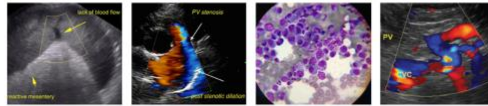


PATIENT

Buddy Doyle

SPECIES

Canine

BREED

Labrador Retriever Mix

SEX

Neutered Male

AGE

11 Years

WEIGHT

58.8 Pounds

INTERPRETED BY

Eric Lindquist, DMV, DABVP, Cert. IVUSS, CEO of SonoPath.com

IMAGING PERFORMED BY

Pamela Harrigan, RDCS

HOSPITAL NAME

Rhode Island AMC

REFERRING VET

Rachel Rogoff, DVM

INVOICE

21673

DATE

PRESENTING CLINICAL SIGNS

History: Anorexia, vomiting, lethargy, weight loss, jaundice. On Prednisone 20 mg BID, Entyce 30 mg/ml, 2.7 mls q24h.

Abnormal PE/Chem/CBC/UA Results: RBC 5.01, HCT 27.9, MCV 55.8, retic 118, ALT 660, ALP ++ 2080, GGT 91, Tbil 6, Chol 381, Lipase 3252.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The ureters were not visible which is normal. No uroliths or sediment were visualized and anechoic urine was present. No evidence of inflammatory or neoplastic changes were noted. Ureteral papillae were normal. The pelvic urethra was imaged 3.0 cm beyond the cystourethral junction. The prostate was uniform, measuring 1.15 cm.

The **kidneys** were bilaterally swollen with mildly thickened cortices. The right kidney measured 7.4 cm. The left kidney measured 7.5 cm.

Adrenal Glands

The **right adrenal gland** was visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The right adrenal gland measured 0.51 cm at the caudal pole and 0.46 cm at the cranial pole.

The **left adrenal gland** was mildly enlarged, with a hyperechoic nodule (0.86 cm x 0.64 cm at the caudal pole). The left adrenal gland measured 0.9 cm at the caudal pole and 0.67 cm at the cranial pole.

Spleen

The **spleen** was enlarged with scalloping contour and coarse architecture.

Liver

The **liver** was enlarged/swollen and revealed coarse architecture, increased portal markings and multifocal nodular changes. The gallbladder was overdistended with suspended debris.

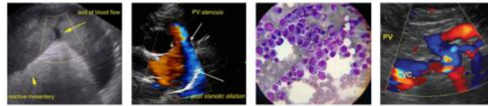
Gastrointestinal

The upper **gastrointestinal tract** revealed retention of ingesta and regional infiltrative duodenal pattern The duodenum measured up to 4.0 cm in thickness. Loss of mural detail was noted in the upper duodenum. Variable intestinal thickening was noted elsewhere. Regional lymph nodes were also enlarged and irregular with localized free fluid. The colon was slightly thickened.

Pancreas

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

Free Abdomen



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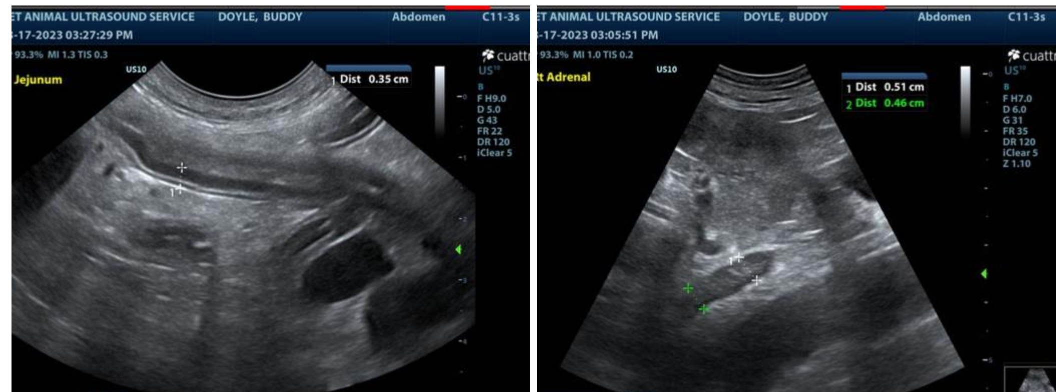
Trace amounts of **free fluid** were noted. Regional inflammation was noted throughout the cranial abdomen particularly around the duodenum.

ULTRASONOGRAPHIC FINDINGS

- Mildly thickened distal small intestine and thickened colon
- Hepatomegaly with coarse architecture, increased portal markings and multifocal nodular changes
- Gallbladder debris
- Bilaterally swollen kidneys with mildly thickened cortices
- Enlarged spleen with scalloping contour and coarse architecture
- Mildly enlarged left adrenal gland
- Irregular regional lymphadenopathy

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the clinical profile and sonographic presentation, I'm strongly concerned for infiltrative disease in the duodenum and liver. Posthepatic obstruction owing to the duodenal pathology is possible, however, reactive mesentery was noted that obscured portions of the common bile duct. The duodenal infiltrative patterns are in the region of the duodenal papilla, yet distortion of architecture did not allow for complete visualization. Irregular regional lymphadenopathy would suggest underlying round cell neoplasia or metastatic carcinoma. FNA of the duodenum, spleen, liver and lymph nodes all indicated. Minor potential for non-neoplastic duodenitis. Prednisone may be suppressing a more significant presentation. I cannot rule out hepatosplenic lymphoma as well.



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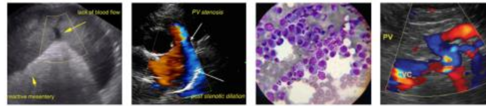

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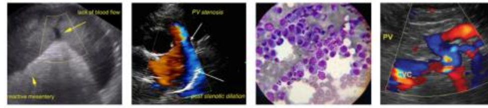

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Eric Lindquist, DMV, DABVP, Cert. IVUSS, CEO of SonoPath.com

info@SonoPath.com