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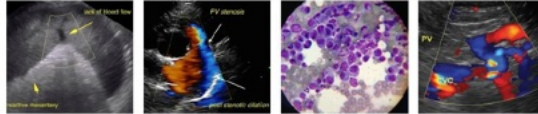


IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Bogey Foster

SPECIES

Canine

BREED

Lab Ret

SEX

Spayed Female

AGE

06/03/2014

WEIGHT

29.9kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

MountRose AH

REFERRING VET

Dr. Lori Burnham

INVOICE

10407

DATE

8/10/2023

PRESENTING CLINICAL SIGNS

Several month history of weight loss. Bogey initially had vomiting and diarrhea. The diarrhea has resolved, although owner did mention that the stool starts of firm but throughout the day will get progressively softer. Bogey usually weighs in the mid-to upper 70's but currently weighs 65 lbs. Owner reports that her appetite has decreased. Owner will make a new food, which she will eat, but then won't eat the next time. Entyce appetite stimulant did not help to increase appetite. Unrelated history - last November, she was diagnosed with paraparesis at the local orthopedists office. Negative for Myasthenia and thyroid disease. She is receiving physical therapy, which owner feels has been beneficial. Working diagnosis Hypoalbuminemia, Hypoproteinemia, weight loss: GI disease, neoplasia, atypical Addison's, inflammatory, less likely infectious, other MEDS Rimadyl 75 mg BID, Gabapentin 100 mg.

Abnormal PE/Chem/CBC/UA Results: LABs attached- HCT 36% (3803-56.5), MCH critically low 15.8 (21.9-26.1), MCHC 31.4 (32.6-39.2), platelet critical high 1,015 (143-448), MCV 50 (59-76), reticulocytes 178 (10-110), acanthocytes slight. Na/K 27 (28-37), TP 4.8 (5.5-7.5), Albumin 1.6 (2.7-3.9), BUN 7 (9-31)

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 (5.12 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.

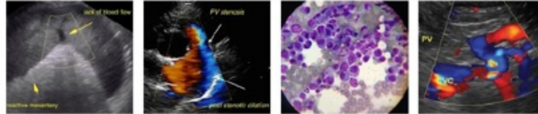
The right kidney has a normal shape and size (6.57 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex: medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is borderline large and slightly irregular in shape measuring 0.65 cm at the cranial pole, 0.95 cm at the caudal pole, and 2.96 cm in length. It is visualized in its normal position cranial to the left renal artery. It is slightly abnormal in appearance in that there is a small “bulge” at the area of the phrenic vein possible consistent with early invasion or expansion.

The right adrenal gland is normal/borderline large in size measuring 0.96 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



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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. There is a 1.67 cm x 1.29 cm somewhat ill-defined hyperechoic nodule visualized within the parenchyma.

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 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 uniform diameter with minimal fluid distension. Bowel loops follow a typical curvilinear path. Visualized peristalsis appears appropriate. There is a focal area of small bowel with irregular focal wall thickening and loss of layering. In this area the bowel wall measures approximately 0.61 cm, and the thickening extends for over 4 cm in length. The duodenum measured 0.57 cm in diameter and the jejunum measured 0.41 cm in diameter.

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

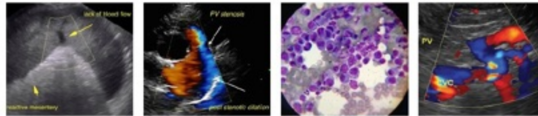
The pancreas is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There are occasional prominent hypoechoic mesenteric lymph nodes visualized. One such lymph node measures 1.6 cm x 2.02 cm and another measures 0.94 cm. The omentum is hyperechoic around the abnormal bowel.

PRIMARY FINDINGS

- Borderline bilateral adrenomegaly with an irregularity associated with the caudal pole of the left adrenal. The bilateral adrenomegaly could be consistent with bilateral hyperplasia (e.g., secondary to pituitary-dependent hyperadrenocorticism), bilateral infiltrative neoplasia, inflammatory adrenal disease, other. Correlation with clinical findings is recommended. Continued monitoring of the irregularity of the caudal pole is warranted as this could represent early vascular invasion.
- Hyperechoic nodule visualized within the liver. The appearance of this nodule trends toward a more benign process. Recommend continued monitoring.



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- Focal wall thickening and irregularity of the small bowel with complete loss of layering. Finding is very concerning for focal infiltrative disease (neoplasia, severe IBD, etc.)

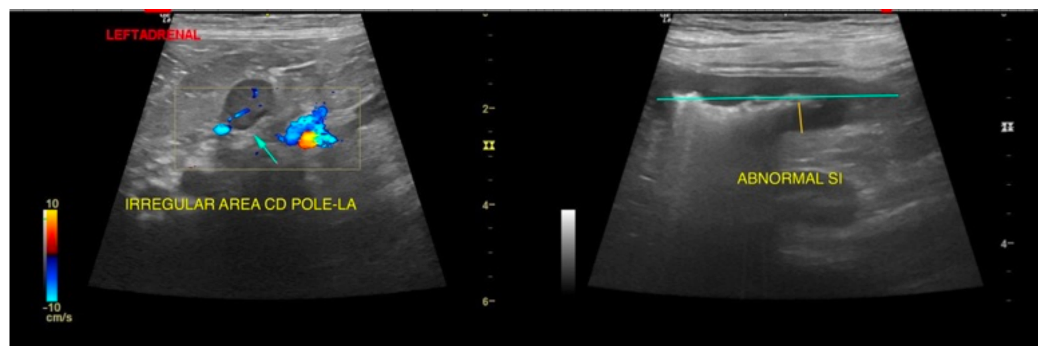
- Occasional large round hypoechoic mesenteric lymph nodes. The moderate mesenteric lymphadenopathy could be concerning for a neoplastic process, although you can see significant lymphadenopathy in some cases of autoimmune/inflammatory disease, infectious disease (tick born disease-such as bartonella, fungal infections, etc. A fine needle aspirate with cytology is recommended for further evaluation.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a section of small bowel with severe wall thickening, loss of layering and irregularity. This area is concerning for possible infiltrative neoplasia less likely severe IBD, enteritis, etc. A fine needle aspirate of the bowel wall in this region could be considered. Additionally, there are large rounded hypoechoic lymph nodes in the region and a fine needle aspirate could be considered. I suspect this lesion could be the source of the hypoalbuminemia and possible reticulocytosis/anemia reported. If a cytologic diagnosis can not be obtained recommend surgical evaluation for biopsy/possible resection.

Both adrenals are somewhat "plump in appearance" the caudal pole of the left adrenal is slightly irregular and there is some soft tissue in the region of the phrenicoabdominal vein which could represent early invasion. This is not definitive continued monitoring with ultrasound (recheck ultrasound in 2-3 months) is typically recommended. Additionally, a contrast CT scan of the region could be considered.

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



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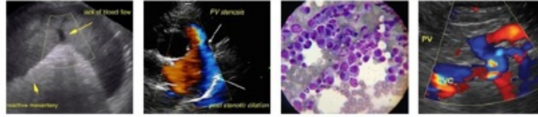

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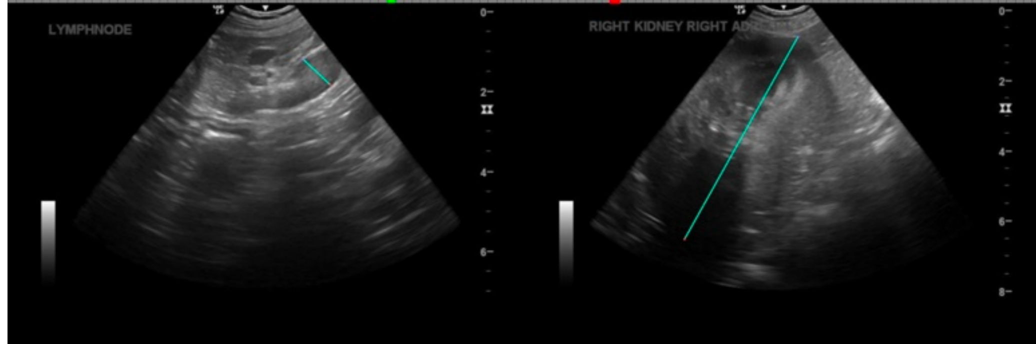

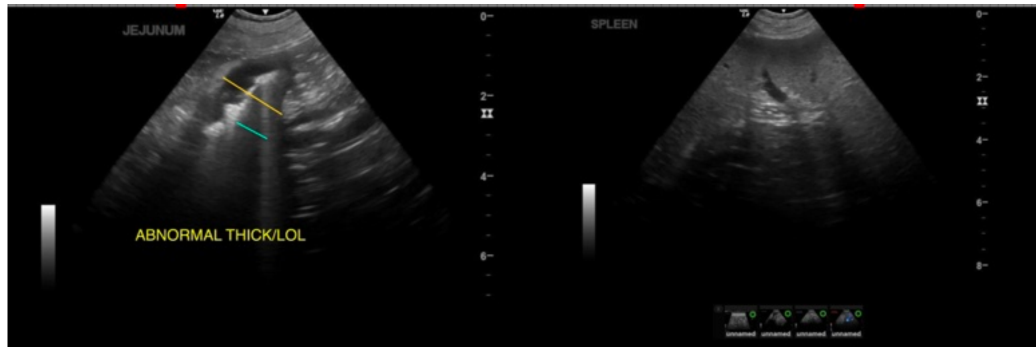

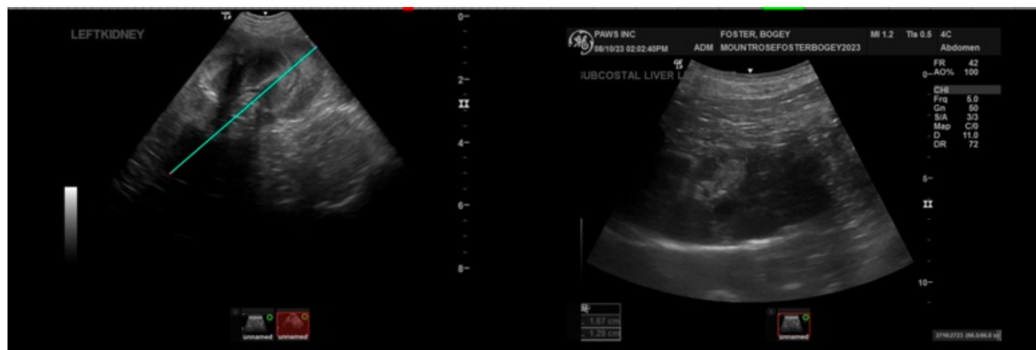

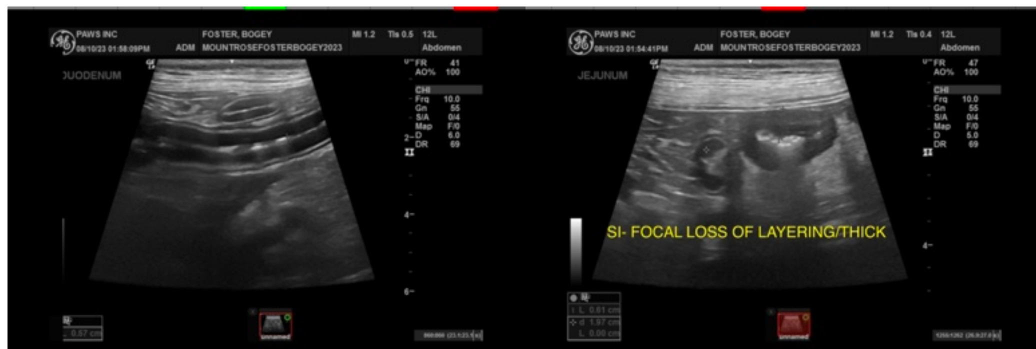

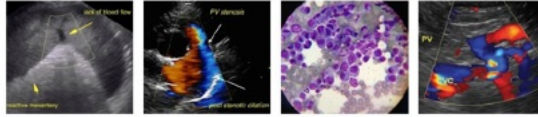

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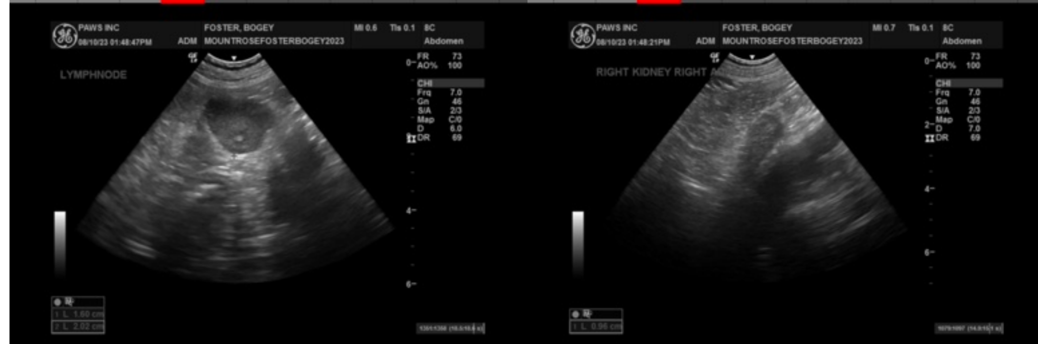

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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