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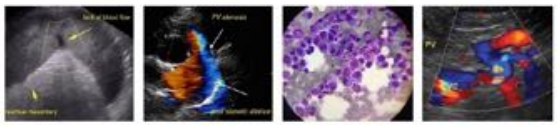


THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

**PATIENT**

Rylie Standen

**SPECIES**

Canine

**BREED**

Greyhound

**SEX**

Spayed female

**AGE**

11 years

**WEIGHT**

28 kg

**INTERPRETED BY**

Dr Brittany Sinclair, BVSc(hons), DACVECC

**IMAGING PERFORMED BY**

Crystal Hill

**HOSPITAL NAME**

Animal Hospital of Stoney Creek

**REFERRING VET**

Dr. Egbers

**INVOICE**

43756

**DATE**

4/10/23

## PRESENTING CLINICAL SIGNS

History of chronic, intermittent diarrhea since adoption in 2015. Had been treated for hookworm at adoption. Last 6 months marked increase severity with very few normal stools. Previously very consistent with monthly parasite prevention, but no prevention since Oct 22. Increased urgency and frequency of BMs with occasional accidents in the house. Stools are voluminous and pudding to liquid consistency. Increased flatulence. On PE significant pain response to palpation of caudal abdomen, rectal NAF. Metronidazole, Fenbendazole.
Abnormal PE/Chem/CBC/UA Results: CBC all WNL, TP 37(55-75) ALB 19(27-39)Globulins 18(24-40) Cobalamin 176(209-617) Folate 44(7-39) TLI normal 21.2

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder, trigone, and visible pelvic urethra were of normal thickness. 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 were both normal size and structure, with smooth capsule and normal corticomedullary definition and ratio (cortex 1/3 of medulla). Medullary structure differed distinctly from that of the cortex. No evidence of pelvic dilation was present. The right kidney measured 7.22 cm. The left kidney measured 7.16 cm.

### *Adrenal Glands*

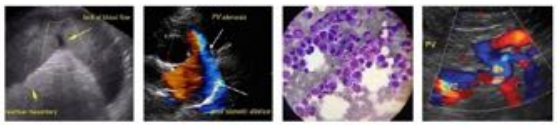
Both adrenal glands were visualized and recognized. Both were subjectively prominent and hypoechoic with no specific masses or nodules seen. Visualization of the right adrenal gland was somewhat limited by patient conformation and depth. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The left adrenal gland measured 2.42 cm in length x 0.95 cm at the caudal pole and 0.88 cm at the cranial pole. The right adrenal gland measured 2.35 cm in length x 1.12 cm at the caudal pole and 1.81 cm at the cranial pole.

### *Spleen*

The spleen had a generally smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma and smooth capsule, with normal splenic vasculature with no signs of congestion or thrombosis. Perivascular hyperechoic nodules visualized most consistent with benign myelolipomas. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarct changes were noted.

### *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





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### *Gastrointestinal*

Distal colon is slightly thickened with maintenance of normal curvilinear wall layering and no focal mass effects. No surrounding lymphadenopathy. Descending and proximal colon are of normal thickness and layering.

The stomach contains minimal luminal contents. 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.

### *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

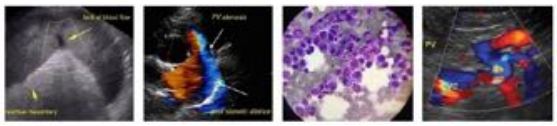
1. Distal colitis
2. Perivascular splenic myelolipomas
3. Bilateral adrenomegaly

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Panhypoproteinemia along with GI signs are most consistent with a protein losing enteropathy. Urinalysis should be evaluated to rule out protein losing nephropathy and bile acid profile could be considered to rule out hepatic disease, though these are considered less likely.

Small intestine is ultrasonographically normal. Colon is slightly thickened with normal curvilinear wall layering consistent with reported colitis signs. GI panel (TLI/PL/cobalamin/folate), extended fecal pathogen PCR panel, and empiric high fiber diet, broad spectrum deworming and treatment with probiotics should be considered. GI biopsy including upper and lower endoscopy or full thickness surgical biopsies should be considered. Colonoscopy may reveal pathology not visible on ultrasound.

Splenic changes are a common age related change and nodules are most consistent with benign myelolipomas, but infiltrative disease (lymphoma, MCT, other) cannot be definitively ruled out. No significant disruption of architecture noted to suggest significant pathology. Fine needle aspirate could





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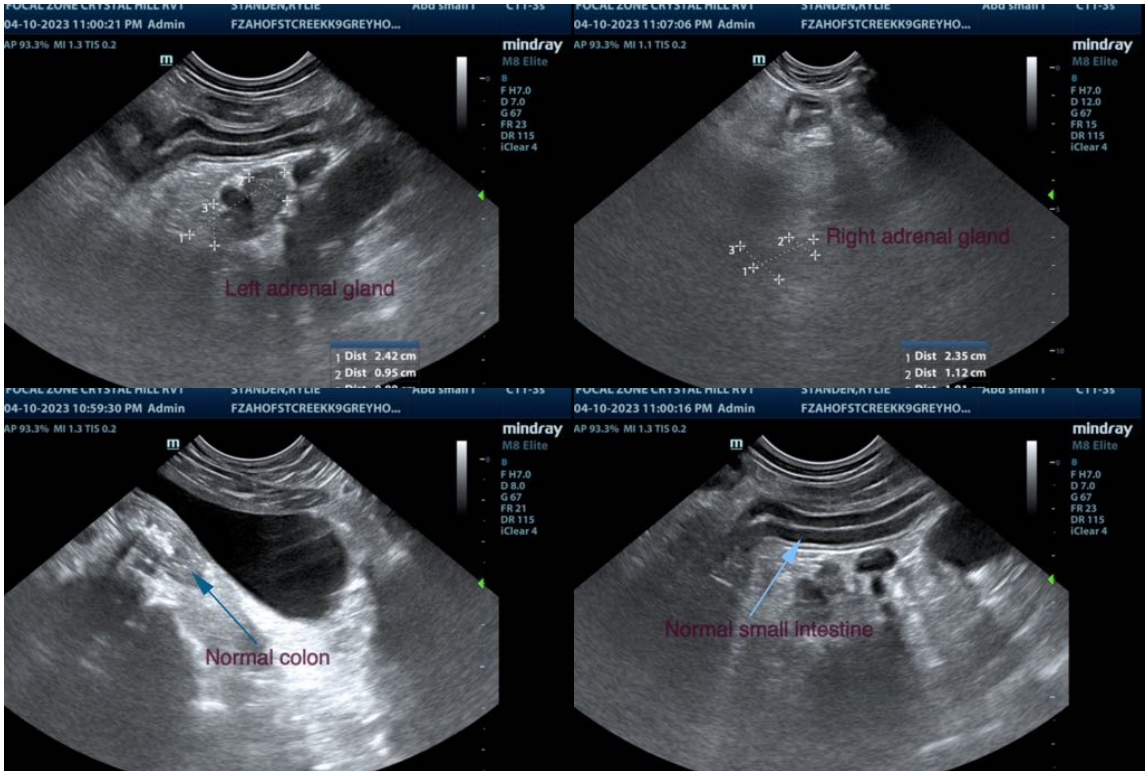
be considered to further characterize parenchymal changes if clinically indicated, especially if any weight loss is noted or for baseline cytological assessment.

Adrenomegaly is bilateral and may represent stressful illness or hormonal stimulation as is seen with pituitary dependent hyperadrenocorticism. If corresponding clinical signs are present, testing for hyperadrenocorticism should be considered (ACTH stimulation test vs LDDST).



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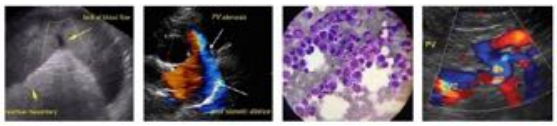

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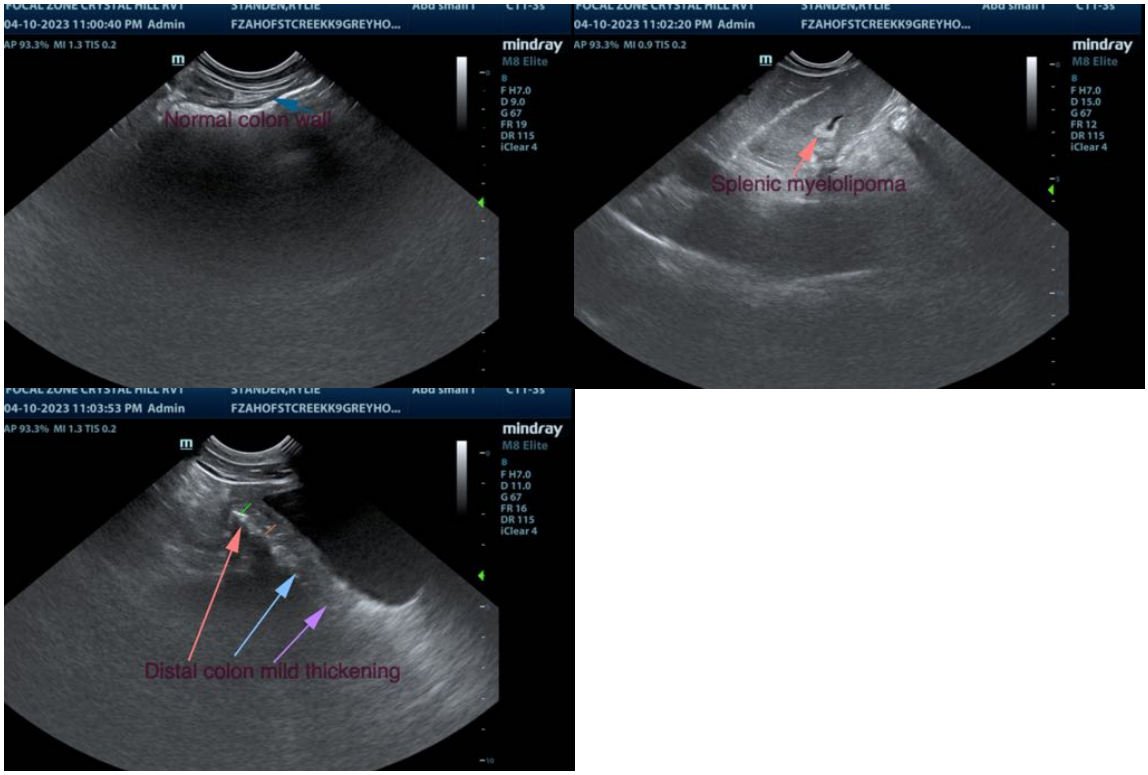


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**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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
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