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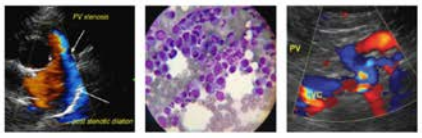

SonoPath
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PATIENT

Murphy Nye

SPECIES

Canine

BREED

Irish Goldendoodle

SEX

Neutered Male

AGE

10 Years

WEIGHT

59 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Rachel Runnells, RVT

HOSPITAL NAME

SVS Imaging KC

REFERRING VET

Dr. Michelle Hall

INVOICE

39348

DATE

7/8/22

PRESENTING CLINICAL SIGNS

P has been waxing and waning for 6 months about now. In March came in for vomiting daily (can be up to 10x/day), we did BW which was WNL. P had a 6 pound weight loss so did full body rads. Radiologist report came back with hypovolemia, otherwise unremarkable abdomen. Cortisol was done and it was low at 1.4 (N 2-6). At that time, p was put on prednisone for an infection on the nose-unilateral. Crusting and green. Antibiotics as well. Rec ACTH stim once pred was done for weeks. Did ACTH stim in May and pre draw was 2.3, and post draw was 8.1. P has been doing fine since then, but presented before 4th of July with not feeling well, lethargy, vomiting, and crusting nose again. Has been on prednisone and antibiotics for 1 week. After a day or two on meds O states pt was back to feeling like himself. Abnormal PE/Chem/CBC/UA Results: Most recent exam: slight dehydration, QAR, vomiting at home again.

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 (0.88 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 (7.29 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 (7.7 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 0.63 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 0.72 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. There is a hypoechoic focal heterogeneous mass effect visualized towards the cranial third of the spleen measuring 3.27 cm x 3.55 cm. This lesion deviates the splenic capsule.

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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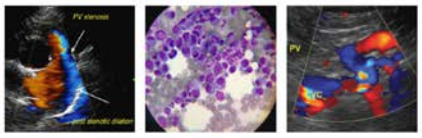

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The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are primarily anechoic. The cystic and common bile ducts are normal/not visible.

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. Jejunum wall measured 0.32 cm. Visualized peristalsis appears appropriate. There is one focal area of shadowing visualized within what appears to be the small intestine, measuring 1.14 cm. This could represent passing ingested material, partial obstruction, etc. No significant obstructive pattern is visualized.

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.

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

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

- Focal hypoechoic splenic – A focal, solid, mixed echogenic mass is present within the splenic parenchyma. This mass distorts the splenic capsule. Differentials include benign lesions such as lymphoid hyperplasia, hemangioma, etc., or neoplastic lesions such as hemangiosarcoma, lymphoma, histiocytic sarcoma, etc.

- Questionable shadowing material within the small intestine – This could represent passing ingested material or a partial obstruction/ingested foreign material.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The GI tract largely appears normal on today's scan. There are occasional bowel loops with mild fluid dilation, and there is a small area of shadowing within what appears to be the small intestine, which could represent ingested foreign material. There is no obvious obstruction associated with it, but this should be monitored. Correlate these findings with abdominal radiographs.

Additionally, there was a focal mass lesion on the spleen. This is relatively small and non-cavitated. This could represent a neoplastic or benign lesion.

I suspect with the historical information in this patient there is underlying GI disease such as dietary intolerance/food allergy, dysbiosis, chronic pancreatitis (none observed), IBD, or much less likely intestinal neoplasia. Additional diagnostics can be recommended, but ultimately, GI biopsies may be warranted. Additionally, considering the splenic lesion, I would consider splenectomy for both diagnostic and therapeutic purposes. Even if this is a benign lesion, there is some risk for future rupture.

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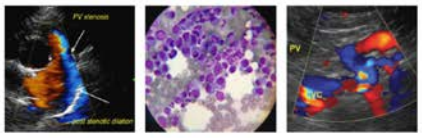

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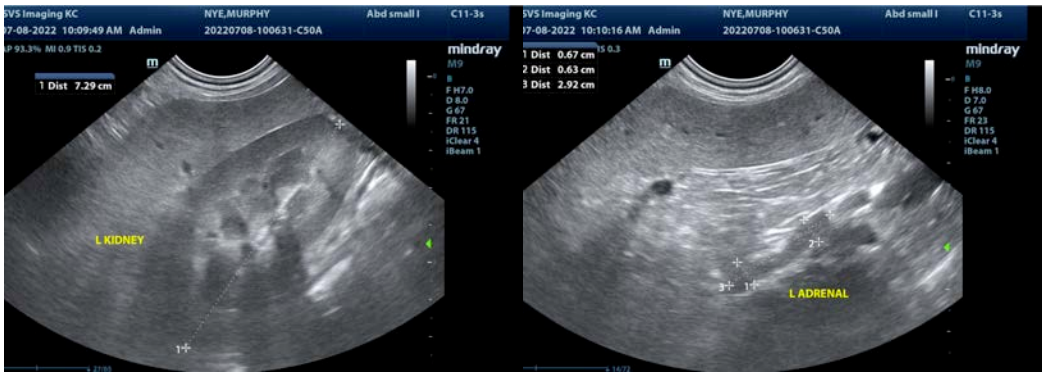
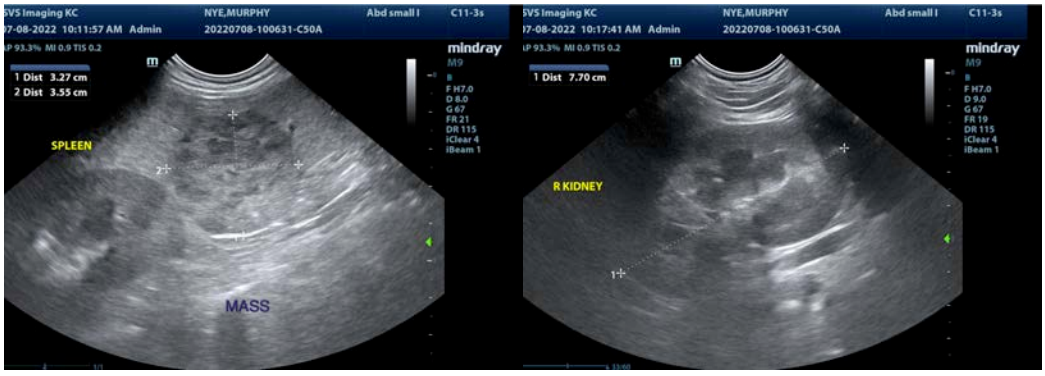
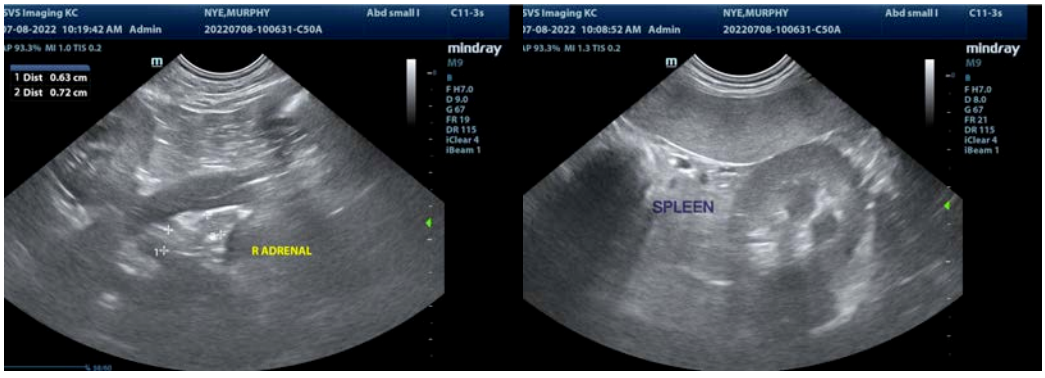
If surgery is not desired, you could consider a fine needle aspirate.

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

- Correlate these findings with abdominal radiographs, looking for any evidence of an obstructive pattern/foreign body.
- Consider a novel protein/hydrolyzed protein prescription diet.
- Consider a GI panel to Texas A&M for a qualitative PLI, TLI, cobalamin and folate to further evaluate the pancreas and small intestine.
- Recommend chronic probiotic therapy.
- Consider obtaining GI biopsies if symptomatic therapy is not helpful.
- In this case, if you are going to surgery for the spleen, you could potentially address both situations.







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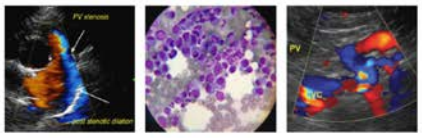

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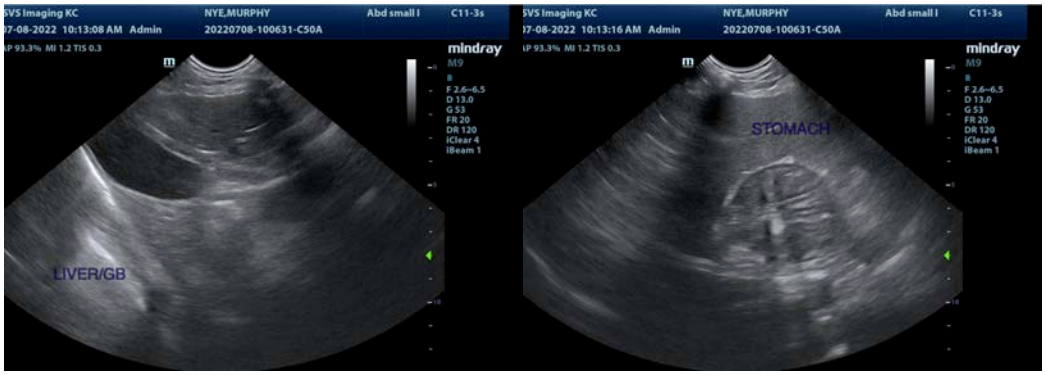

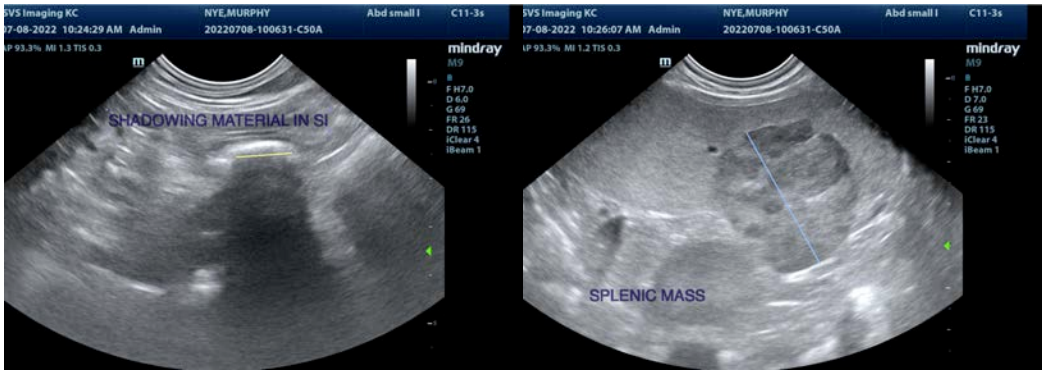

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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