



PATIENT

Rusty Tinsley

SPECIES

Canine

BREED

Poodle X

SEX

Neutered Male

AGE

12 Years

WEIGHT

26 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Mandy Becker

HOSPITAL NAME

Stoney Creek VH

REFERRING VET

Dr. Mandy Becker

INVOICE

25170

DATE

9/2/21

PRESENTING CLINICAL SIGNS

Acute onset of abdominal distension. Ascites confirmed as transudate with TP 1.8 g/dL, SG 1.018 rafts of mesothelial cells and 1+ rbcs. Moderate pleural effusion confirmed. Patient had history of ataxia/bilateral facial nerve paresis and diarrhea that resolved with clindamycin and tapering prednisone course (3 weeks at 0.5 mg/kg/day tapered and finished 8/30). No vomiting, patient has decreased appetite, but is eating and having soft stool.

Abnormal PE/Chem/CBC/UA Results: Pale mucous membranes, abdominal fluid wave noted on PE. Patient auscults normally, but has increased respiratory rate and effort on inspiration. Bloodwork: Hct 21% (was 45 % 8/4), Plt 60k with no peripheral signs of regeneration (normocytic normochromic). No spherocytes on PBS and neg saline agglutination test. Alb 2.0, Glob 2.0, Chol 99. ALT 215 and ALP 1000 (normal 8/4). Owner declined cytology of ascites to Penn. Suspect PLE secondary to neoplasia.

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 (0.95 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 (5.13 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 (4.9 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 0.58 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 0.74 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 large and irregular The spleen echotexture is heterogenous and mottled. The blood flow through the hilus and splenic parenchyma appears normal. There is an isoechoic irregular bulge in the splenic capsule measuring 1.5 cm x 1.55 cm.

Liver

The liver is large, and normal in 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.



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The gallbladder lumen is mildly distended. The wall appears thickened and hyperechoic at 0.43 cm. There is minimal luminal contents. The gallbladder is surrounded by free abdominal fluid (not of gallbladder origin). Changes likely represent edema.

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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.

BREED

Poodle X

There is a very large area of abnormal bowel with severely thickened walls at approximately 0.98 cm with complete loss of layering. Hypoechoic tissue surrounds this area as well, creating a mass effect measuring approximately 3.6 cm in diameter. Wall thickness in this area measures 1.7 cm. Numerous other areas of bowel are abnormal, surrounded by hyperechoic mesentery with thick walls and loss of layering, measuring 0.82 cm, 0.45 cm, etc.

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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 area of 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

Evaluation of the peritoneal cavity revealed large volume free fluid. No lymphadenopathy. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The mesentery is of increased echogenicity around the bowel mass and other areas of abnormal bowel.

INTERPRETED BY

Kathleen Sennello DVM,
MS, Diplomate ACVIM
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Medicine)

PRIMARY FINDINGS

- Large area of small intestine with loss of layering and severe wall thickening – The bowel wall thickening could be consistent with inflammation, edema, or infiltrative neoplasia. A reduction in the detail of wall layering favors either severe intestinal disease or neoplastic infiltration. Biopsy is recommended.
- Large, mottled spleen with irregular capsule – 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.
- Large, 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.

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SECONDARY FINDINGS

- Large volume abdominal fluid – likely secondary to hypoalbuminemia as it is a transudate per history provided.

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- Thickened gallbladder wall – changes are likely associated with edema – cannot rule out neoplastic infiltration.



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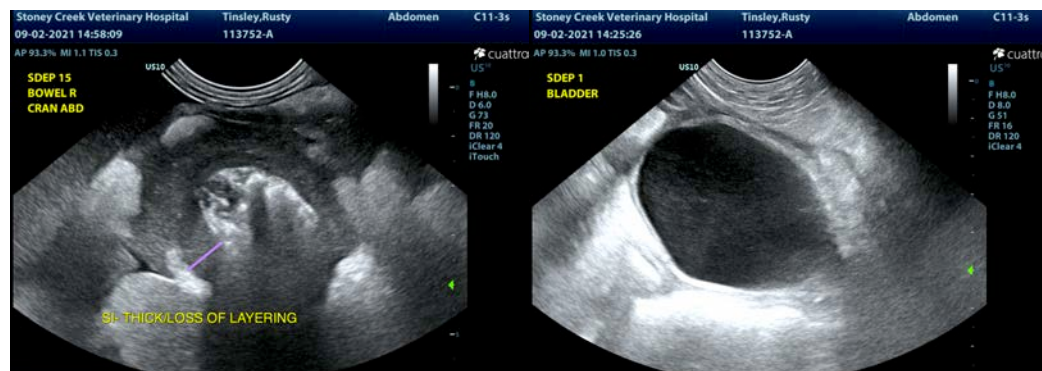
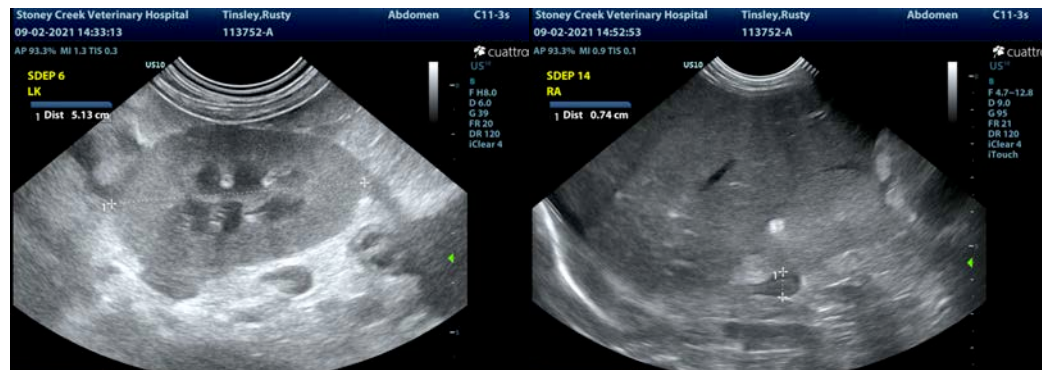
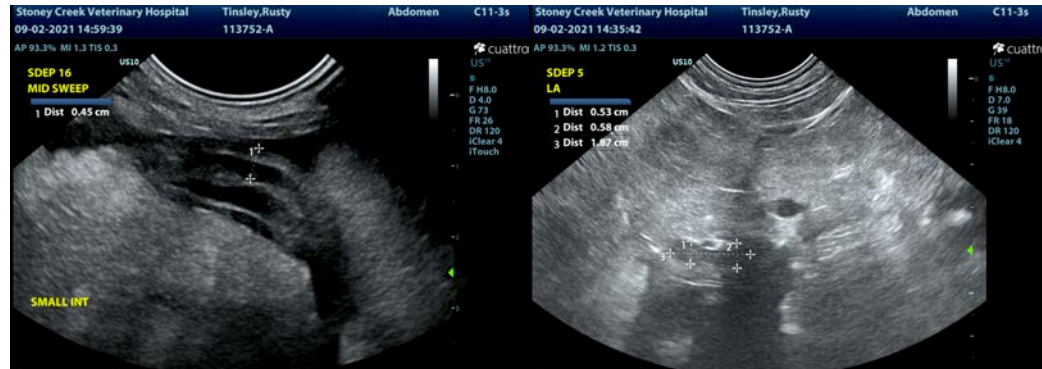
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The findings are very concerning for neoplastic infiltration of the bowel, creating a bowel mass. Recommend fine needle aspirate of abnormal bowel. Also consider a fine needle aspirate of the liver and spleen. The reported anemia could be due to acute loss, melena, or be due to primary bone marrow disease. If diagnose can be obtained, recommend referral to a veterinary oncologist for further assessment and treatment.

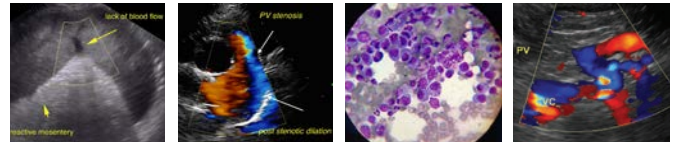


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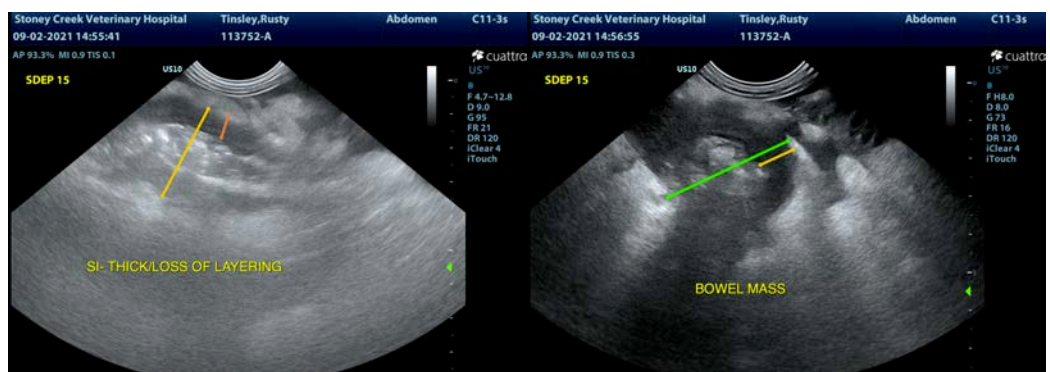
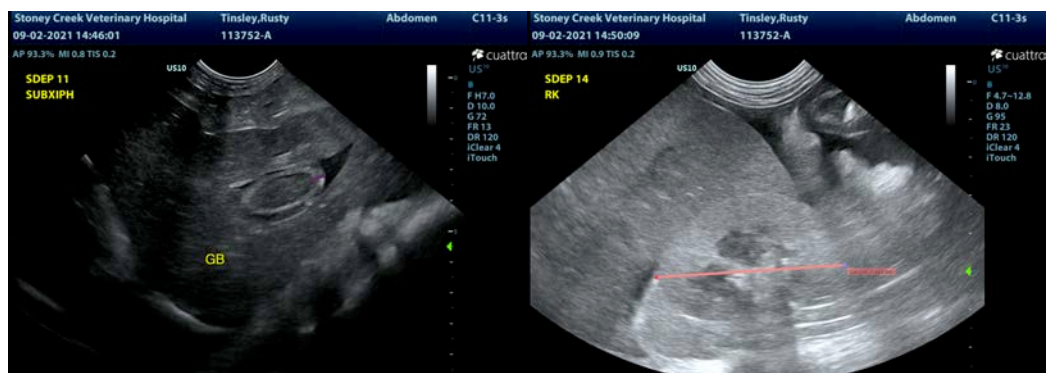
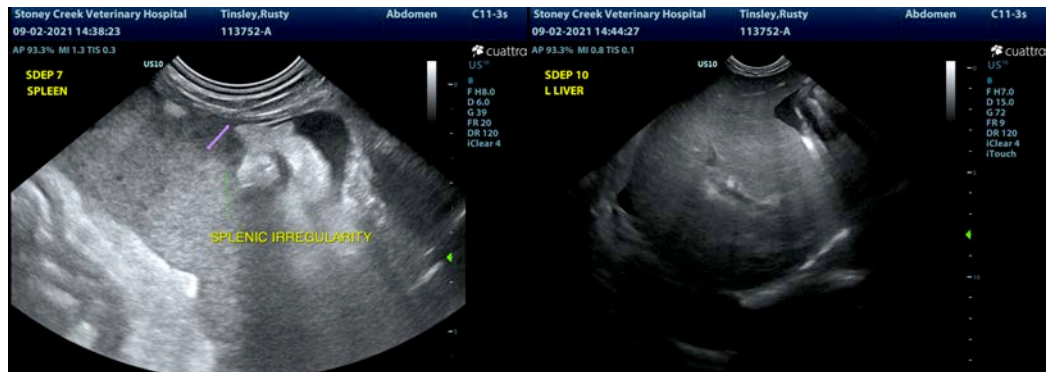
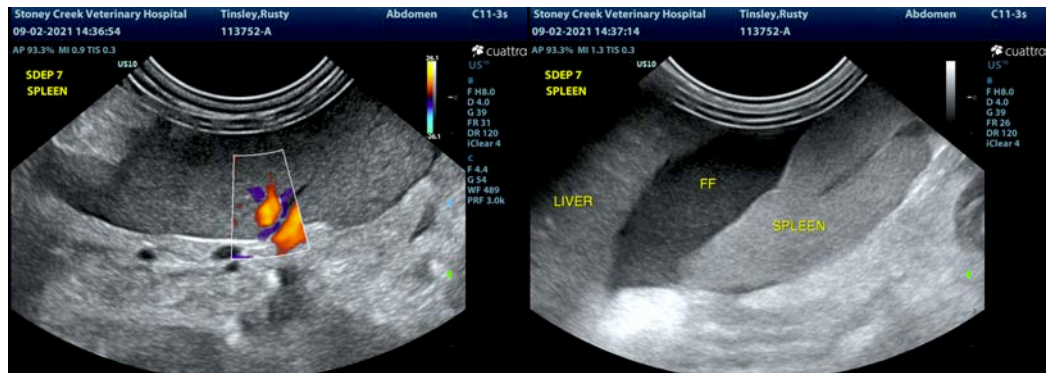
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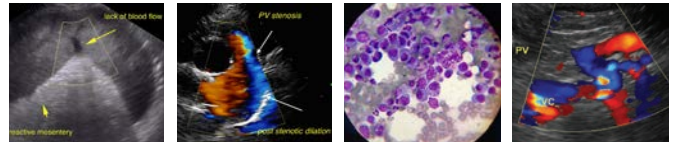
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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