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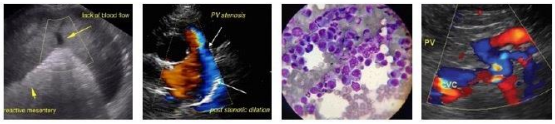


THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT
Millie Bain

SPECIES
Canine

BREED
Springer Spaniel

SEX
FS

AGE
12 years

WEIGHT
19 kg

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

IMAGING PERFORMED BY
Kelly Reschny

HOSPITAL NAME
Chippawaw Animal Hospital

REFERRING VET
Dr. Dowell

INVOICE
10714ag

DATE
06/02/2022

PRESENTING CLINICAL SIGNS

History: blood in stool, VERY hungry lately

Abnormal PE/Chem/CBC/UA Results: ALT 206, ALKP 193

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. 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 left kidney measured 5.33 cm in length.

The right kidney has a normal shape and size. 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 measured 5.02 cm in length.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.6 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 0.68 cm 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 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

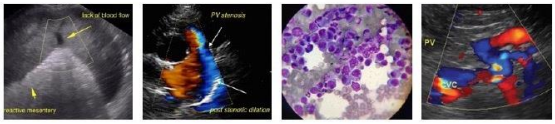
The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed

The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are 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 <0.7cm 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 relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. The duodenum measured as normal



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(between 0.3-0.5cm in wall thickness) and the jejunum measured as normal (0.3cm) Visualized peristalsis appears appropriate. There is a focal area of hypoechoic thickened bowel which I suspect is most consistent with colon, but a small intestinal mass cannot be excluded as a possibility.

The ileocecal junction was visualized and appears relatively normal but as you move distally into the abdomen there is a section of bowel with severe wall thickening and loss of layering. This area of bowel extends for over 9 cm. This area of the bowel wall measured up to 1.6 cm in thickness and the bowel is 3.4 cm in diameter. This section of bowel is surrounded by hyperechoic mesentery and enlarged mesenteric lymph nodes. This area is most consistent with descending colon.

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 fluid around the abnormal bowel. There are very large hypoechoic lymph nodes in the region of the bowel mass, the largest measuring 2.37 cm x 4.38 cm. The omentum is of increased echogenicity around the abnormal bowel and lymph nodes.

ULTRASONOGRAPHIC FINDINGS

- Focal area of bowel with severe thickening and complete loss of wall layering. This area of bowel is most consistent with a bowel mass and is suspected to be the descending colon.
- Heterogeneous liver. 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.
- Severe mesenteric lymphadenopathy in the area of the bowel mass. The moderate/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, FIP (cats)) etc.. A fine needle aspirate with cytology is recommended for further evaluation.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a section of bowel which has severe wall thickening and loss of layering creating the effect of a bowel mass. I suspect this is descending colon but normal bowel associated with this area is difficult to visualize. There is a severe localized lymphadenopathy as well. I recommend a FNA of the bowel wall and the associated lymph nodes. Round cell neoplasia would be high on the differential list as well as other neoplasia or possibly fungal disease etc.

Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.

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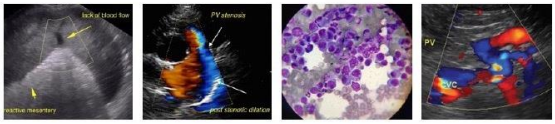

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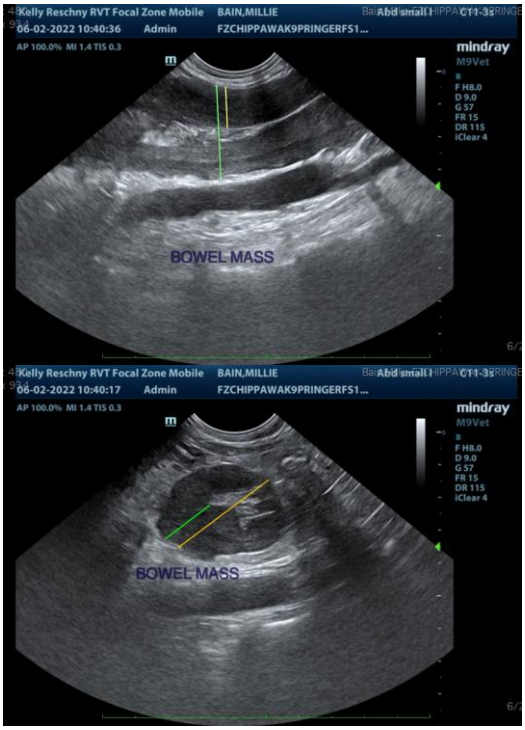

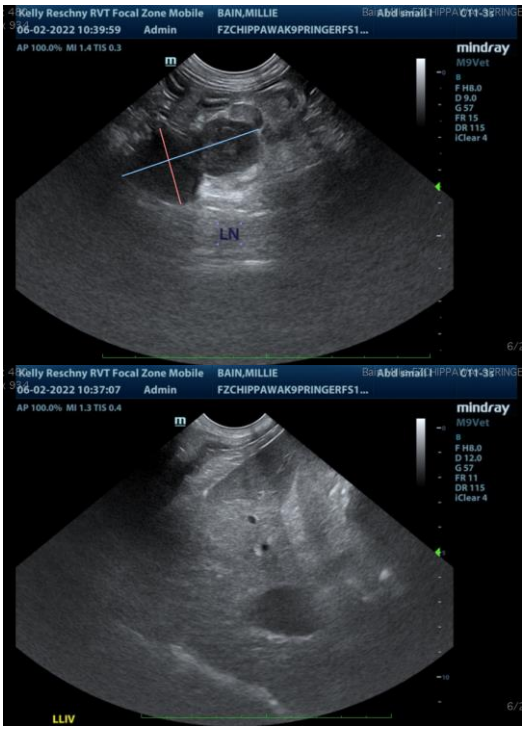

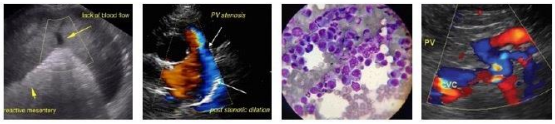

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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