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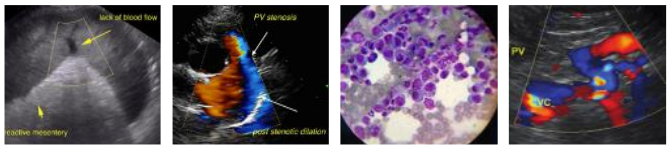


SonoPath.com
1-800-838-4268 info@sonopath.com

**PATIENT**

Chance Karyl Larson

**SPECIES**

Canine

**BREED**

Lab

**SEX**

Neutered Male

**AGE**

12 Years

**WEIGHT**

29 kg

**INTERPRETED BY**

Eric Lindquist, DMV DABVP, Cert. IVUSS

**IMAGING PERFORMED BY**

Dr. Gardner

**HOSPITAL NAME**

Wilvet Salem

**REFERRING VET**

Dr. Gardner

**INVOICE**

17337

**DATE**

9/17/22

## PRESENTING CLINICAL SIGNS

History: Patient presents for vomiting and diarrhea for the last 24 hours. Patient ate dinner last night. Patient lives on property with streams. No meds

Abnormal PE/Chem/CBC/UA Results: Lab/trends: CBC - Mild hemoconcentration HCT 55.8%, Mild leukocytosis 16.84k, bands, Monocytosis 1.16k, rest wnl Chem10 - wnl EPOC - wnl Radiographs of chest and abdomen - ABDOMEN, THORAX: 17 September 2022: 6 views are available for review. FINDINGS: Thorax: There is a small area of increased opacity in the caudal ventral aspect of the caudal subsegment of the left cranial lung lobe. There are pulmonary osteomata throughout the lungs. There is a small amount of gas in the oesophagus, considered within normal limits. The thorax is otherwise radiographically within normal limits. The cardiac silhouette, blood vessels, pleural cavity, width of the cranial mediastinum, trachea, oesophagus and thoracic lymph nodes are within normal limits. There is multifocal spondylosis deformans. The soft tissues ventral to the thorax are irregularly margined. Abdomen: The intra-abdominal serosal detail is moderately reduced. Retroperitoneal contrast is normal. The stomach is mildly filled with gas and fluid. Some segments of small intestine are mildly to moderately dilated, and others are normal in size. Just to the right of midline in the mid abdomen there is a collection of mineral opaque material which could be inside or outside the gastrointestinal tract. It is difficult to determine if it is associated with the mass-effect due to the loss of serosal detail. The colon contains a mild amount of faeces. The urinary bladder is full. The region of the prostate is unremarkable. There is multifocal spondylosis deformans along the spine, including at the lumbosacral junction. CONCLUSIONS: There is intra-abdominal fluid, which could be due to a septic abdomen given the concurrent pyrexia. There is mineralisation in the mid abdomen that could be associated with a mass, the gastrointestinal tract or mesentery. There is segmental small intestinal dilation, so a partial or complete small intestinal obstruction is possible. The urinary bladder is full. The thorax is within normal limits. RECOMMENDATIONS: Analysis of the abdominal fluid is recommended. Abdominal ultrasound is recommended as soon as possible. If it is not immediately available then exploratory laparotomy could be considered. S/O:: _QAR, T: , HR: , RR , mm pk/m w/ CRT < 2s. EENT: no nasal or ocular discharge. H/L: NMA, SSP; lungs clear, eupneic. ABD: SNP. M/S: amb x 4 w/ no lameness. NEU: appropriate mentation. _ A:: _acute collapse Vomiting Diarrhea _ P:: __ LRS 120 ml/hr Cerenia 1 mg/kg IV SID 2.6mL @ 4p Baytril 10 mg/kg IV SID dilute, slow @ 4pm

## 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 moderate 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 **kidneys** were mildly swollen with slight irregular contour and reactive surrounding fat, suggestive for nephritis or emerging neoplasia. The pelvic urethra was imaged 2.0 cm beyond the cystourethral junction. A cortical infarct was noted at the caudal pole of the left kidney. Both kidneys measured approximately 6.0 cm.

### *Adrenal Glands*

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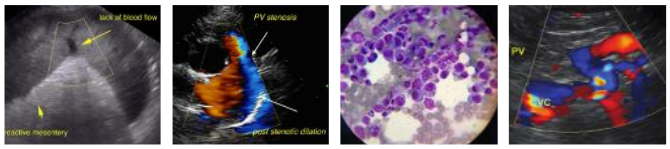


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The **left adrenal gland** was visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The left adrenal gland measured 0.5 cm.

The **right adrenal gland** was not visualized.

### *Spleen*

The **spleen** was enlarged, irregular with micronodular granular appearance and enhanced surrounding mesentery and expansive tissue proliferation.

### *Liver*

The **liver** was also swollen and dramatically hypoechoic and irregular in contour. The gallbladder and common bile duct were unremarkable. The hepatic lymph nodes were mildly enlarged.

### *Gastrointestinal*

Some **gastric** stasis was noted. Variable small intestinal thickening was present with an overt intestinal mass, measuring approximately 5.0 cm with regional undifferentiated tissue, likely of lymph node origin.

### *Pancreas*

The **pancreas** was obscured by the reactive mesentery throughout the cranial abdomen. Some level of pancreatitis is also likely present yet a secondary issue.

### *Free Abdomen*

Reactive **mesentery** was noted throughout the mid cranial abdomen associated with the spleen and liver, as well as regional lymph nodes and intestinal tract.

## ULTRASONOGRAPHIC FINDINGS

- Multicentric round cell neoplastic pattern involving intestines spleen, liver and regional lymph nodes
- Urinary bladder debris
- Swollen irregular kidneys

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This is an aggressive presentation. FNA of the intestines spleen and liver indicated with immediate chemotherapeutic intervention.

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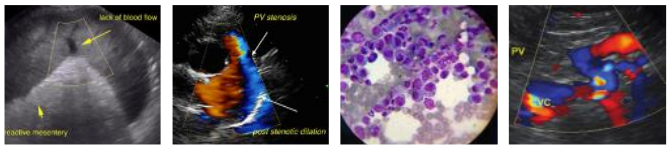

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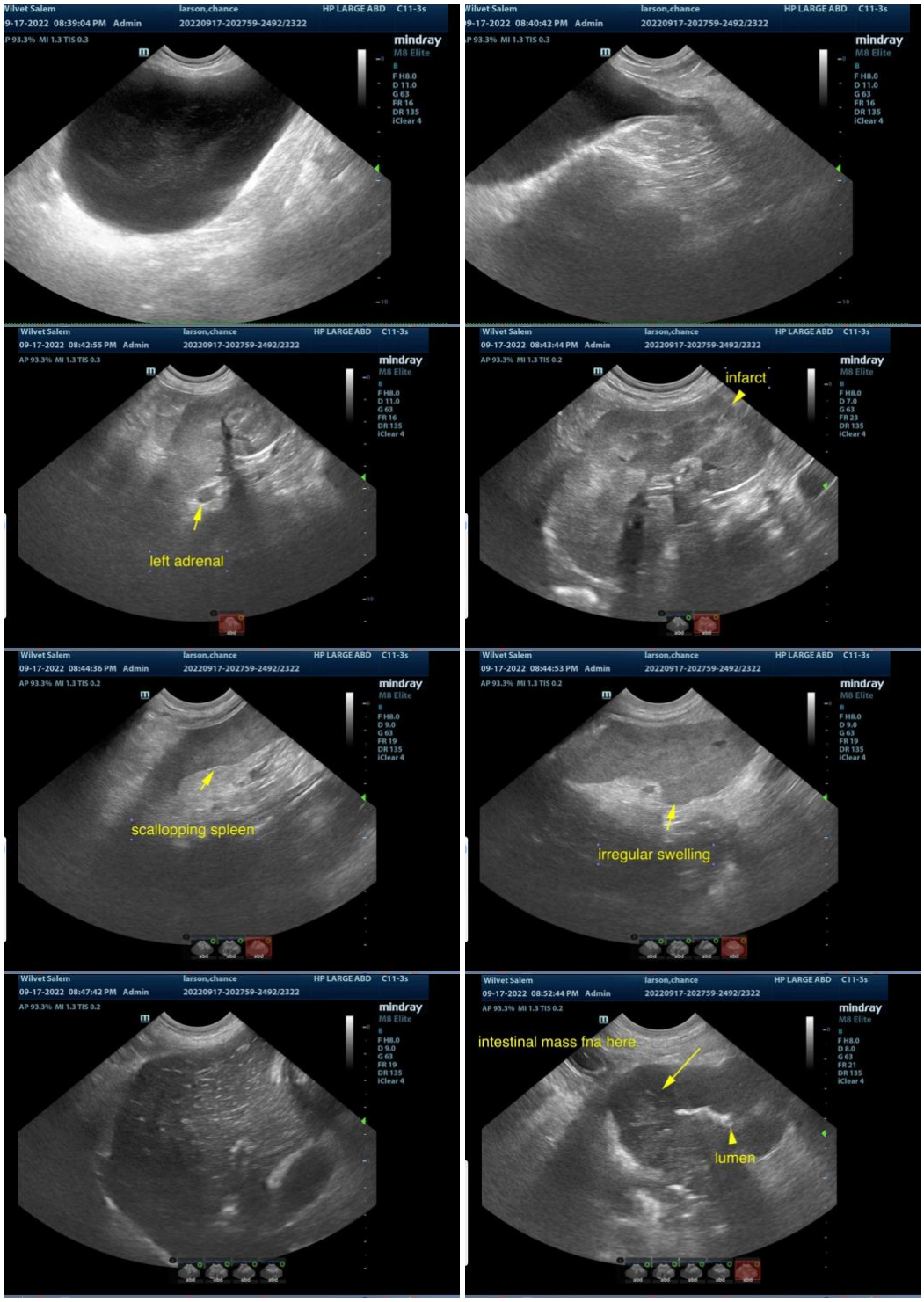

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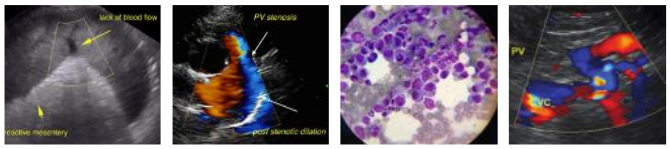

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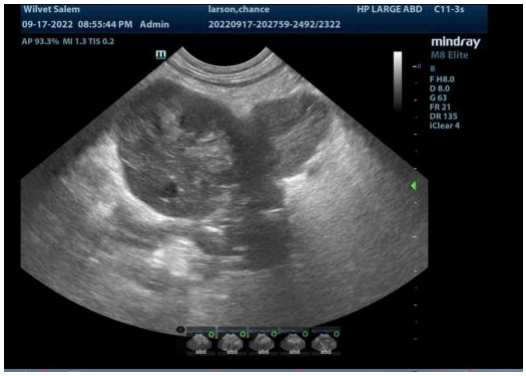


**The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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