



**PATIENT**

Bud E McGregor

**SPECIES**

Canine

**BREED**

Labrador

**SEX**

Neutered Male

**AGE**

10 Years 6 Months

**WEIGHT**

36.9 kg

**INTERPRETED BY**

R. McKenzie Daniel,  
DVM, DABVP  
(Canine and Feline)

**IMAGING PERFORMED BY**

Dr. Patti Mayfield

**HOSPITAL NAME**

Bend Animal  
Emergency & Specialist  
Center

**REFERRING VET**

Dr. Patti Mayfield

**INVOICE**

34293

**DATE**

1/16/22

**PRESENTING CLINICAL SIGNS**

Presented today for inappetence in last 24 hrs. Normally food motivated. O says he looks like he is stretching his neck out. He is also very lethargic. No known Vomiting or Diarrhea. Has had intermittent loose stools for several months, but client believes that could have been secondary to ingesting cow feces. Hasn't seen any limping, but his knees are both typically swollen. Is negotiating stairs normally. Blood work was last performed ~ 6 months; and was reported as normal. Goes to RDVM for the cytopoint injection q 2 months.

Abnormal PE/Chem/CBC/UA Results: Patient is ~ 7% dehydrated, febrile (103.7F), pink and tacky mm's. Doughy abdomen with no palpable masses or pain. Severe thickening of the stifles bilaterally with moderate pain on palpation of the R stifle. Approx. 2.5 cm<sup>3</sup> firm, freely movable mass in the deep SQ tissues of the neck, distal to the hyoid apparatus (non-painful). Other age related changes; worn dentition with dental disease and moderate lenticular sclerosis, lean muscle atrophy of the pelvic limbs and reduced ROM of the hips/stifles. CBC: Unremarkable; HCT: 45.6% (wnl) WBC: 6510/uL (WNL) PLT: 155,000/uL (WNL) CHEM: WNL THORACIC RADS: Bony remodeling at the costo-chondral junctions of the sternum consistent with OA. Bridging spondylosis of T9-10 No pleural effusion or obvious pulmonary edema. Mild bronchointerstitial pattern consistent with age-related changes. No discreet pulmonary nodular changes or consolidation. Mild, subjective cardiomegaly (R atrial region), however VHS is WNL at 10.7 Caudal vena cava is small consistent with dehydration. ABDOMINAL RADS: Mild gas within the stomach, however normal gastric axis with no obvious gastric FB or obstruction. Multiple loops of SI have mild-moderate gas distention, however no blunting or stacking that would suggest FB/obstruction and no obvious FB. Moderate-significant increased opacity and loss of serosal detail in the R caudal quadrant, consistent with either ascites or mass effect, with deviation of additional loops of SI laterally. Moderate gas within the colon. Accumulated radiodense debris within the urinary bladder, consistent with miliary stones or crystalluria. Moderate spondylosis at T13-L1, L2-L3, LS space. STIFLE RADS: LEFT: Mild proliferative bony change at the proximal patella consistent with OA RIGHT: Implants appear secure (no plates). Severe proliferative bony changes associated with patella, febellae and proximal tibia-- all consistent with severe OA LATERAL CERVICAL NECK: The ~2cm<sup>3</sup> soft tissue mass that is palpable is not obviously visualized, but mild deviation of the trachea and mineralization in the area of the palpable mass is appreciated. No other obvious changes US-guided cystocentesis: Anechoic urine is present within the urinary bladder. Hyperechoic sediment/possible cystic calculi is present in the apex of the bladder. No thickening of the urinary bladder wall, no obvious trigone tumor. Brief evaluation of the abdomen reveals a region of SI (at the duodenal flexure) of loss of mural layering and hyperechoic mesentery in the periphery with mild scan ascites, concerning for neoplasia and/or obstruction.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra exhibited normal thickness and tone. Anechoic urine was present in the lumen. Mild dependent mineral to small calculi noted. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

No overt pathology in the area of the residual prostate.

The area of the aortic trifurcation was free of pathology.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 6.9 cm. The right kidney measured 7.4 cm.



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**Adrenal Glands**

The adrenal glands were uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.68 cm at the cranial pole and 0.68 cm at the caudal pole. The right adrenal gland measure d0.79 cm at the cranial pole and 0.43 cm at the caudal pole.

**Spleen**

The spleen exhibited primarily finely textured parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Mild generalized parenchyma heterogeneity was present without evidence of nodular changes. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. The parenchymal heterogeneity is likely consistent with benign changes such as extramedullary hematopoiesis or age related remodeling with minor potential for inflammatory or neoplastic disease.

**Liver**

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to benign parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

**Gastrointestinal**

The visualized gastric walls exhibited intact and sonographically unremarkable wall layering. Mild to moderate retained ingesta present exhibiting subtle progressive distal acoustic shadowing. Ventral gastric body wall measured 0.50 cm.

The small intestine revealed ill-defined area of mural hypertrophy and loss of discernable wall layering measuring approximately 3.0 cm in diameter with wall width measuring up to 0.60 cm, subjectively within the right mid abdomen, medial to the right kidney. Normal appearing areas of small intestine exhibiting intact wall layering and maintained 1:3 muscularis/mucosa ratio measured 0.30 cm. Evidence of concurrent regional enteritis likely.

Normal visible colon wall layers were present with apparent formed feces in lumen.

**Pancreas**

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

**Free Abdomen**

Regional hyperechoic mesentery noted around the intestinal mural mass with small pockets of scant free fluid. No evidence of significant lymphadenopathy.

**ULTRASONOGRAPHIC FINDINGS**

- Mild urinary bladder mineral/small calculi
- Intestinal mural mass with associated regional peritonitis and likely regional enteritis
- Mild age related kidneys



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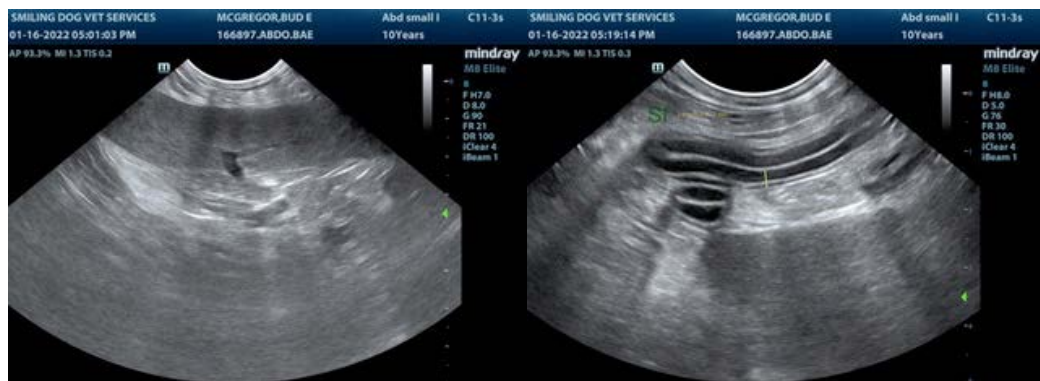
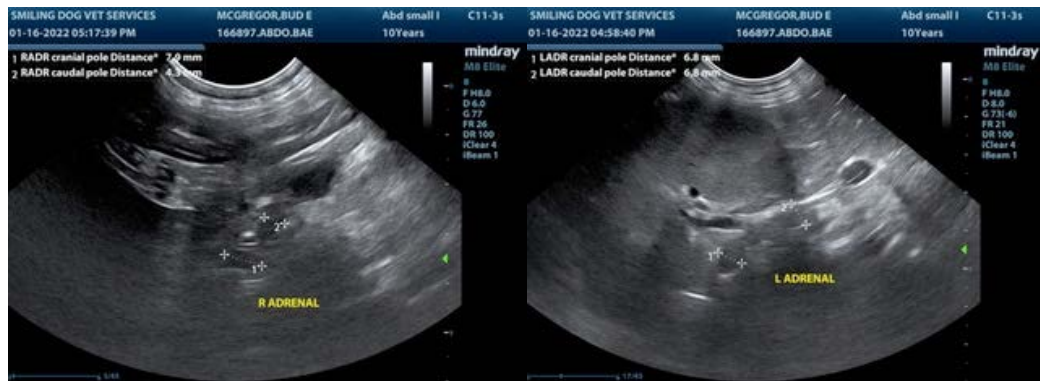
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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The intestinal mural mass may indicate significant inflammatory or neoplastic etiologies with potential for associated necrosis and likely regional peritonitis. Neoplasia such as carcinoma, round cell neoplasia, or other is favored in this case. Potential for ileocolic location of the mass suspected, although not definitive. Exploratory laparotomy for gross inspection of the intestinal mural mass and potential for biopsies or resection and anastomosis warranted. Overt evidence of foreign material was not evident and is considered unlikely given the lack of intestinal obstructive pattern.





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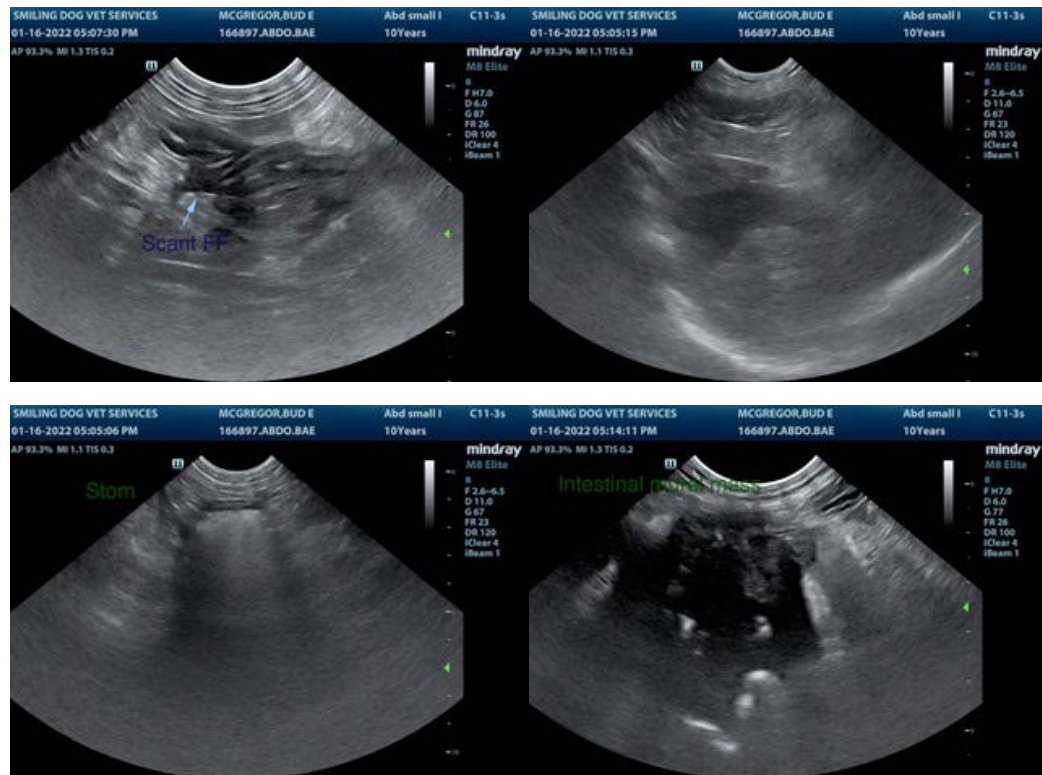
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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