**PATIENT**

Kash Dreher

SPECIES

Canine

BREED

Aussie Mix

SEX

MN

AGE

6yrs 7 mos

WEIGHT

45.6 lbs.

INTERPRETED BYR. McKenzie Daniel,
DVM, DABVP (Canine
and Feline)**IMAGING
PERFORMED BY**

Amy Mayhew LVT

HOSPITAL NAME

SVS Imaging MI

REFERRING VETFamily Pet Practice-
Dr. Craig**INVOICE**

15818

DATE

1/13/23

PRESENTING CLINICAL SIGNS

Recent Medications following exam 1/3/23: Metronidazole 250mg 1.5 tab PO BID x 5d #15 albon 500mg 2 tab PO once, then give 1 tab PO SID x 5d #7 Panacur 4.5g PO SID x 5d #22.5g Trazodone 100mg 1 tab PO q12h as needed for sedation/anxiety fortiflora and calming canine supplements Neopoly dex ophth 1 drop OS q12h x 10d Maropitant 24mg 2 tab PO once daily for nausea #4 Recommended Diet- RC GI 3 1/4 cups per day- divide into 2-3 meals per day.

Patient History: Presented for AUS following continued declined over past 1 month. Acute profound weight loss (approx 10lbs) over past month. Initially on 1/3 presented for diarrhea but still maintaining good appetite. Presented again today 1/13 diarrhea improving but appetite poor, will only eat treats/table food. O's noticing abdomen now appears distended and P seems uncomfortable

Abnormal PE/Chem/CBC/UA Results: 1/3/23 Exam: Hx of diarrhea after boarding. O noted stress in home (passing of father in-law), P was not boarded prior to this current episode of diarrhea Improved in past within 2 days after starting trazodone. P does ingest non-clumping litter, chicken feces in yard. Per O good appetite, no vomiting 1. BAR 3. OS- moderate chemosis with hyperemic/edematous conjunctiva OS, retinal exam wnl, nodular eyelid marginal mass medial third of upper palpebra- Per O ocular changes started just prior to Medvet visit OD- WNL Email recent labs, radiographs and this form to: SVSimagingMI@gmail.com OU- symmetrical pupils, normal PLR's 9/10. Soft abdomen, rectal exam normal, no palpable masses/fb 13. Thin BCS- considerable acute weight loss Recommend AUS- rule-out Pancreatitis, fb, IBD, other- Baseline cortisol- recommended to rule-out Addison's, reviewed potential life-threatening complications with baseline cortisol, rec full ACTH stim. - O declined baseline cortisol Fecal- see log- giardia +, clostridium +, coccidia + CHP - O declines Maldigestion panel, must be fasted- O declines Eye stain -Negative uptake OU sTT - OD 14mm OS- 8mm **Low STT, rule-out inflammatory vs KCS, recheck following empiric tx with neopolydex tonometry- unable to obtain (unit out of batteries) Update Exam 1/13/23 1. QAR 3.OS- moderate chemosis and conjunctival edema, Addison's, if low Suspect icteric hue to sclera - slight 5. Pale MM with light icteric hue. Mild generalized tartar 9/10. Mild to moderate tensing on abdominal palpation, distended mid to cranial abdomen- rule-out hepatomegaly, fb, intussusception, neoplasia. P vocalized on rectal exam but otherwise normal. matted dried stool around anus.

WBC - 11.6 with neutrophilia and lymphopenia, HCT 32.9, Cortisol 11.1, BUN 30.6, Albumin 1.7, Globulin 2.7, ALP 241, AST 77, Na/K ratio 31

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**Urinary System**

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 4.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

The residual prostate was free of pathology.

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Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. The left kidney measured 7.0 cm in length. The right kidney measured 7.3 cm in length.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.57 cm width at the caudal pole and 0.68 cm width at the cranial pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.61 cm width at the caudal pole.

Spleen

A mildly expansive, nonhomogeneous, cranial splenic mass measuring 4.5 cm in diameter was present. Generalized mild splenic parenchyma heterogeneity was noted with normal splenic vascularity.

Liver/ Gallbladder

The liver was enlarged with mildly nonhomogeneous parenchyma exhibiting focal cyst-like parenchyma changes in the deep mid-liver. The gallbladder was non-distended in size with mildly prominent to hyperechoic gallbladder walls containing anechoic content with no evidence of gallbladder mucocele or post hepatic obstructive criteria. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented mild to moderate wall thickening secondary to echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. The stomach contained a moderate amount of retained primarily anechoic fluid with no evidence of mechanical pyloric outflow obstruction.

The small intestine presented intact wall layering and subjective maintained 1:3 muscularis/mucosa ratio to the level of the ileum. The ileum exhibited intact mildly indistinct, mildly prominent wall layering to the level of the ileocolic junction.

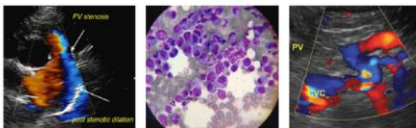
The colon walls presented intact yet prominent wall layering with mildly thickened to echogenic submucosa. The colon contained semi-formed to non-formed fecal matter consistent with the patient history.

Pancreas

The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

Free Abdomen

Multiple mesenteric and medial iliac lymph nodes were present, including potential for marked hepatic lymphadenopathy adjacent to the portal vein vs. lymph node-like mass lesion, concurrent

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small portal vein thrombus. The lymph nodes exhibited symmetrical to rounded margination with abnormal width: length ratio (>0.5). The enlarged lymph nodes were bordered by echogenic to reactive mesentery. An example of a mesenteric lymph node measured 3.2 cm x 1.7 cm. An example of a marked hepatic lymph node measured 6.0 cm x 5.0 cm.

Moderate volume echogenic peritoneal free fluid was present. Generalized nonuniform hyperechoic mesentery was noted. An ill-defined irregular to nonhomogeneous mass was noted mid-abdomen potentially in the area of the ileocolic junction measuring approximately 7.0 cm in diameter was present.

ULTRASONOGRAPHIC FINDINGS

- Mildly expansive cranial splenic mass
- Hepatomegaly exhibiting mild nonhomogeneous focally cystic parenchyma
- Hypomotile stomach, overtly intact small bowel walls with mild to moderate ileocolitis
- Ill-defined nonhomogeneous mass mid-abdomen possibly in area of ileocolic junction - lymphatic or intestinal origin possible
- Multicentric variably enlarged nonhomogeneous mesenteric and medial iliac lymphadenopathy, possible marked hepatic lymphadenopathy with subjective nonobstructive portal vein thrombus
- Moderate volume echogenic peritoneal free fluid and generalized nonuniform hyperechoic omentum

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Although sampling is required for further assessment, the sonographic abnormalities are consistent with multicentric neoplastic criteria. Potential for significant nonspecific to diffuse inflammatory process i.e., nonspecific peritonitis, is considered a less likely differential diagnosis. Further assessment may include, assuming normal clotting status, FNA cytology of the ill-defined mid-abdominal mass, accessible lymph node, spleen, liver, as well as peritoneal effusion analysis, cytology, +/- C/S if evidence of inflammatory cells and possible oncology consult.

This case is non-surgical. Unfortunately, an unfavorable prognosis is indicated.



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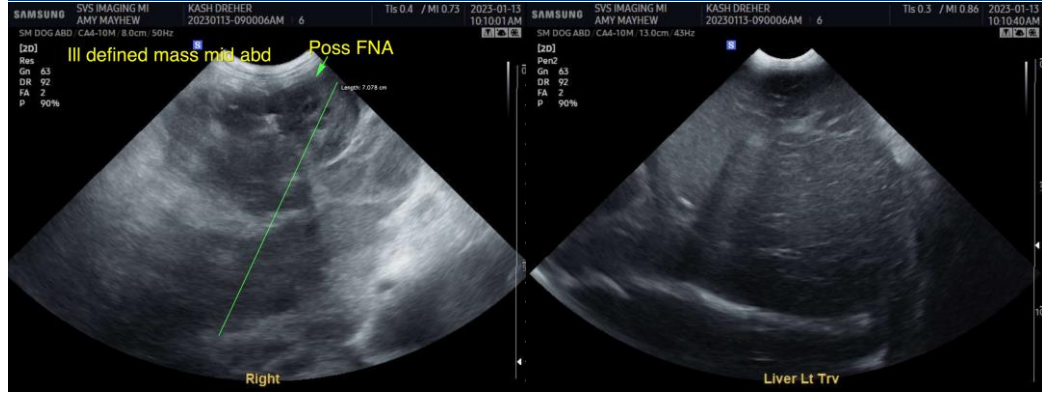
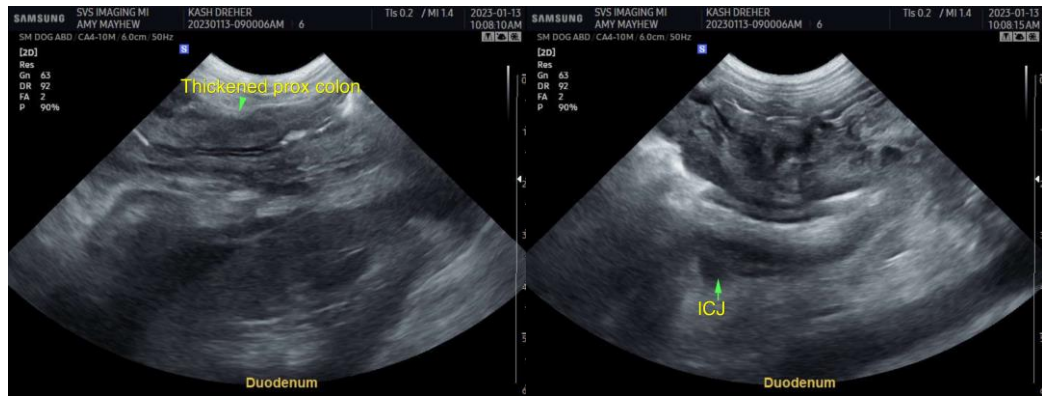
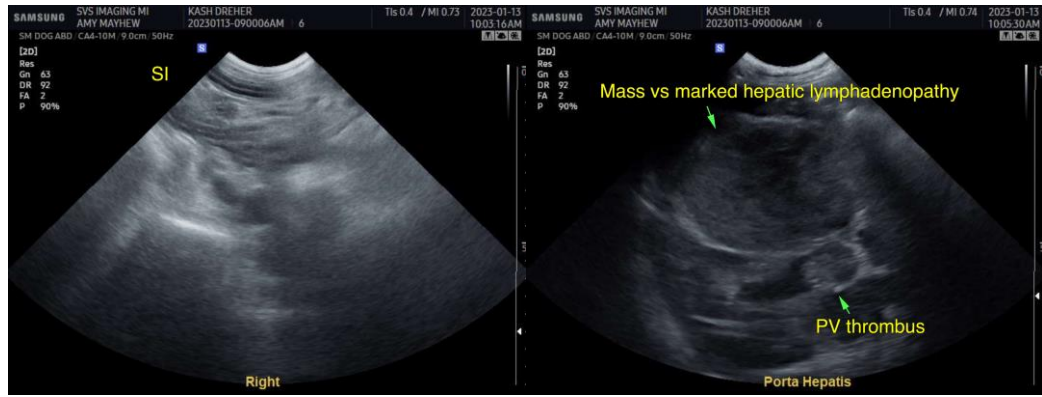
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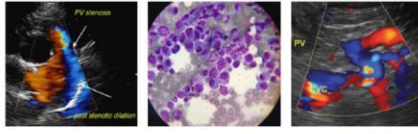
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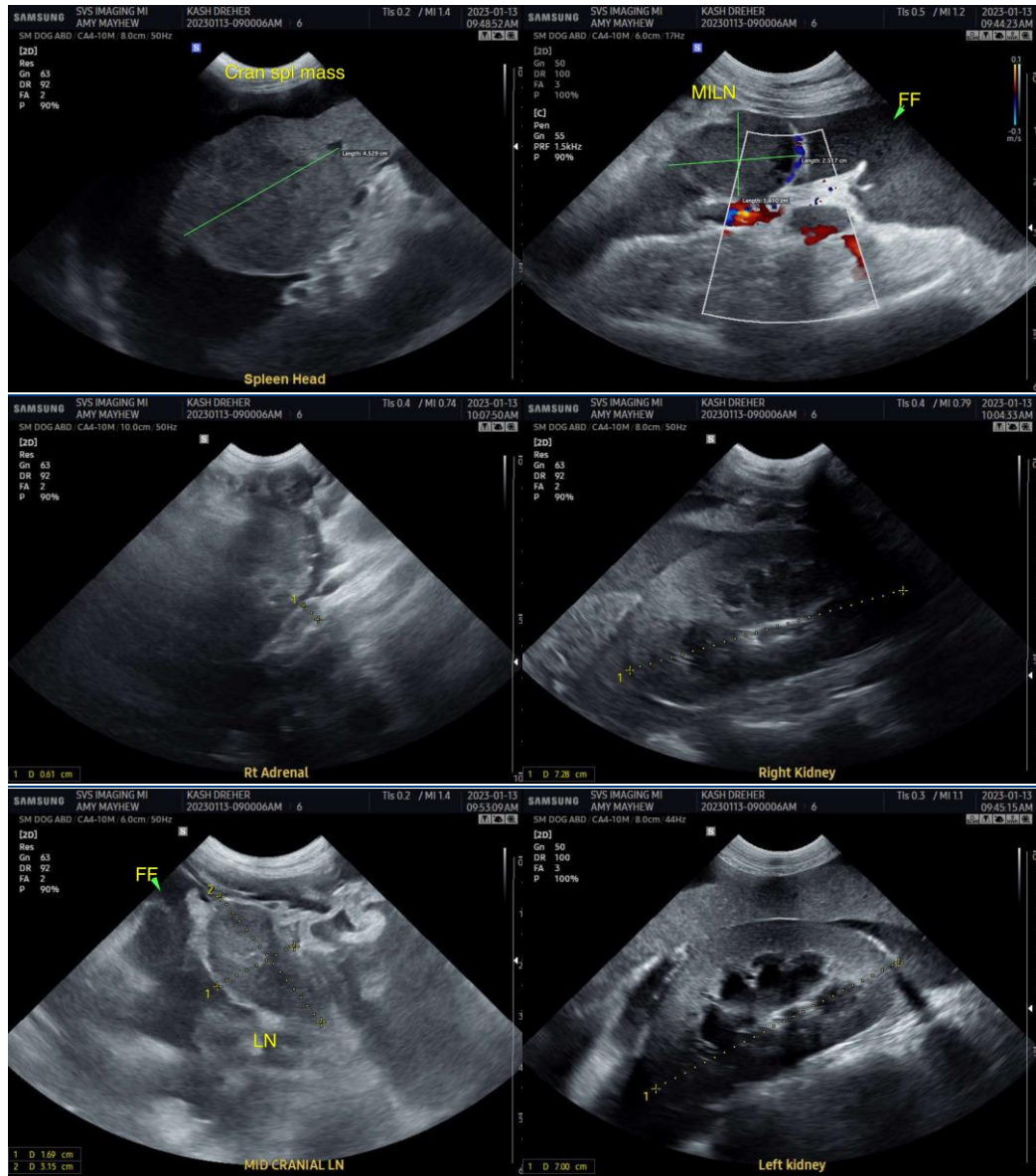
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)
info@SonoPath.com