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Clinical Sonography & Telecytology
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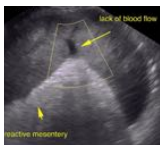
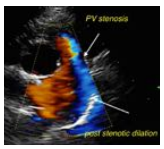
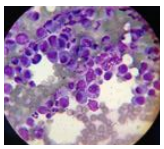
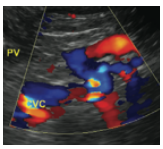

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1-800-838-4268 info@sonopath.com

PATIENT
Jax Taylor

SPECIES
Canine

BREED
Boxer Mix

SEX
Neutered male

AGE
9 years

WEIGHT
60.2 lbs

INTERPRETED BY
Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY
Carissa Rhoades

HOSPITAL NAME
Elizabeth AH

REFERRING VET
Dr. Anderson

INVOICE
43759

DATE
4/10/23

PRESENTING CLINICAL SIGNS

History: Fecal incontinence after anal gland resection (anal gland carcinoma) 11/22. Finished his last round of radiation in January. He was having issues with constipation but since the end of March is leaking diarrhea. He is on Tylan, Lomotil, bland diet and is still leaking diarrhea and now straining so much he is bleeding. Dr.Allyn recommended AUS, concerned the cancer has spread. He is on other meds but has not been able to give them because everything just runs through him. Has been giving fiber supplements to try and get the diarrhea under control. Lori said he is on Galliprant for pain and I think Proin ER and some others.
Abnormal PE/Chem/CBC/UA Results: PE: Raw Anus and poor anal tone on rectal exam but healthy other wise. NO RECENT BW.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder lumen volume is small and walls are diffusely thickened most consistent with pseudohypertrophy. The ureters were not visible which is normal. There was normal wall layering with no masses, uroliths or abnormal thickening visualized. Urine was anechoic. No evidence of inflammatory or neoplastic changes were noted.

The kidneys have a smooth capsule and with hazing of corticomedullary definition to the point of inability to determine cortical/medullary ratio. No evidence of pelvic dilation was present. Visualization of right kidney was slightly limited making measurement possibly inaccurate. This is commonly related to breed related anatomical positioning. The left kidney measured 6.7 cm and the right kidney measured 5.87 cm.

Adrenal Glands

Both adrenal glands were visualized and recognized as having normal shape, size, position and echogenicity for this breed. The caudal pole of the left adrenal gland was slightly prominent with a normal ultrasonographic appearance, and this is suspected to be a variation of normal. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The left adrenal gland measured 2.8 cm in length x 1.0 cm at the caudal pole and 0.55 cm at the cranial pole. The right adrenal gland measured 1.84 cm in length x 0.56 cm at the caudal pole and 0.48 cm at the cranial pole.

Spleen

The spleen was normal with a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma and smooth capsule, with normal splenic vasculature with no signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarct changes were noted.

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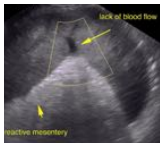
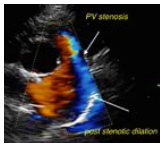
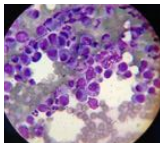
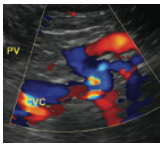

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Liver

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed. Gallbladder is moderately distended with normal wall thickness and anechoic contents. Common bile duct is non-distended and tapers normally

Gastrointestinal

The stomach is distended with ingesta and gas shadowing. It measures at a normal thickness of with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

Sections of colonic wall are normal in thickness and wall layering. Other section of colonic wall is visualized and is significantly thickened (up to 0.65cm) with complete loss of wall layering.

Pancreas

The base and limbs of the pancreas were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour and parenchyma were normal. No overt evidence of active inflammatory or neoplastic disease was noted.

Lymph Nodes

No clinically significant lymphadenopathy or abnormalities noted.

Free Abdomen

No masses or free fluid were noted.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

1. Colonic thickening, loss of wall layering
2. Degenerative renal changes
3. Thickened urinary bladder wall - suspect pseudohypertrophy

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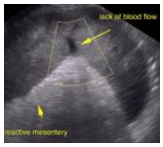
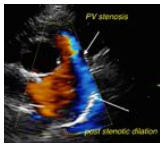
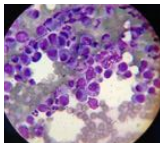
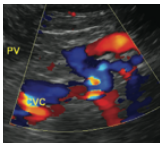

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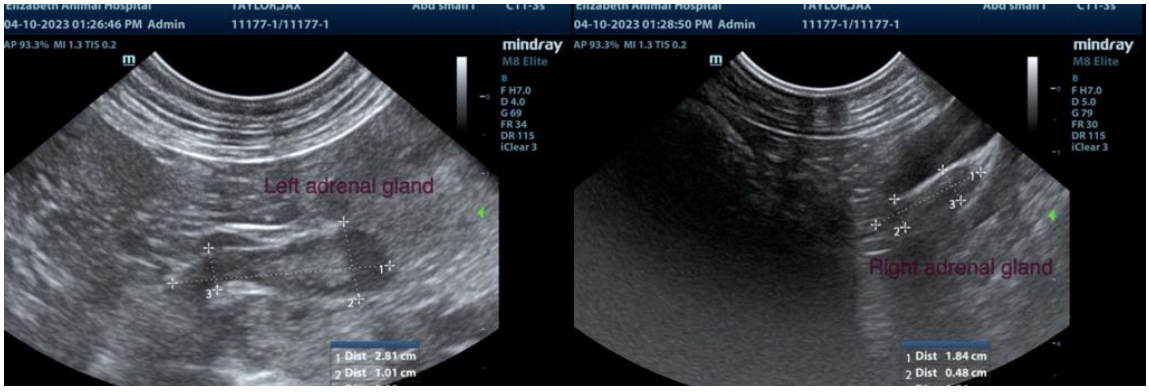
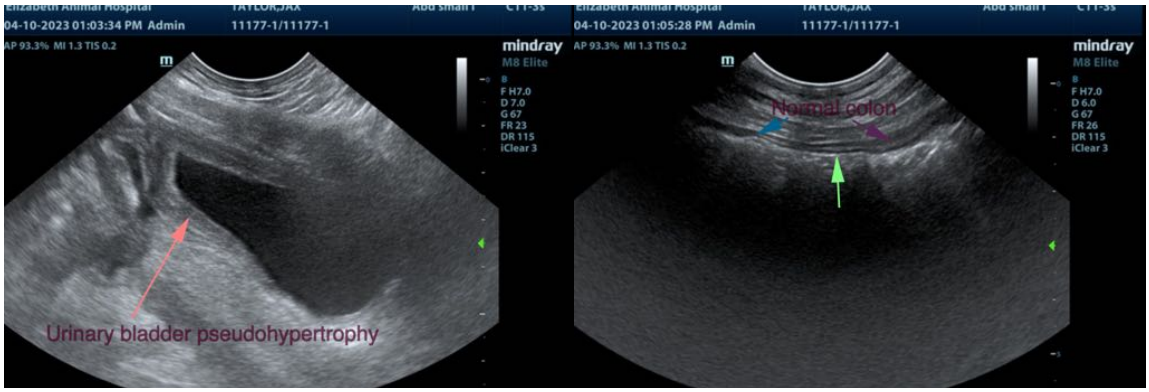
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Colonic thickening with loss of wall layering is most concerning for infiltrative disease with adenocarcinoma, lymphoma, gastrointestinal stromal tumor (GIST), leiomyosarcoma, mast cell tumor, extraskeletal osteosarcoma, hemangiosarcoma, and extramedullary plasmacytoma being differentials. Non-neoplastic inflammatory disease remains a possibility. Colonoscopy may be of benefit to further evaluate the colonic wall and obtain biopsy. Ultimately surgical biopsy may be both curative and diagnostic if excision is possible.

Renal changes are likely age related degeneration. Correlate clinical significance with blood work/urinalysis findings and clinical signs.

Urinary bladder wall thickening is likely pseudohypertrophy secondary to low volume of urine and lack of luminal distension, however, true mural thickening cannot be definitively ruled out. Re-examination when urinary bladder lumen volume is increased with time and/or fluid therapy should be considered if clinical suspicion for urinary bladder disease is high.





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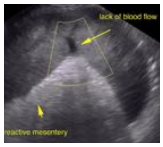
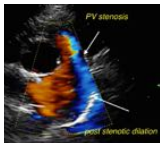
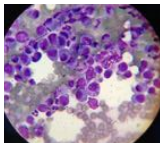
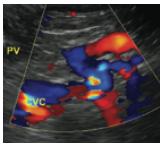

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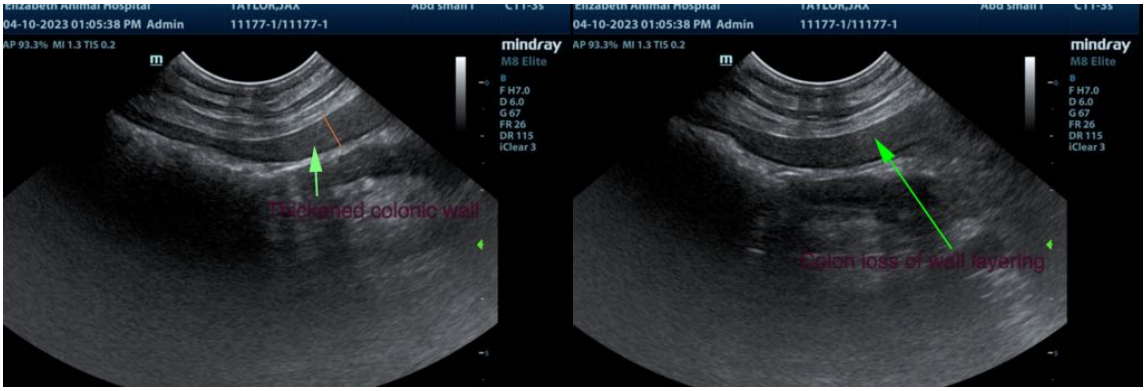

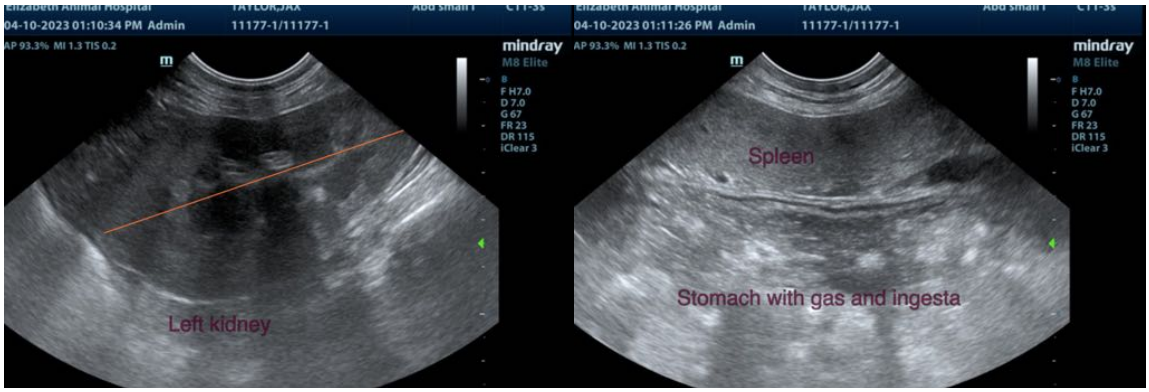

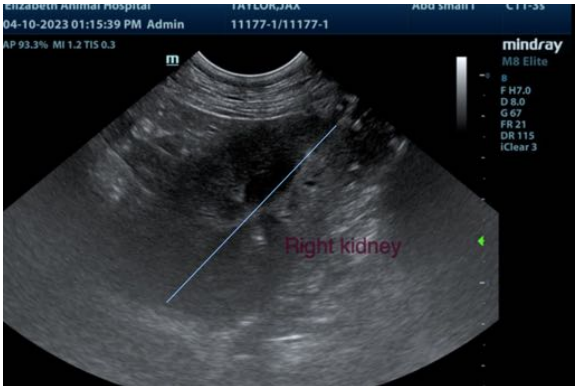

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Dr Brittany Sinclair, BVSc(hons), DACVECC
info@SonoPath.com