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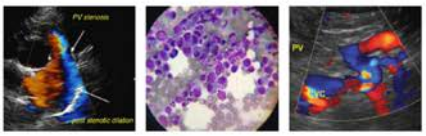

SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
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PATIENT

Leena Maso 44373A

SPECIES

Canine

BREED

Boxer

SEX

Spayed Female

AGE

14 Years 1 Month

WEIGHT

32.1 kg

INTERPRETED BY

IMAGING PERFORMED BY

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VET

Madison VS – Dr. Graham

INVOICE

44291

DATE

1/18/23

PRESENTING CLINICAL SIGNS

Leena presented today for evaluation of lethargy. Started vomiting Monday afternoon, 6 times. Had acupuncture that day, saw Dr. Peek, had an AUS and cerenia. Leena seemed more comfortable afterwards but was then up all night pacing but no vomiting. Tuesday Leena still did not seem her normal self so was seen at pcDVM where bloodwork was done, attached to file, along with x-rays. There was a slight increase in kidney values according to owner, x-rays appeared clear, received SQ fluids and a cerenia injection. This morning when owners woke up, Leena was found at end of bed and unable to stand and continues with no appetite and loose stools. Lena previously presented to the MVS Oncology service on 11/7/22 for evaluation of a pulmonary mass in the right caudodorsal lung field after a history of coughing. Owner's declined further diagnostics and elected palliative care. Lena has a history of Addison's disease. Current medications: Xycortal injection due on friday, Prednisone 2.5mg SID (owner gave 5mg last night Ondansetron 16mg BID Galliprant given on Monday Dasaquinn, Cobalequin, fish oil, Amantadine

Abnormal PE/Chem/CBC/UA Results: Blood Pressure: (cuff size 4, right hind limb) 8am 42 mmHg 9:15am 50 mmHg 11am 82 mmHg 12:30 pm 58 mmHg 1pm 84 mmHg (post-bolus) SDMA 20, Crea 2.5, BUN 52, Phos 6.9,

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (6.53 cm) with mild pyelectasia at 0.23 cm. Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (6.59 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal/small in size, measuring 0.29 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. No evidence of a mass effect is visualized.

Spleen

The spleen is subjectively normal in size, echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of

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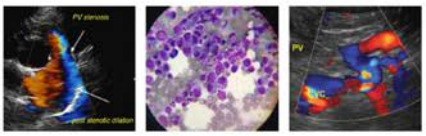

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the vasculature and biliary tract appear normal. There is a hypoechoic nodule visualized in the left dorsal aspect of the liver measuring 0.88 cm x 1.41 cm.

The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and primarily anechoic. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of 0.34 cm 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 uniform diameter with minimal fluid distension. Wall thickness is moderately increased. Bowel loops follow a typical curvilinear path. Some areas have reduced detail of wall layering. Jejunum wall measures 0.35 cm. Duodenum wall measures 0.35 cm. Visualized peristalsis appears appropriate. There is a focal section of jejunum that shows progressive all thickening leading to a segment of bowel with asymmetrical wall thickening and complete loss of layering, creating a mass effect. In this region, the bowel wall measures at 1.17 cm. There is over 9.0 cm of bowel involved. This creates somewhat of a mass effect with surrounding hyperechoic mesentery.

The area of the ileocecal junction is visualized. Sections of more distal colon are visualized, which appear to have evidence of wall thickening, and they are moderately dilated with non-formed fecal material. Colon wall in this region measures at 0.37 cm.

Pancreas

The pancreas is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

There is scant free abdominal fluid. There are prominent/mildly enlarged iso- to mildly hypoechoic mesenteric lymph nodes. One such lymph node is visualized measuring 1.0 cm in width. The omentum is hyperechoic around the abnormal section of small bowel.

PRIMARY FINDINGS

- Heterogeneous liver with a hypoechoic nodule – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy. The appearance of the hypoechoic nodule trends towards a more benign lesion. Recommend continued monitoring.
- Focal section of small bowel with severe asymmetrical wall thickening and loss of layering – Findings are most concerning for infiltrative disease to the bowel (round cell neoplasia, carcinoma, etc.). Other differentials are possible.
- Thickened colon wall with non-formed fecal material – Findings are most consistent with colitis. Infiltrative disease cannot be ruled out.
- Scant free abdominal fluid
- Mild/moderate mesenteric lymphadenopathy – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is

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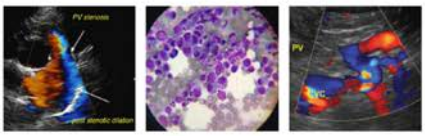

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considered less likely.

SECONDARY FINDINGS

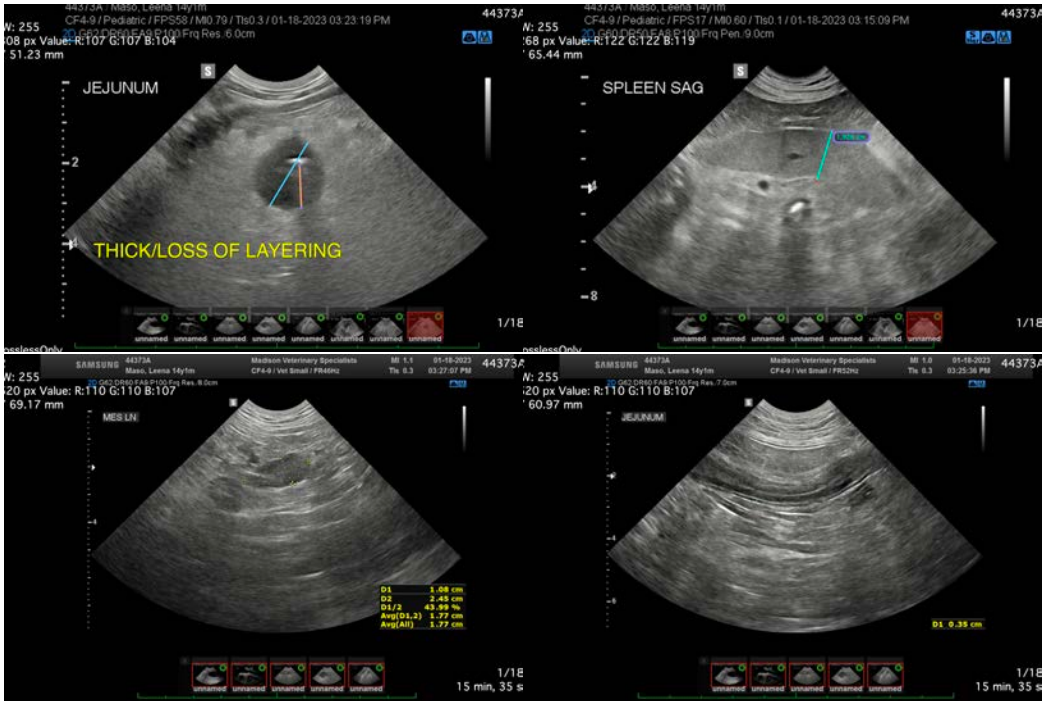
- Small, difficult to visualize adrenals – This is consistent with the diagnosis of hypoadrenocorticism.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a section of small bowel that appears to have complete loss of layering and asymmetrical thickened bowel wall. This is concerning for a bowel mass, but the abnormal tissue is fairly extensive, running along a significant section of small intestine. Recommend a fine needle aspirate of the small intestinal wall/mass effect where it is at its thickest.

Additionally, there are prominent mesenteric lymph nodes, and the liver is somewhat heterogeneous with a small hypoechoic nodule. If cytologic diagnosis cannot be obtained based on evaluation of the free fluid (if able to collect) and an aspirate of the bowel wall, then consider an aspirate of the liver, or surgical biopsies may need to be considered. The section of bowel visualized is fairly extensive, and normal bowel cannot be visualized on both ends to clearly determine if this can be surgically resected.

If recent radiographs of the thorax have not been taken, consider 3-view thoracic radiographs to look for any new nodules, mediastinal involvement, etc. in addition to the pulmonary nodule previously diagnosed.



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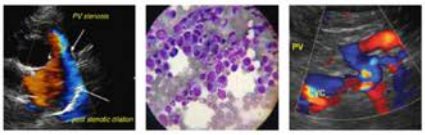

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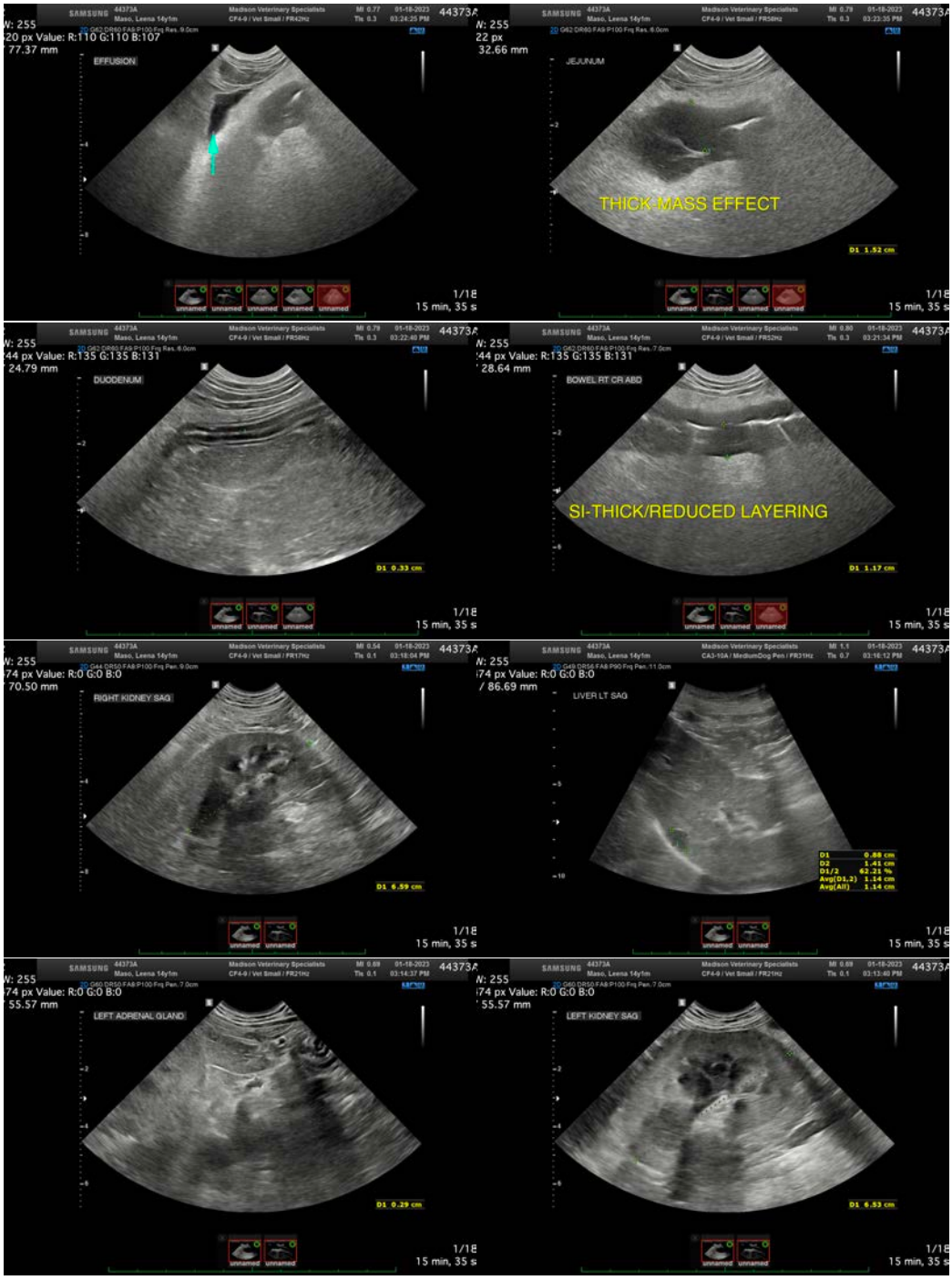

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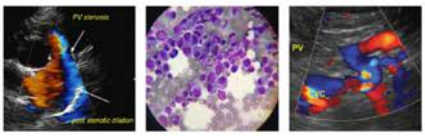

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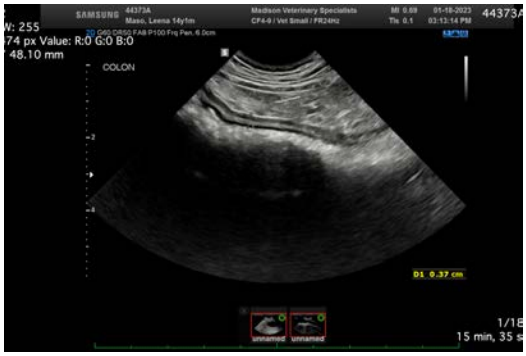

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)

kathleen.sennello@sonopath.com