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Clinical Sonography & Telecytology
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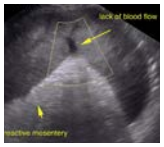
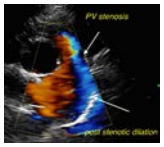
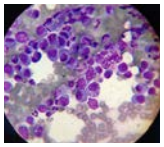
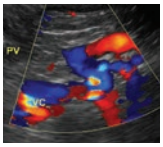

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Bean Omkara

SPECIES
Canine

BREED
Labrador

SEX
Spayed Female

AGE
2 Years

WEIGHT
22.2 kg

INTERPRETED BY
Eric Lindquist, DMV
DABVP, Cert. IVUSS

IMAGING PERFORMED BY
Dr. Crystal Ebert

HOSPITAL NAME
Wilvet Salem

REFERRING VET
Dr. Crystal Ebert

INVOICE
40639

DATE
8/20/22

PRESENTING CLINICAL SIGNS

Originally presented to Ark on 8/8 for a three day history of diarrhea (hematochezia), decreased appetite, eating grass/vomiting, possible lethargy. Treated (as below) and has had soft stool with blood and persistently low appetite since that appointment. On Wednesday 8/17 she started acting uncomfortable and trembling. Patient has exposure to compost pile and multiple types of mushrooms (dog vomit fungus/ghost pipes). Occasional eats cooked meat scraps (recently chicken). Patient is shared between 3 households. otherwise healthy - this past summer had dermatitis on belly. vaccinated

Abnormal PE/Chem/CBC/UA Results: seen on 8/8 for diarrhea. fecal on 8/9 - negative - treated w/cerenia, metro, and omeprazole Seen at pDVM on 8/19 - BW HCT 38%, Neu 6.4, Lym 1.05*, PLT 441. Chem - Creat 1.1, BUN 8, TP 6, Glu 96, ALB 2.3*, Glob 3.8, ALP >2000, ALT did not read, UA - WBC 2/hpf, RBC 5/hpf, orange, USG 1026, pH 8, leuk neg, pro trace, glu/ket neg, UBG 8, Bili 6, bld 10, snap CPL abnormal. Treated w/fluids , torb at 12 and 3pm, cerenia at 1230pm, ampicillin at 1230pm, vitamin B complex SQ, famotidine, EN and denamarin ate at 330pm 8/20 Witness snap - negative PT - 14 (n), PTT - 72 (n) liver chemistry to Idexx - Glu 74, BUN 9, TP 5.3*, ALB 2.3*, Glob 3, ALT 1952*, AST 175*, ALP 1710*, GGT 54*, Tbili 4.8*, bili - unconj 1.6*, bili - conj 3.2*, chol 235 EPOC - pH 7.444, BE -2.4, Na 151, K 4.1, Cl 121, Ca 1.31, Lact 1.57, BUN 8, Creat 1.05, glu 100, HCT 37% Pending lepto PCR through Ark Animal Hospital S/O: QAR on examination. T: 103.6F HR: 100 RR: pant approx 50 MM icteric and moist CRT < 2 seconds. BCS 3/5. Seems uncomfortable on abdominal palpation. Heart rate and rhythm regular. Eupneic. Increased respiratory rate. Rectal had soft stool with blood present. Ambulatory all four limbs. Appears neurologically appropriate at

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** and visible pelvic urethra were unremarkable for the level of repletion presented. The urine, however, did present some mildly echogenic debris consistent with mucous, exfoliated cells from renal or bladder origin, and/or blood clots as these echogenic changes can all present similarly. This is often related to urinary tract infection but may represent simple evidence of exfoliated debris or sterile inflammation. Cystocentesis, urinalysis, +/- culture would be recommended to rule out and define any UTI. The pelvic urethra was imaged 1.0 cm beyond the cystourethral junction.

The **kidneys** revealed normal size and structure, corticomedullary definition and ratio for this age. The cortices presented largely uniform texture with normal echogenic relationship to liver and spleen. Medullary structure differed distinctly from the cortex and no evidence of pelvic dilation was present. The capsules were acceptably uniform without significant irregularities. The left kidney measured 6.11 cm. The right kidney measured 6.0 cm.

Adrenal Glands

Both **adrenal glands** were 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 left adrenal gland measured 0.50 cm.

Spleen

The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes were noted.

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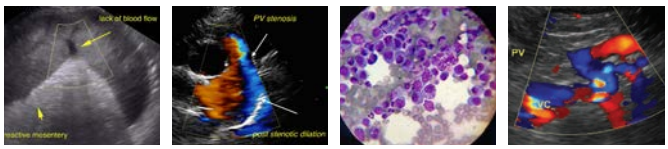

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Liver

The **liver** revealed slight increased portal markings, consistent with cholangitis. The gallbladder presented a minor amount of excessive debris and slight overdistention, yet not likely a clinical issue, likely secondary to anorexia.

Gastrointestinal

The **stomach** was overdistended with echogenic chyme. Delayed outflow pattern or gastric ileus. The small intestine revealed a focal mass measuring 2.0 cm x 3.0 cm, appeared to be in the jejunum. A second intestinal thickening was noted in the distal small intestine, measuring approximately 2.0 cm. Fluid filled colon noted. Mesenteric lymph nodes were enlarged, measuring up to 3.0 cm x 1.5 cm.

Pancreas

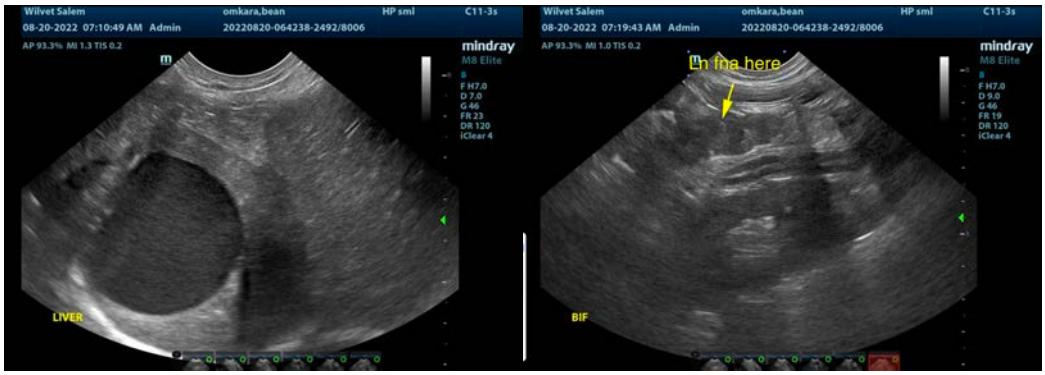
The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour were acceptably normal and parenchyma respected normal curvilinear patterns. No overt evidence of active inflammatory or neoplastic disease was noted.

ULTRASONOGRAPHIC FINDINGS

- Multifocal intestinal neoplastic pattern with regional lymphadenopathy
- Delayed outflow gastric pattern
- Cholangitis liver pattern

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the intestinal presentation, underlying occult hepatic neoplasia cannot be ruled out. Recommend ultrasound guided FNA of the intestinal lesions, lymph nodes and liver in this patient. Leptospirosis titers warranted to assess for comorbidity. Round cell neoplasia suspected in the intestinal tract. Granulomatous, non-neoplastic intestinal lesions possible, yet less likely. Eventual surgical resection of the intestinal lesions could be considered with dual resection and anastomosis and lymph node and hepatic biopsy. However, these may be multifocal manifestations of a systemic disease such as lymphoma. Prognosis is extremely guarded.



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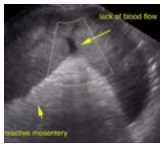
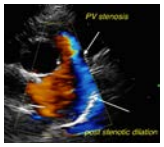
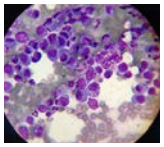
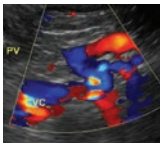

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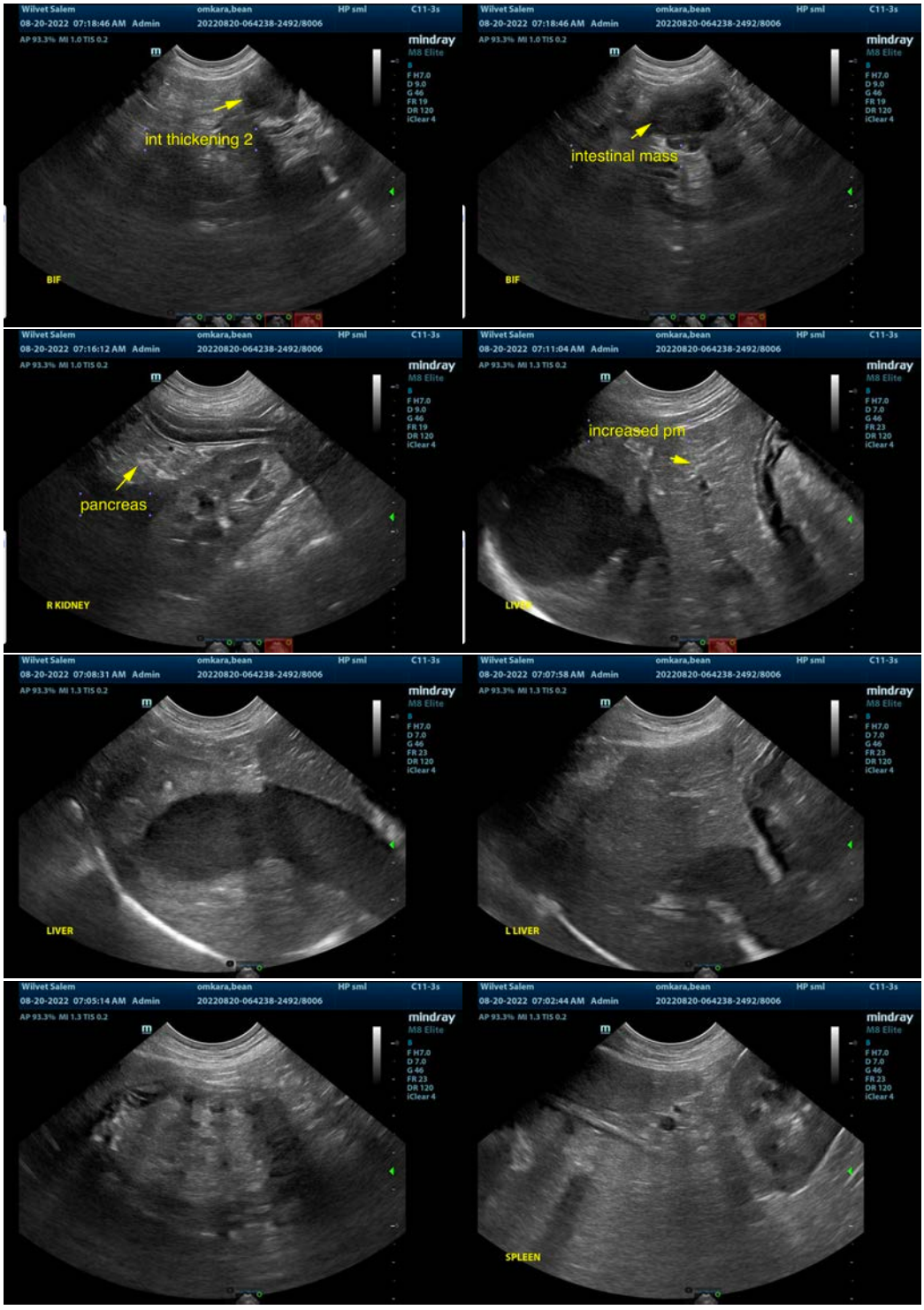

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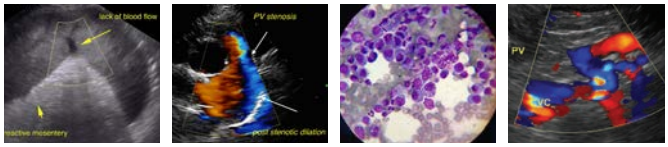

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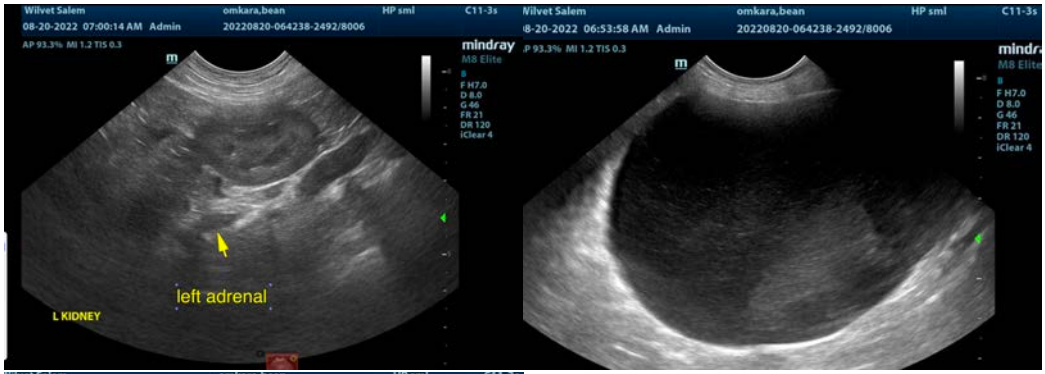

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

info@SonoPath.com