



PATIENT PRESENTING CLINICAL SIGNS

Chance Vickroy

SPECIES

Canine

BREED

Springer Spaniel

SEX

Neutered male

AGE

11 years

WEIGHT

37.5 lbs

INTERPRETED BY

Eric Lindquist, DMV,
DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Sara Hansen

HOSPITAL NAME

Willakenzie Animal
Clinic

REFERRING VET

Dr. Fischer

DATE

1/12/23

Invoice

42080

History: History of Polycythemia- been stable on Droxia 200 mg EOD since 2019 Beginning November mild decrease in Albumin, 2.6 (2.8-3.9)- suspected maybe early GI (did have a few bouts of diarrhea at her sons) Beginning December continuing to see decrease in Albumin 2.4 and some weight loss. O reported vomiting more often than normal. Owner called 1-5-23, reported that diarrhea started up again. Seen on 1-7-23, 5# weight loss, dark loose stool Owner called 1-10-23, not responding to medications started on 1-7. TAMU panel is pending sent on 1-9-23
Abnormal PE/Chem/CBC/UA Results: Will send lab work Current Medications Diet changed to Gastrointestinal 12-7-22; 1-7 started on omeprazole, sucralfate, tylen powder; 1-10 started on Cerenia
Radiographic Findings None

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 **kidneys** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some age-related loss of curvilinear patterns regarding the capsule and C/M junction. The cortices presented largely uniform texture with some increased echogenicity expected for his age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. An anechoic cyst was noted in the dorsal cortex of the left kidney. This is not a clinical issue and measured 1.5 cm. The left kidney measured 6.15 cm. The right kidney measured 5.45 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 2.03 x 0.61 cm at the caudal pole and 0.78 cm at the cranial pole. The left adrenal gland was heterogenous, irregular and expansive measuring 3.17 x 1.36 cm and 1.01 cm at the cranial pole.

Spleen

The **spleen** revealed slight irregular contour. Hyperechoic, lipogranulomatous changes were noted.



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The **liver** images from right and left intercostal as well as subcostal views revealed subjectively normal liver size, contour, and structure. Some age-related parenchymal remodeling was noted but likely not clinically significant at this time. Vascular and biliary tracts were of normal volume and no evidence of congestion was noted. The gallbladder presented some dependent debris with essentially normal contour. The cystic and common bile ducts were normal. No overt evidence of active inflammatory, infiltrative or regenerative pathology was noted but should be paired with current or past LE elevations regarding any clinical significance to this presentation. The hepatic lymph nodes were unremarkable.

Gastrointestinal

Examination of the **gastrointestinal tract** revealed a stomach free of stasis, of normal wall thickness, acceptable curvilinear mural detail, and peristaltic activity. Variable areas of small intestinal thickening was noted. There was occasional area of mural detail. An overt intestinal mass was noted and appears to be jejunum and measured 2.5 x 6.0 cm. The mesenteric **lymph node** presented abnormal length to width ratio with distorted, swollen, irregular contour. Parenchymal detail was indiscernible. This is most consistent with lymphoproliferative disease such as lymphoma/round cell neoplasia, metastatic disease, or an aggressive inflammatory process. FNA, cytology and culture are warranted. Grouping of the lymph nodes comprised a 5.0 cm mass and encompassed the mesenteric artery. Regional inflammation was noted.

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

Reactive mesentery was noted throughout the midabdomen.

ULTRASONOGRAPHIC FINDINGS

Intestinal mass with infiltrative regional lymphadenopathy.

Reactive mesentery.

Heterogenous spleen and liver.

Heterogenous and irregular left adrenal gland.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

I believe there are two separate issues in this patient, infiltrative lymphoma is likely in the small



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intestine and lymph nodes. Adenoma, adenocarcinoma, hyperplasia and pheochromocytoma are all possible underlying pathology of the left adrenal gland. The heterogenous spleen and liver should be aspirates as well as the intestinal mass and lymph nodes for staging purposes. Lymphoma with secondary polycythemia is likely in this patient. Confirmation can be made by FNA and CBC path review.

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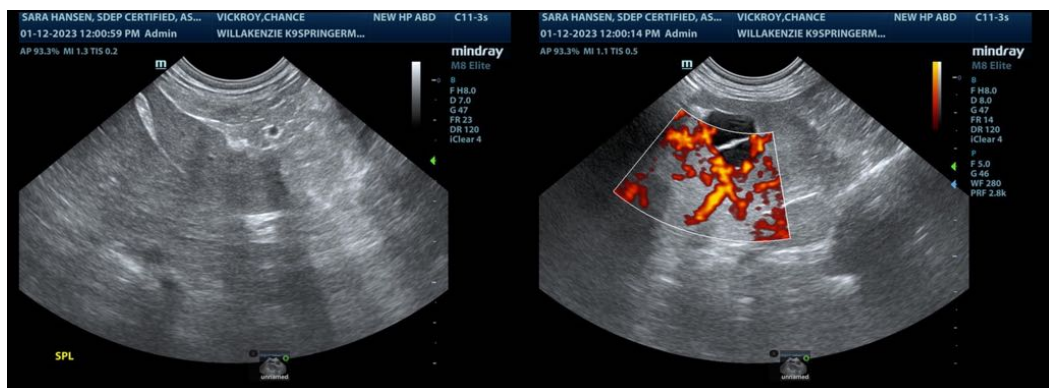
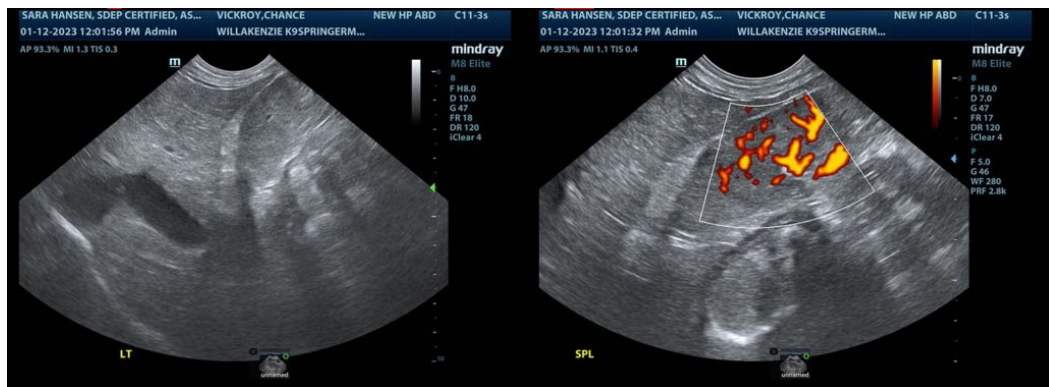
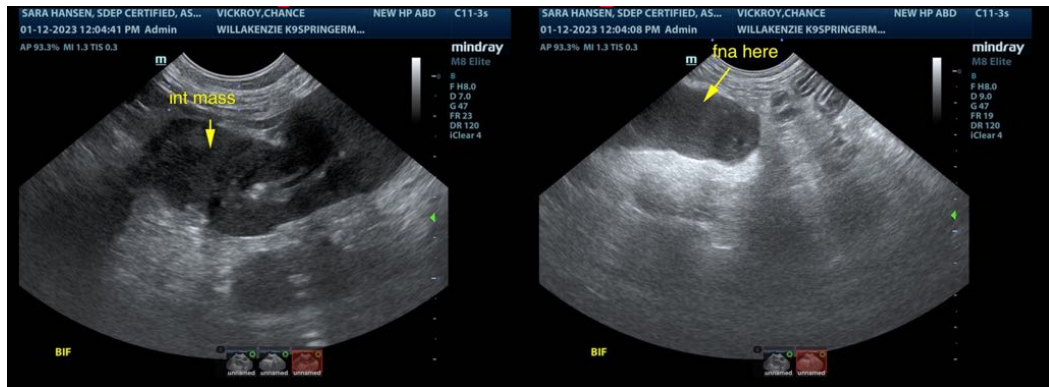
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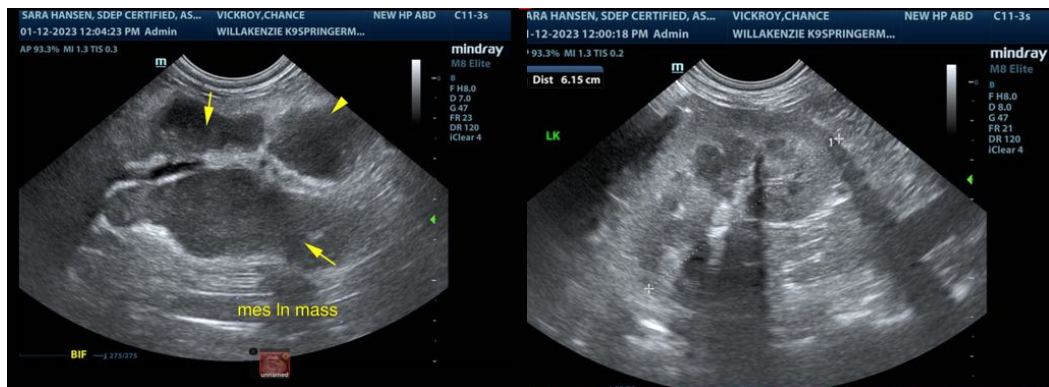
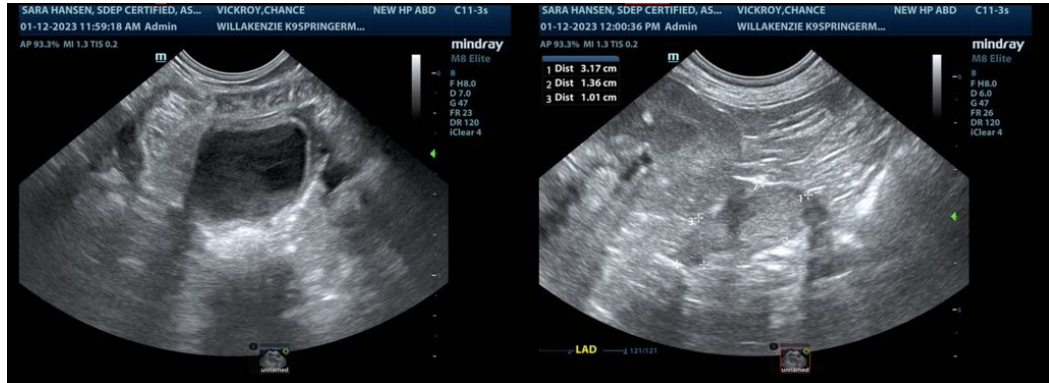
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

Eric.Lindquist@SonoPath.com