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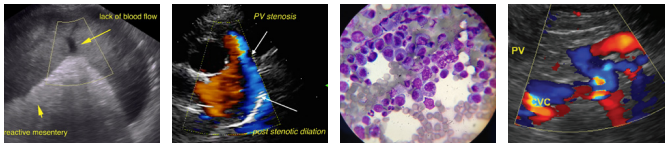
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Berkley Roberts

SPECIES

Canine

BREED

Labrador Retriever

SEX

Neutered Male

AGE

10 Years

WEIGHT

76 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Schanche/Harris

HOSPITAL NAME

TotalBond VH

REFERRING VET

Dr. Schanche

INVOICE

35500

DATE

2/8/22

PRESENTING CLINICAL SIGNS

10 yr old MN labrador presented for wellness exam in Dec 2021 - just moved to area. Did full blood work - alb came back mildly low at 2.5 - not protein loss through urine. O revealed has had on and off soft serve stool in last year. Started on fortiflora, fecal negative. Rec GI panel and US - did GI panel first - low cobalamin started on B12 injections weekly O giving at home. US performed today - since starting B12 2 weeks ago diarrhea has gone from soft serve to liquid, decreased energy, decreased appetite, weight loss ¬1 lb
Abnormal PE/Chem/CBC/UA Results: CBC today 32 - mildly low - anemia of chronic disease Wt = 76 Alb 1.8 on 2/7/22 TP 3/8 on 2/7/22 Glob 2.0 on 2/7/22 12/14/21 Wt: 84.5 UPC -0.1 UA - USG 1040, 1+ protein Alb 2.5 TP 4.5 Glob 2 Ca 8.8 corrected to 9.8 HCT 44

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 visualized areas of prostate and surrounding tissue appear normal. Unfortunately, the prostate is not fully visualized likely due to its intrapelvic location. Correlate with rectal exam findings.

The left kidney has a normal shape and size (7.99 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of 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 (6.85 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of 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 in size measuring 0.70 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.

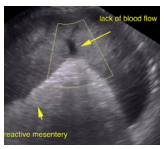
The region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. No evidence of a mass effect.

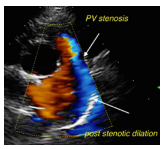
Spleen

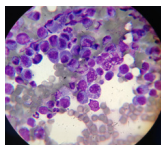
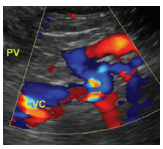
The spleen is subjectively normal in size, echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.





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The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a moderate amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach is dilated with a moderate/large amount of shadowing ingesta. It measures at a normal thickness of 0.41 cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layering 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 moderate fluid distention (particularly of the duodenum). Wall thickness is increased (duodenum 0.56 cm, jejunum 0.37, 0.32 cm). Bowel loops follow a typical curvilinear path. Some areas have reduced detail of wall layering. Visualized peristalsis appears appropriate. There is a focal area of bowel with moderate fluid distention and a decrease in the distinction of wall layering. This section of bowel has a wall thickness of 0.58 cm and is suspicious for a focal mass effect.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with nonformed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

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 anechoic free fluid. There is a severe mesenteric lymphadenopathy present with mesenteric lymph nodes visualized measuring 1.0 cm in diameter, and a cluster of large lymph nodes with the largest measuring 2.0 cm x 4.6 cm. The omentum is hyperechoic around these enlarged lymph nodes.

PRIMARY FINDINGS

- Subjectively thickened small intestine with some areas that display a focal decrease in distinction of wall layering – The bowel wall thickening could be consistent with inflammation, edema, or infiltrative neoplasia. A reduction in the detail of wall layering favors either severe intestinal disease or neoplastic infiltration. Biopsy is recommended.

- Moderate to severe mesenteric lymphadenopathy –_The severe mesenteric lymphadenopathy is most concerning for a neoplastic process, although you can see significant lymphadenopathy in some cases of autoimmune/inflammatory disease, infectious disease(tick born disease-such as bartonella, fungal infections, etc. A fine needle aspirate with cytology is recommended for further evaluation.

- Large amount of shadowing material within the gastric lumen – Correlate with feeding history and abdominal radiographs. If this patient was adequately fasted consider such differentials as delayed gastric emptying, ingested foreign material or a partial outflow tract obstruction (none observed.)

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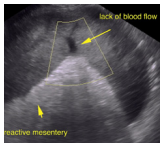

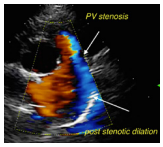

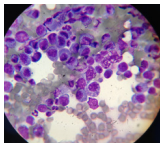
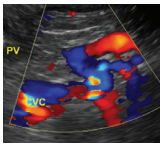

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SECONDARY FINDINGS

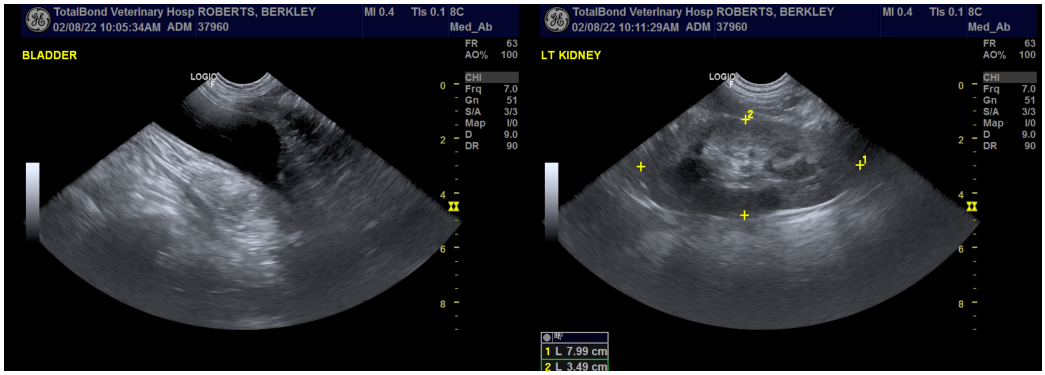
- Moderate gallbladder debris – The significance of the aggregated gallbladder sludge is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting.

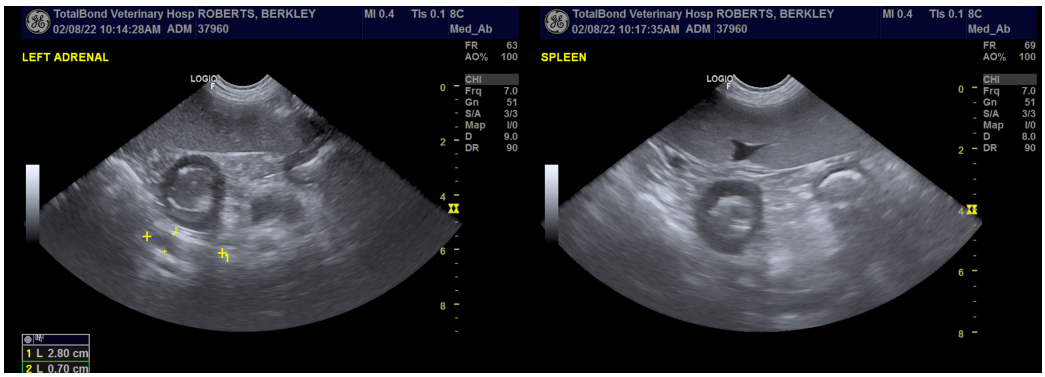
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The stomach and proximal small intestine appear somewhat fluid dilated. Additionally, there is shadowing material within the gastric lumen, which could represent a recent meal or possibly foreign material. Correlate with abdominal radiographs and history. Additionally, there is a section of bowel that appears to be focally thickened with some loss of layering, which is concerning for focal enteritis or infiltrative disease such as neoplasia.

There is a cluster of very enlarged mesenteric lymph nodes. Recommend a fine needle aspirate and cytology of these lymph nodes. Based on the information provided, a protein losing enteropathy is very likely. This is supported by your GI panel findings.

- Recommend 3-view thoracic radiographs.
- Recommend fine needle aspirate of mesenteric lymph nodes.
- If a diagnosis is not obtained based on cytology, then recommend surgical evaluation and biopsy of the small intestine, evaluation of the stomach, and possible resection of a bowel mass if identified.
- If there is any concern for concurrent hepatic disease, a liver function test could be considered.





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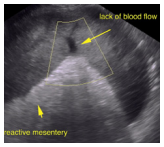

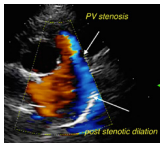

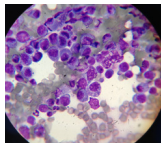
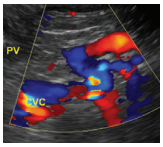

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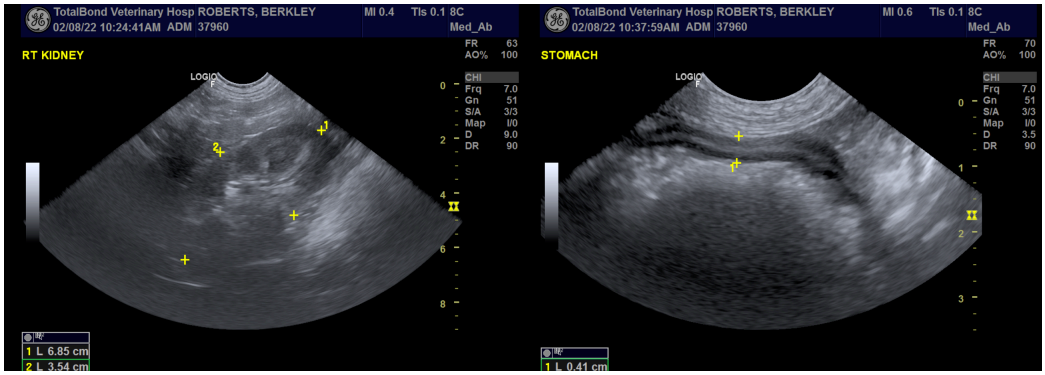

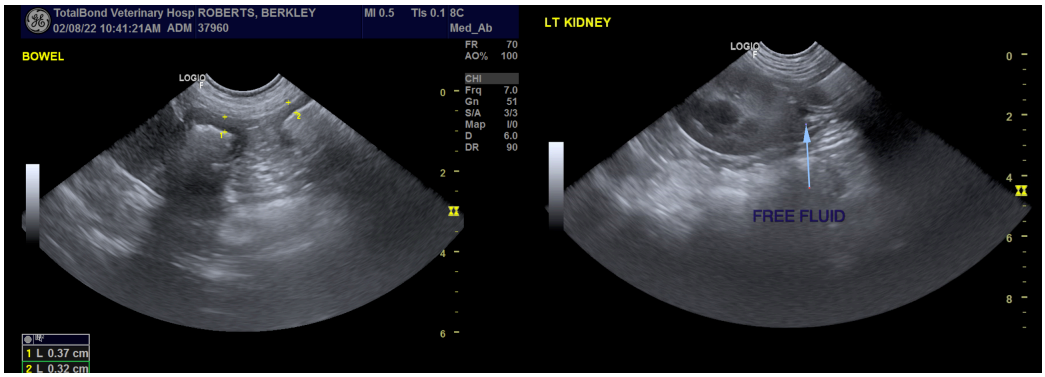

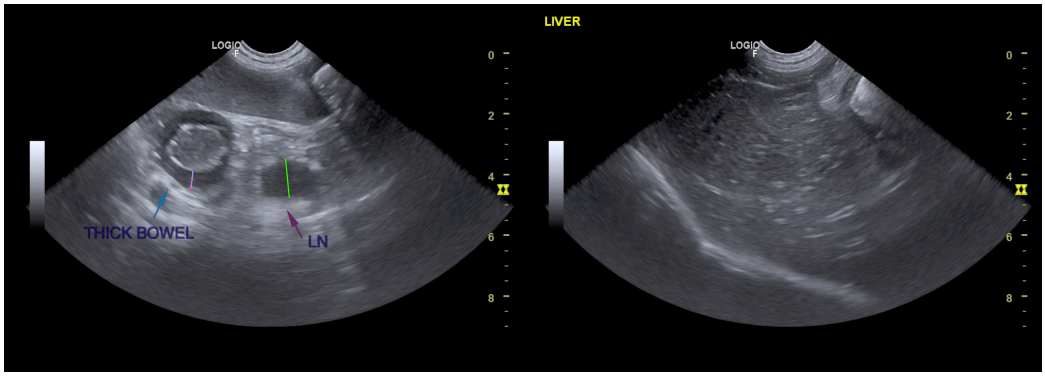

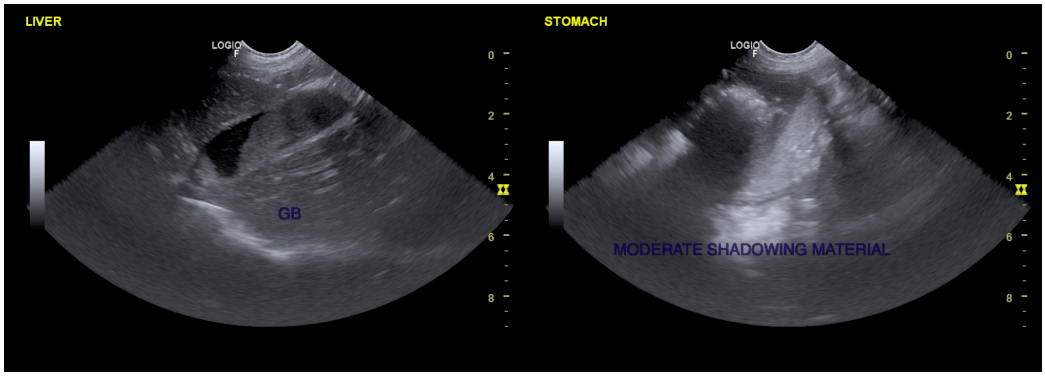

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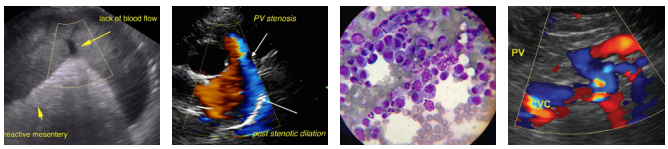

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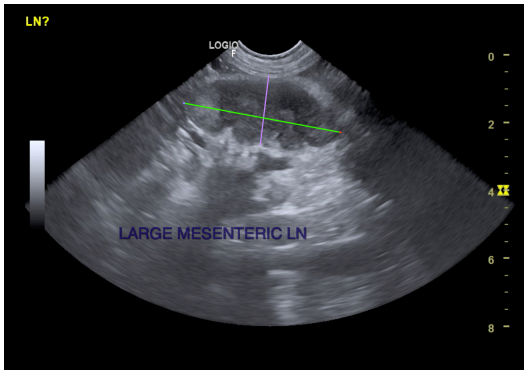

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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