



PATIENT

Winston Hillman

SPECIES

Canine

BREED

German Shepherd

SEX

Neutered Male

AGE

12 Years 10 Months

WEIGHT

95 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Leal

HOSPITAL NAME

Blaristown AH

REFERRING VET

Dr. Harker

INVOICE

37389

DATE

5/4/22

PRESENTING CLINICAL SIGNS

Dog presented ADR. Bloodwork shows low albumin and PCV 28%. Dog had previous splenectomy (2-3 years ago) due to benign mass. Radiographs show vague changes. Ultrasound done for further diagnostics

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly 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, masses or cystic calculi. The mucosa is mildly irregular, measuring 0.40 cm in diameter. Findings are most consistent with diffuse cystitis or lack of significant urine distention.

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 (7.69 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 (8.03 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 0.55 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 right adrenal gland is normal in size measuring XXcm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is absent, previously removed surgically.

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.

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 contains minimal luminal contents. It measures at a normal thickness of <0.7cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is



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adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

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The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal fluid distension. Wall thickness is increased. Bowel loops follow a typical curvilinear path. Some areas have reduced detail of wall layering. Visualized peristalsis appears appropriate. There is a large section of small intestine that appears severely thickened with a complete loss of layering. In this area, the wall thickness is 1.0 cm, and the length of bowel involved is over 7.0 cm.

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

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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.

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Free Abdomen

There is a significant mesenteric lymphadenopathy at the mesenteric root. Mesenteric lymph nodes measure 1.13 cm and 1.2 cm in thickness. The omentum is of normal echogenicity. No free fluid.

Other

A brief view of the heart was submitted. No significant pericardial effusion was seen.

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PRIMARY FINDINGS

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- Mildly irregular urinary bladder wall – The bladder mucosal changes could be consistent with cystitis or artifactual due to lack of adequate luminal distension. Bladder neoplasia cannot be ruled out but is considered unlikely in this patient.
- Focal area of small intestine with severe wall thickening and complete loss of layering – findings are most consistent with a small bowel mass. Primary differentials are round cell neoplasia, carcinoma, other.
- Moderate mesenteric lymphadenopathy – The moderate 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, FIP (cats)) etc. A fine needle aspirate with cytology is recommended for further evaluation.

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SECONDARY FINDINGS

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- Absent spleen – surgically removed previously.
- 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.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a focal section of small intestine that has a complete loss of layering and a severely thickened wall. This correlates with the anemia and low albumin reported. Recommend rectal exam to look for evidence of melena.

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There is a high concern for round cell neoplasia.

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Recommend a fine needle aspirate of the bowel wall and a mesenteric lymph node in addition to 3-view thoracic radiographs.

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If cytology is not diagnostic, consider surgical evaluation with resection of abnormal bowel and biopsy.

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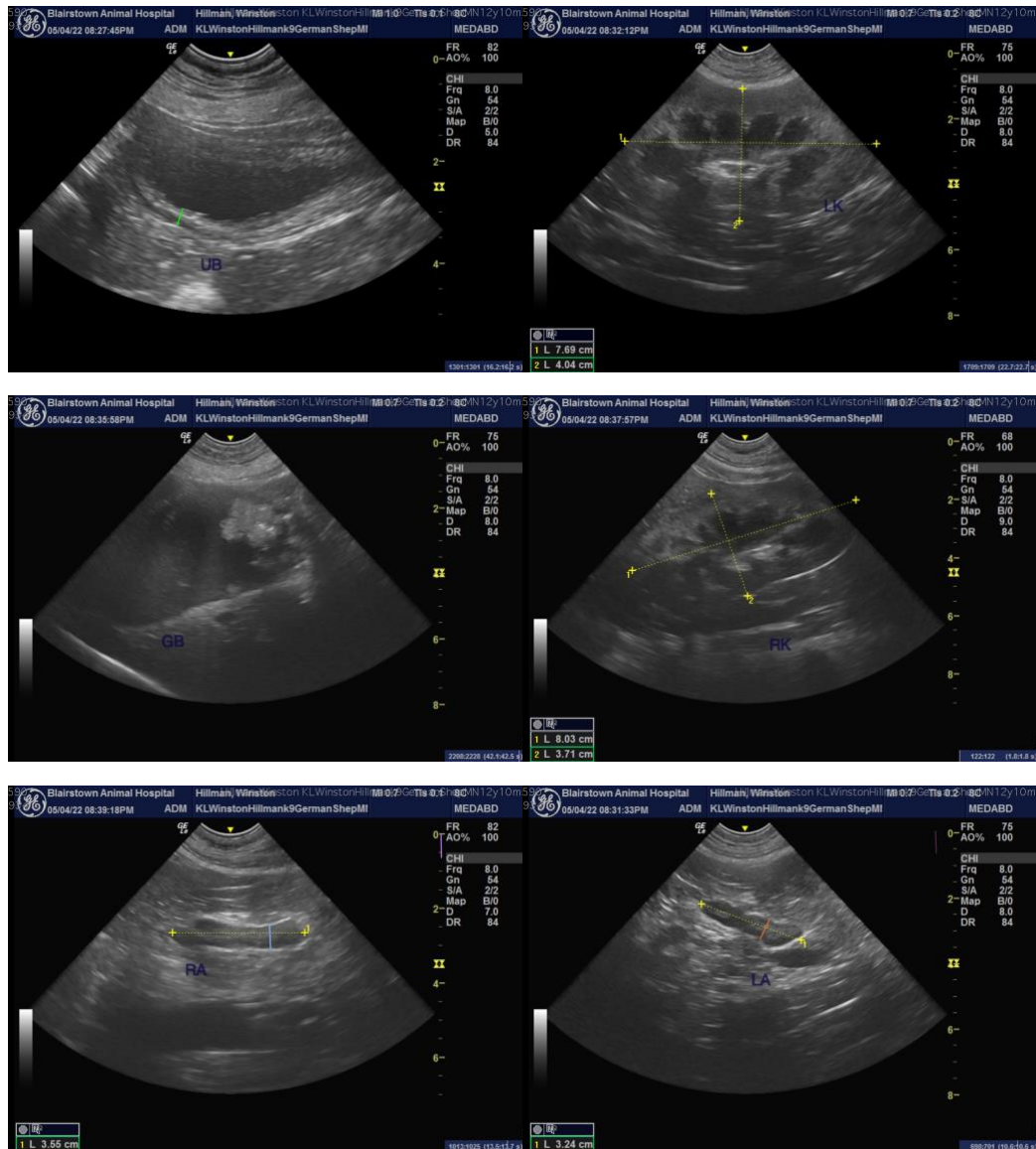
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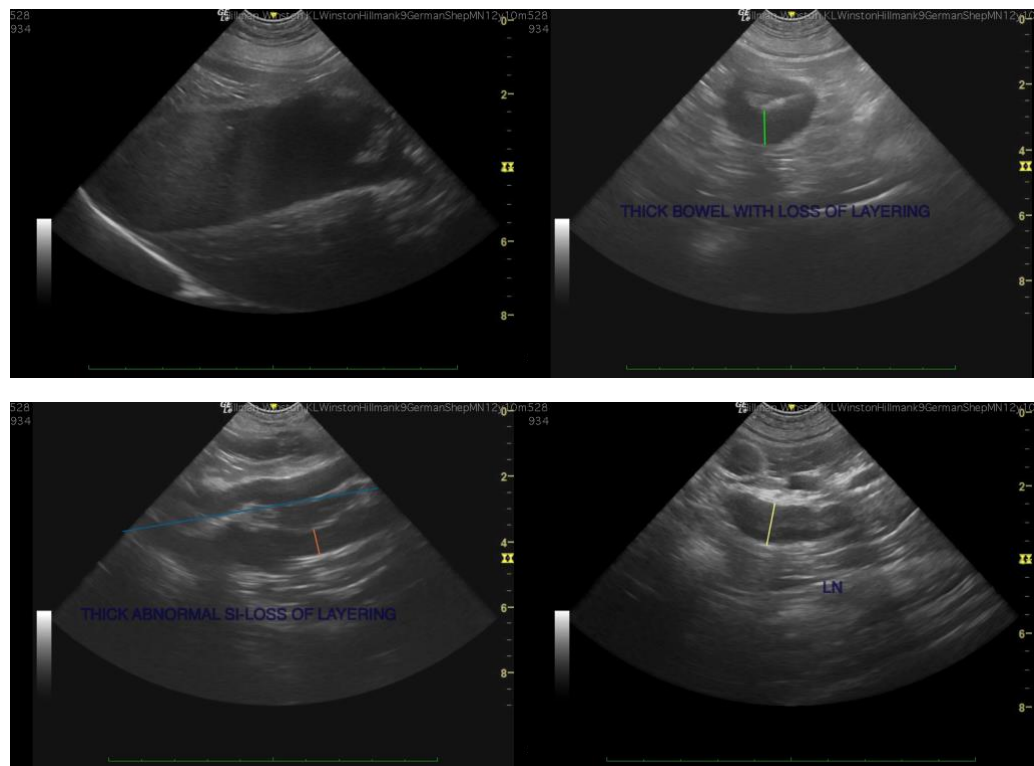
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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