



**PATIENT**

Tazer Shaak

**SPECIES**

Canine

**BREED**

Husky Mix

**SEX**

Neutered male

**AGE**

11 years

**WEIGHT**

70 lbs

**INTERPRETED BY**

Lisa Carioto, DVM,  
DVSc, Diplomate  
ACVIM

**IMAGING PERFORMED BY**

Dr. Myers

**HOSPITAL NAME**

Hershire AH

**REFERRING VET**

Dr. Myers

**INVOICE**

30188

**DATE**

5/9/22

**PRESENTING CLINICAL SIGNS**

Pet has history of highly aggressive soft tissue sarcoma grade 3 removed from front leg- clean margins but very close. Pet started on chlorambucil 4 weeks ago for metronomic chemo. Monitoring for re-growth- none since original removal 6 weeks ago. Chest rads clear today. Pet developed acute onset anorexia over last 3 days- today eating very small amounts, acute diarrhea began today. Painful with ultrasound probe at right mid abdomen pet was given an adequate injection a week ago and last time he had adequate there was GI upset around that time but was attributed to other changes, could be adequate causing this? won't use again. (previous history: primary hyperparathyroid- treated via parathyroidectomy, hypothyroid - on soloxine, enucleation due to glaucoma, CBC- wnl chem with lytes: increased t.bili, lipase normal 4dx: negative chest xrays; no mets abdomen xrays: possible soft tissue opacity mid abdomen- colon overlying

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder is very well distended with anechoic contents. Although the wall is smooth and regular, it is mildly to moderately thickened, measuring 2.23 mm along the dorsal wall. No abnormalities are present with the trigone. The proximal urethra is not visualized in longitudinal view. A small amount of free floating sediment is present, however, there is no evidence of cystoliths, polyps or a mass.

**Kidneys**

The **left** kidney measures 7.18 cm. The capsule is smooth. The cortex is mildly hyperechoic and a mild to moderate loss of the normal definition of the cortico-medullary junction is noted. Mineralizations of the diverticulae and pelvis are present, without evidence of nephroliths or pyelectasia. An accumulation of intrapelvic fat is noted. Blood flow is adequate. The surrounding mesentery is not hyperechoic.

The **right** kidney measures cm. The capsule is smooth. The cortex is mildly hyperechoic and a mild loss of the normal definition of the cortico-medullary junction is present. Very small, punctate mineralizations of the diverticulae and pelvis are present, without evidence of nephroliths or pyelectasia. The surrounding mesentery is not hyperechoic.

**Aortic bifurcation/trifurcation**

No abnormalities observed.

**Adrenal Glands**

The **left** adrenal gland measures 1.00 cm at the cranial pole in diameter. No abnormalities are noted with the gland's overall architecture, echogenicity or echotexture. The phrenico-abdominal vein and surrounding vasculature and mesentery are unremarkable.

The **right** adrenal gland is not visualized due to Tazer's abdominal pain.



<b>PATIENT</b>	<b>Spleen</b>
Tazer Shaak	Subjectively, the spleen is mildly enlarged and folded on itself. It has a mild, diffuse, miliary to “moth eaten” pattern. The capsule is smooth. Perivascular cuffing is observed, which is attributed to myelolipomas. These are not considered clinically significant. No abnormalities are observed with its vasculature, i.e. congestion and thrombi are not identified.
<b>SPECIES</b>	
Canine	
<b>BREED</b>	<b>Liver</b>
Husky Mix	Hepatomegaly is suspected. The liver’s borders are smooth and sharp. It is homogeneous, however, it is diffusely hyperechoic, i.e. it is isoechoic to the spleen. Focal lesions are not observed. No abnormalities are observed with the hepatic vessels visualized.
<b>SEX</b>	The gallbladder wall is within normal limits in thickness and echogenicity. A small amount of echogenic material is present within the GB. The parenchyma ventral to the GB is hyperechoic, which is suggestive of inflammation. The portions of the cystic and/or common bile ducts observed are not dilated or tortuous, i.e. there are no signs of an obstruction.
Neutered male	
<b>AGE</b>	<b>Gastrointestinal</b>
11 years	The stomach is moderately distended with gas, fluid and ingesta. The gastric wall is within normal limits in thickness and the wall layers are well defined. Peristalsis appears decreased.
<b>WEIGHT</b>	The duodenum is within normal limits in thickness. Gas, fluid and ingesta are present within the lumen within the lumen. Fogging of the mucosa is present.
70 lbs	
<b>INTERPRETED BY</b>	The small intestinal wall thickness is within normal limits and the definition of the wall layers is preserved. Abnormally dilated loops of bowel are not observed, however, the small intestines are filled with gas, ingesta and fluid and ineffective peristalsis is observed (i.e. a “to and fro” motion is noted).
Lisa Carioto, DVM, DVSc, Diplomate ACVIM	Gas is present within the transverse colon.
<b>IMAGING PERFORMED BY</b>	The colonic wall is not thickened and mural detail is considered normal. Soft stools are present within the colon.
Dr. Myers	
<b>HOSPITAL NAME</b>	<b>Pancreas</b>
Hershire AH	No overt abnormalities are observed with the echogenicity or echotexture of the left or right limbs. There is no evidence of hyperechogenicity of the surrounding mesentery, i.e., signs of active pancreatitis are not present.
<b>REFERRING VET</b>	
Dr. Myers	<b>Other</b>
<b>INVOICE</b>	<b>Lymph nodes</b>
30188	No abnormalities are observed
	<b>Abdominal effusion</b> is not visualized.
<b>DATE</b>	A possible subcutaneous lipoma, measuring 0.86 cm in diameter x 1.99 cm in length, is observed.
5/9/22	



<b>PATIENT</b>	<b>ULTRASONOGRAPHIC FINDINGS</b>
Tazer Shaak	<ul style="list-style-type: none"> <li>A delay in gastric emptying is present if Tazer was fasted, and a re-evaluation of the ultrasound of the stomach is suggested after a longer fasting period of approximately 14-20 hours.</li> </ul>
<b>SPECIES</b>	<ul style="list-style-type: none"> <li>The changes observed with the GI tract are suggestive of an ileus and a non-specific gastroenteritis, which may be due an adverse reaction to the administration of Cartrophen.</li> <li>Mild splenomegaly is suspected, in addition to a miliary and “moth eaten” echotexture. Extramedullary hematopoiesis, hypersplenism and reactive hyperplasia are possible differential diagnoses. There are no obvious signs of neoplasia. However, a fine needle aspirate is required to obtain a definitive diagnosis.</li> <li>Cholestasis and cholecystitis cannot be excluded based on the hepatomegaly and its hyperechogenicity, as well as the changes observed with the parenchyma ventral to the gallbladder.</li> <li>Renal changes are suggestive of age-related degeneration, however, glomerulonephritis or interstitial nephritis cannot be excluded.</li> <li>A urinary tract infection must be considered based on the mildly thickened wall of the urinary bladder.</li> <li>A possible subcutaneous lipoma, measuring 0.86 cm in diameter x 1.99 cm in length.</li> </ul>
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<b>INTERPRETED BY</b>	<b><u>INTERPRETATION OF THE FINDINGS &amp; FURTHER RECOMMENDATIONS</u></b>
Lisa Carioto, DVM, DVSc, Diplomate ACVIM	<p>A urinalysis and urine culture and sensitivity are recommended to exclude a urinary tract infection due to the mildly thickened bladder wall, and to rule out pyelonephritis.</p> <p>The splenic changes may be due to a benign process, however, a fine needle aspirate is required to obtain a definitive diagnosis.</p> <p>Treatment for acute gastroenterocolitis is suggested with analgesics, such as gabapentin and maropitant (Cerenia) to help decrease vomiting and nausea.</p> <p>A clay based paste, ideally one containing montmorillonite, is suggested. If not available, a product containing a pre and probiotic may be administered, in addition to two to three doses of bismuth subsalicylate (Pepto bismol).</p> <p>Antibiotics should be avoided, if possible, to decrease further dysbiosis.</p>
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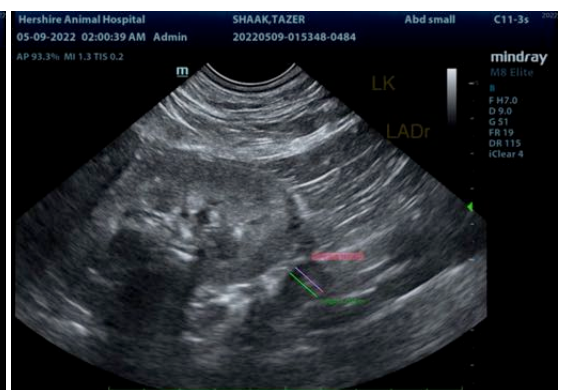
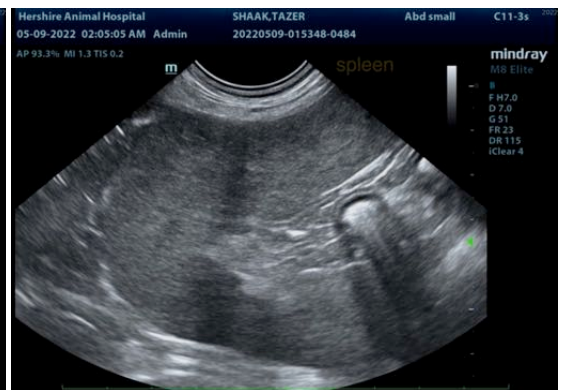
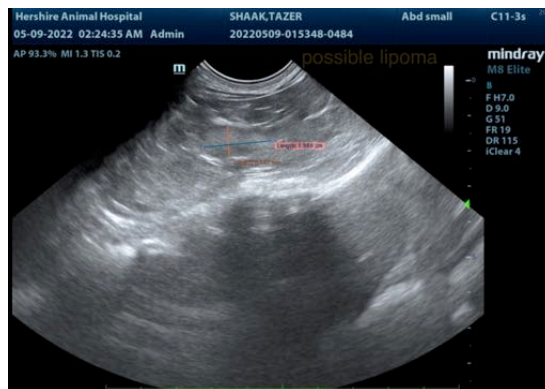
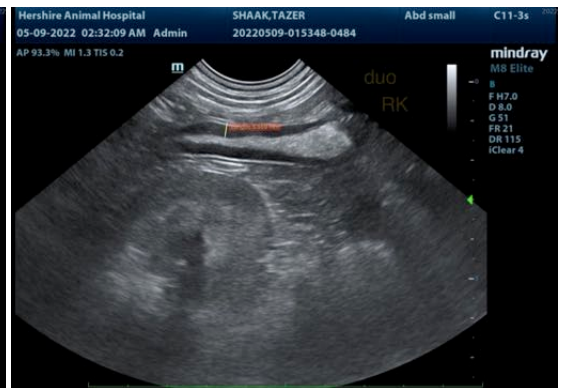
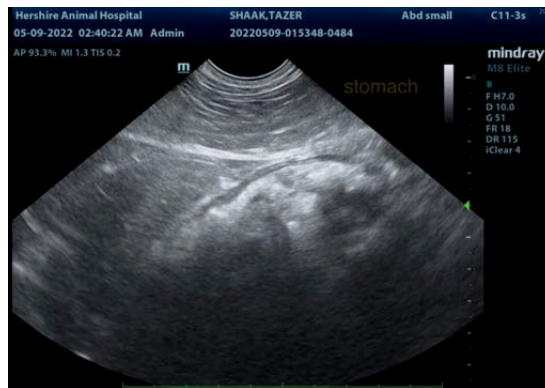
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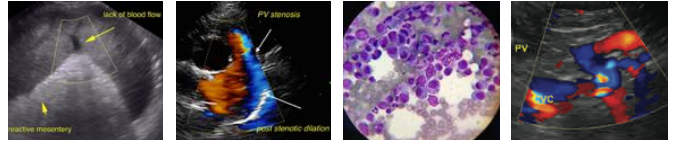
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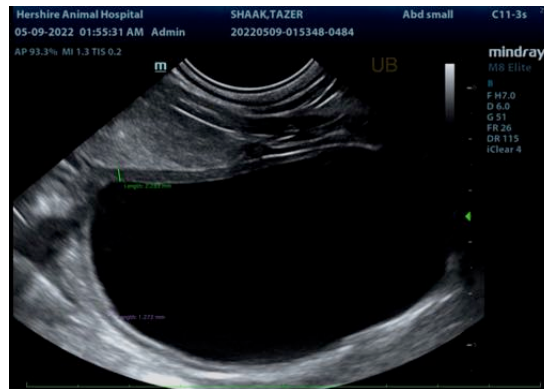
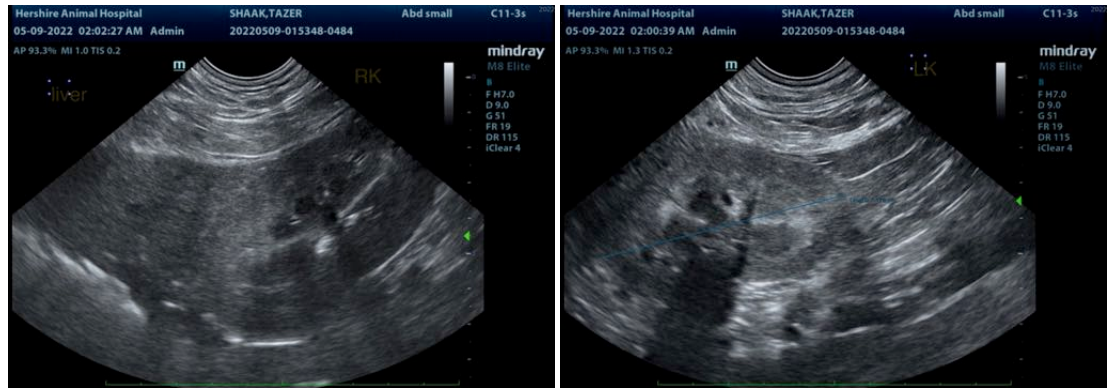
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Lisa Carioto, DVM, DVSc, Diplomate ACVIM

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