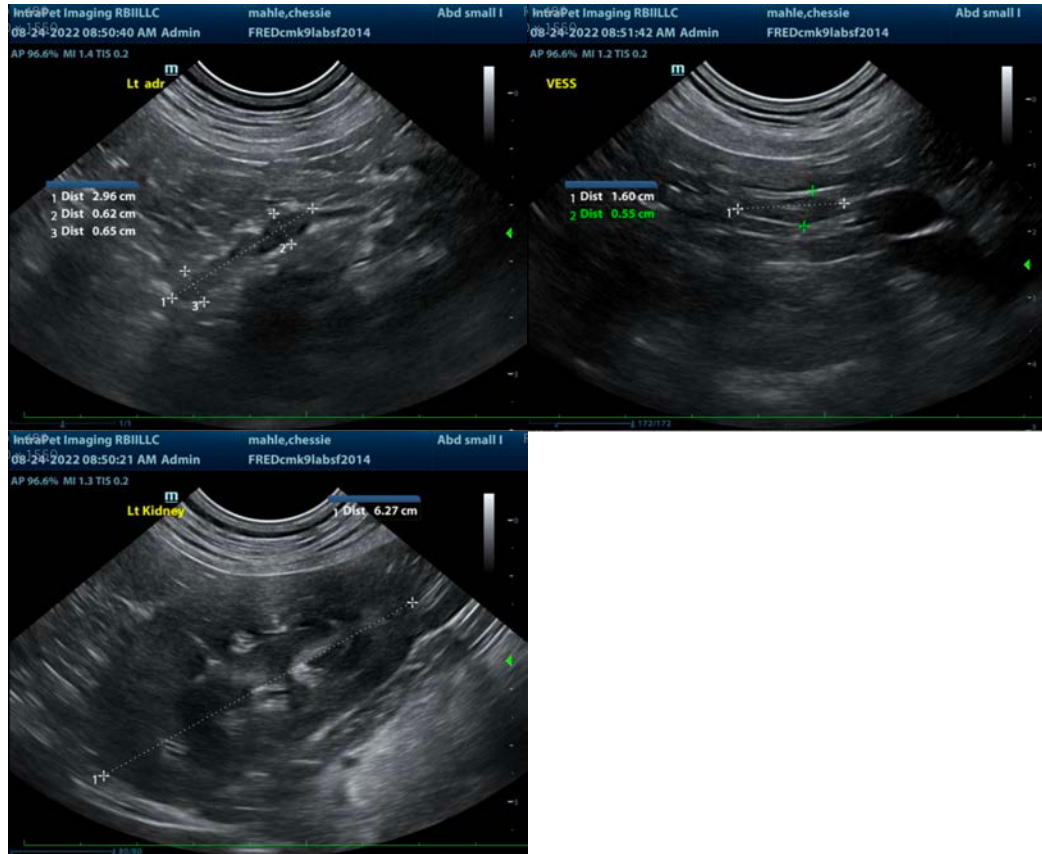
## **INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

A fecal exam is recommended if not recently evaluated. 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.

Ideally, biopsies of the gastrointestinal tract and lymph nodes are recommended to definitively diagnose and therefore manage the suspected infiltrative bowel disease. However, given that this patient also likely has mast cell tumor and will therefore likely be receiving Prednisone, if biopsies are not elected, other empirical therapies could include a diet change to a novel or hydrolyzed protein diet, empirical deworming with a 5-day course of Panacur regardless of fecal results, cobalamin supplementation unless cobalamin level is evaluated and supplementation is not warranted, and the Prednisone.

Other supportive therapeutic considerations include a probiotic, given the reported diarrhea.





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.

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