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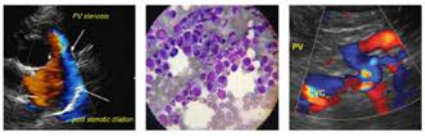

SonoPath
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PATIENT

Cooper Cole

SPECIES

Canine

BREED

Labrador

SEX

Neutered Male

AGE

11 Years

WEIGHT

93.6 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Amy Mayhew, LVT

HOSPITAL NAME

SVS Imaging MI

REFERRING VET

Bell Vet Clinic Oxford

INVOICE

43381

DATE

6/22/23

PRESENTING CLINICAL SIGNS

Dog has had diarrhea for past two weeks Owner thinks dog might be a little uncomfortable Eating more (or at least ravenous and wanting to eat more) may be drinking more seems tender when getting up or down Has lost 14 pounds since last Visit 2020 Abdomen palpates non painful or reactive, organs palpate ok in size Lipoma like growth on Right scapula region, owner notes it has been biopsied in past Heart no murmur Lungs eupneic Skin appears ok, no lesions oral exam stage 1 ears clean Rectal exam no blood Dog does palpate sore on Lumbar spine compression quick dip stick of urine in hospital no ketones or sugar

Abnormal PE/Chem/CBC/UA Results: All the normal lab work T4 is 0.5, but I do not think dog is Hypothyroid, as dog is losing weight, I think this is Euthyroid ALKPHOS is 2172 almost 20 x normal all other liver enzymes normal and dog not jaundiced Urine specific gravity is 1.015

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 prostate is normal in size (1.01 cm) and shape for this neutered male dog. The parenchyma is homogenous and the external margins are smooth. The prostatic urethra appears normal with no evidence of irregularity, invasion, mass effect or calculi.

The left kidney has a normal shape and size (7.97 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 (7.35 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 in size measuring 0.87 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 0.83 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. The spleen echotexture is heterogenous and diffusely moderately mottled, the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. There is a somewhat ill-defined hypoechoic nodule visualized within the parenchyma measuring 0.70 cm x 1.0 cm.

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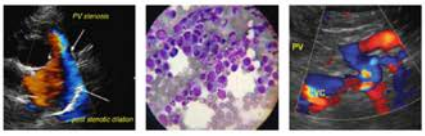

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Liver

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 mild and primarily anechoic. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains moderate fluid. It measures at a normal thickness of 0.40 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 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. Duodenum wall measures 0.54 cm. Jejunum wall measures 0.43 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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. Colon wall measures 0.15 cm.

Pancreas

The right limb of the pancreas appears within normal limits. In the region caudal to the stomach, there is hyperechoic, somewhat cystic/nodular appearing tissue in the region of the pancreas that could be consistent with abnormal pancreatic tissue. Additionally, caudodorsal to the stomach, there is a large cystic lesion measuring 6.08 cm x 5.78 cm, which could represent a pancreatic cyst.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Large, hypoechoic, cystic appearing structure visualized caudodorsal to the stomach with adjacent hyperechoic cystic/nodular tissue – Findings are most concerning for a large pancreatic cyst and pancreatic pathology (inflammation, neoplasia, etc.). An omental cyst, caudal hepatic cyst, etc. cannot be definitively ruled out.

- Mottled spleen with ill-defined hypoechoic nodule – The diffuse splenic changes are non-specific and could be consistent with lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis.

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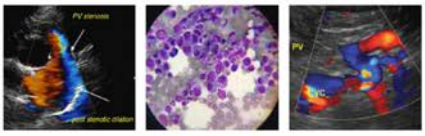

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- Heterogeneous liver – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy.

- Moderate fluid/ingesta within the gastric lumen – Correlate with a feeding history. These findings could be consistent with delayed gastric emptying or a partial outflow tract obstruction (none observed) if the patient was adequately fasted.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a large cystic structure visualized in the right cranial abdomen caudodorsal to the stomach. Adjacent to the cystic structure there is some irregular hyperechoic cystic/nodular tissue in the region of the left limb of the pancreas. Primary differential for these findings would be a pancreatic cyst and pancreatic pathology, although an omental cyst, caudal hepatic cyst, etc. cannot be ruled out.

Options moving forward would include a contrast CT scan to better characterize this lesion and help with therapeutic planning (surgery versus percutaneous drainage, etc.), or you could consider percutaneous drainage with the knowledge that the source of the lesion is clearly known. If this is done, recommend fluid analysis and cytology +/- aerobic and anaerobic cultures. Although I suspect that this lesion is clinically significant based on the abnormal appearing tissue caudal to the stomach, there is also the possibility that this represents a benign pancreatic cyst, and that significant small intestinal disease is driving the clinical signs/diarrhea despite lack of significant ultrasonographic changes. Consider the following:

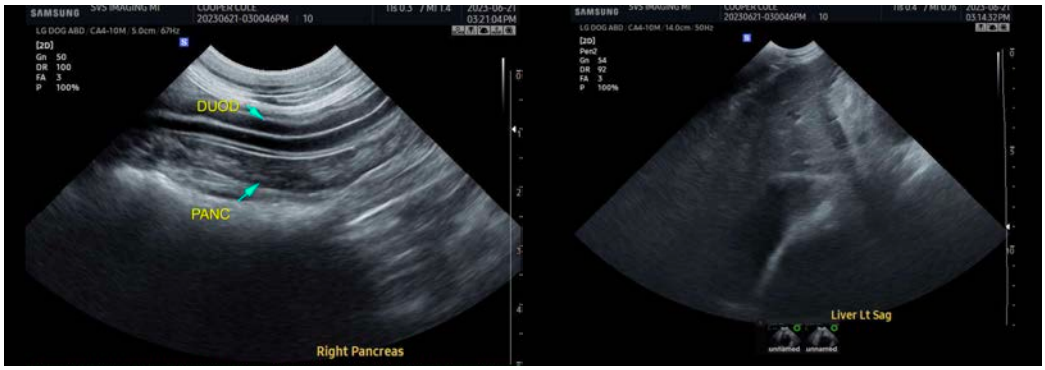
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc.. to further evaluate for pancreatic/small intestinal disease.

- Recommend empirical treatment for pancreatic inflammation.

- Consider a liver function test and a fine needle aspirate of the liver to further evaluate the elevation in ALP reported.

If symptoms are persistent and a primary enteropathy is strongly suspected, consider obtaining GI biopsies.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.



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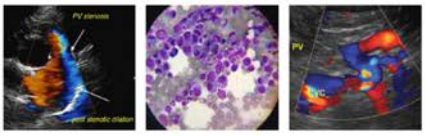

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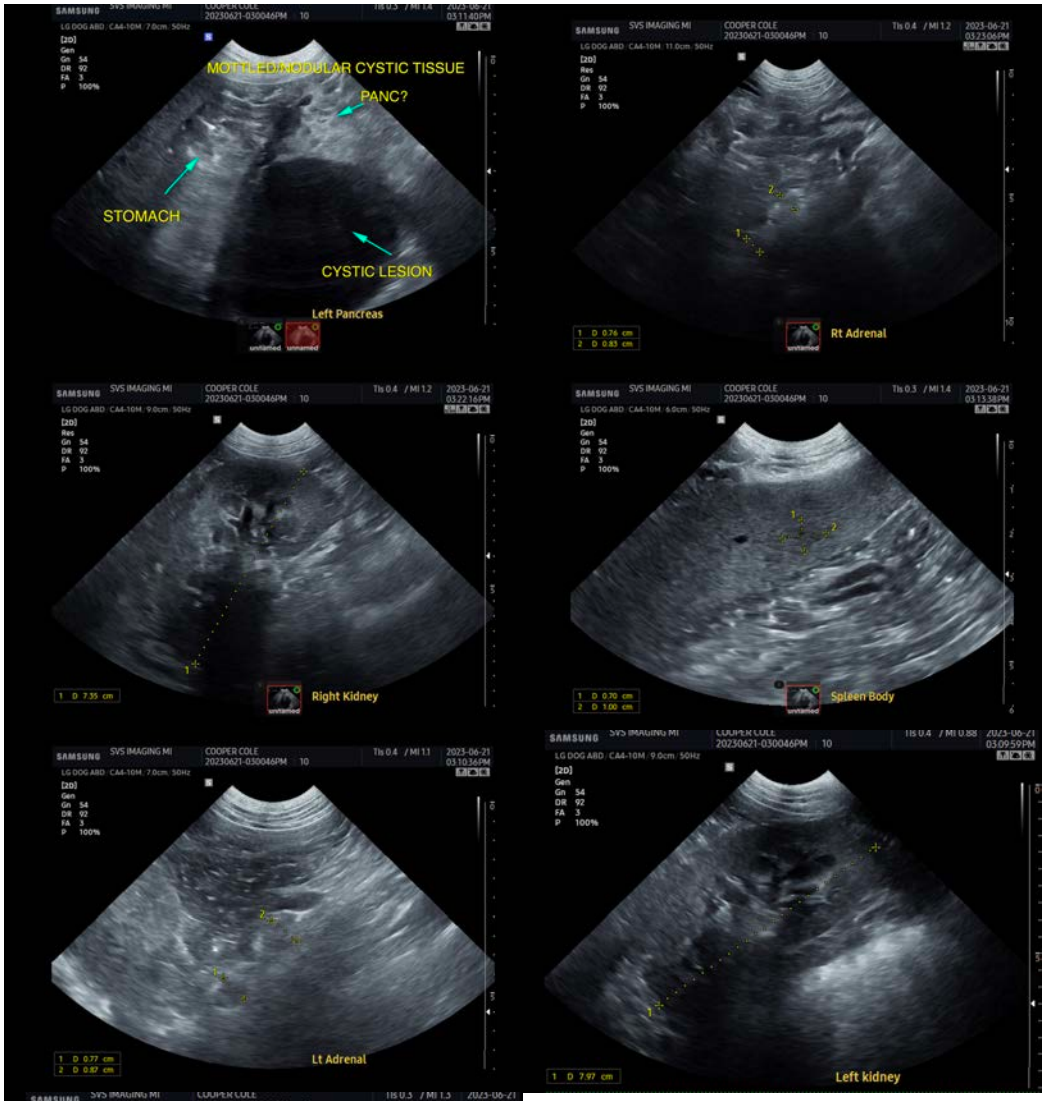

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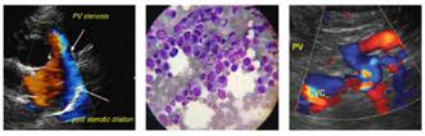

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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