**PATIENT**

Benji Blaesing

SPECIES

Canine

BREED

Shih Tzu

SEX

MN

AGE

11yr

WEIGHT

14.6lb

PRESENTING CLINICAL SIGNS

P presented on 12/21 for some GI upset and diarrhea, lethargy. Not eating. P came back on 1/2 for increased GI upset, now having vomiting and severe diarrhea. Diarrhea almost a black color per O. Not eating or drinking well.

Abnormal PE/Chem/CBC/UA Results: on 12/21: Heart murmur grade 4 or 5 out of 6 more left sided. Lungs clear. Abdomen normal palpation. Took chest rads to evaluate heart/lungs, which have no significant findings on 1/2: Ran CBC and Chemistry. CBC WNL. Chemistry showed ALT of 233, ALP of 228, and Amylase of 378- All other values WNL. Also check cPL- negative.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**Urinary System**

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra exhibited normal tone. Mild nonuniform thickening of the urinary bladder wall was present. Hyperechoic dependent focal echogenicities with distal acoustic shadowing were present in the dependent lumen. The calculi were not obstructive to urinary outflow. The ventral urinary bladder wall measured 0.68 cm in width. An example of an echogenicity measured 0.88 cm width.

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 moderate loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. Pinpoint medullary mineral was present. The left kidney measured 4.2 cm in length. The right kidney measured 4.8 cm in length

The area of the aortic trifurcation was free of pathology.

The area of the residual prostate appeared normal and free of pathology.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.51 cm width at the caudal pole and 0.46 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 0.40 cm width at the caudal pole and 0.45 cm width at the cranial pole.

Spleen

The spleen exhibited primarily finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Multifocal, well-defined, symmetrical, hyperechoic nodules were present throughout the medial parenchyma. 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. Acute to chronic inflammatory or neoplastic changes were not noted. The hyperechoic nodules tend to trend benign and are most consistent with benign hyperplasia or myelolipomas.

Liver/Gallbladder

The liver presented increased in size. The parenchyma of the liver was subjectively increased in echogenicity compared to the spleen and renal cortices. The echotexture of the liver parenchyma was uniform with a mild to moderate coarse echotexture. The capsule of the liver was symmetrical in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with primarily anechoic luminal content and mild echogenic non-organized debris. The cystic and common bile ducts were normal.

INTERPRETED BY

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

IMAGING PERFORMED BY

Rachel Runnells RVT

HOSPITAL NAME

SVS Imaging KC

REFERRING VET

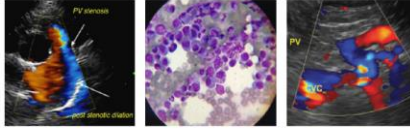
Dr. Simon

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Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained moderate variably echogenic ingesta containing progressive distal acoustic shadowing with no signs of ileus, obstruction or foreign material.

The small intestine presented intact wall layering with segmental mildly prominent mucosal layer. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material.

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

Pancreas

The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum, likely consistent with age related changes and considered incidental. No signs of active inflammation or neoplasia.

Free Abdomen

No omental masses or peritoneal effusion was present.

Several to multiple focally enlarged mesenteric lymph nodes were present. These lymph nodes were homogenous, mildly hypoechoic and smoothly margined. A normal width: length ratio was maintained (<0.5). Evidence of perilymphatic inflammation was evident. An example of lymph node size was 2.3 cm x 1.8 cm.

ULTRASONOGRAPHIC FINDINGS

- Moderate gastric ingesta-possible non-obstructive delayed gastric emptying if documented NPO
- Chronic enteropathy pattern - chronic IBD, potential for infiltrative intestinal neoplasia possible
- Moderate hypoechoic to swollen mid abdominal mesenteric lymphadenopathy-hyperplasia, lymphadenitis, neoplasia possible
- Non-specific hepatopathy
- Mild gallbladder debris (non-mucocele)
- Heterogenous pancreas-likely age related pancreatic changes given normal cPL

Secondary

- Chronic cystitis pattern with cystic calculi
- Bilateral chronic renal changes with pinpoint medullary mineral
- Benign splenic nodules-consistent with myelolipomas

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Assuming normal clotting status, an enlarged mesenteric lymph node +/- hepatic FNA for screening cytology is warranted for further assessment. Given the mesenteric lymph node presentation, concern for possible lymphatic neoplastic criteria with possible early infiltrative intestinal neoplasia is warranted although not definitive. Biopsies may be required for definitive diagnosis. Continued empirical GI support/IBD protocol would be reasonable. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended.

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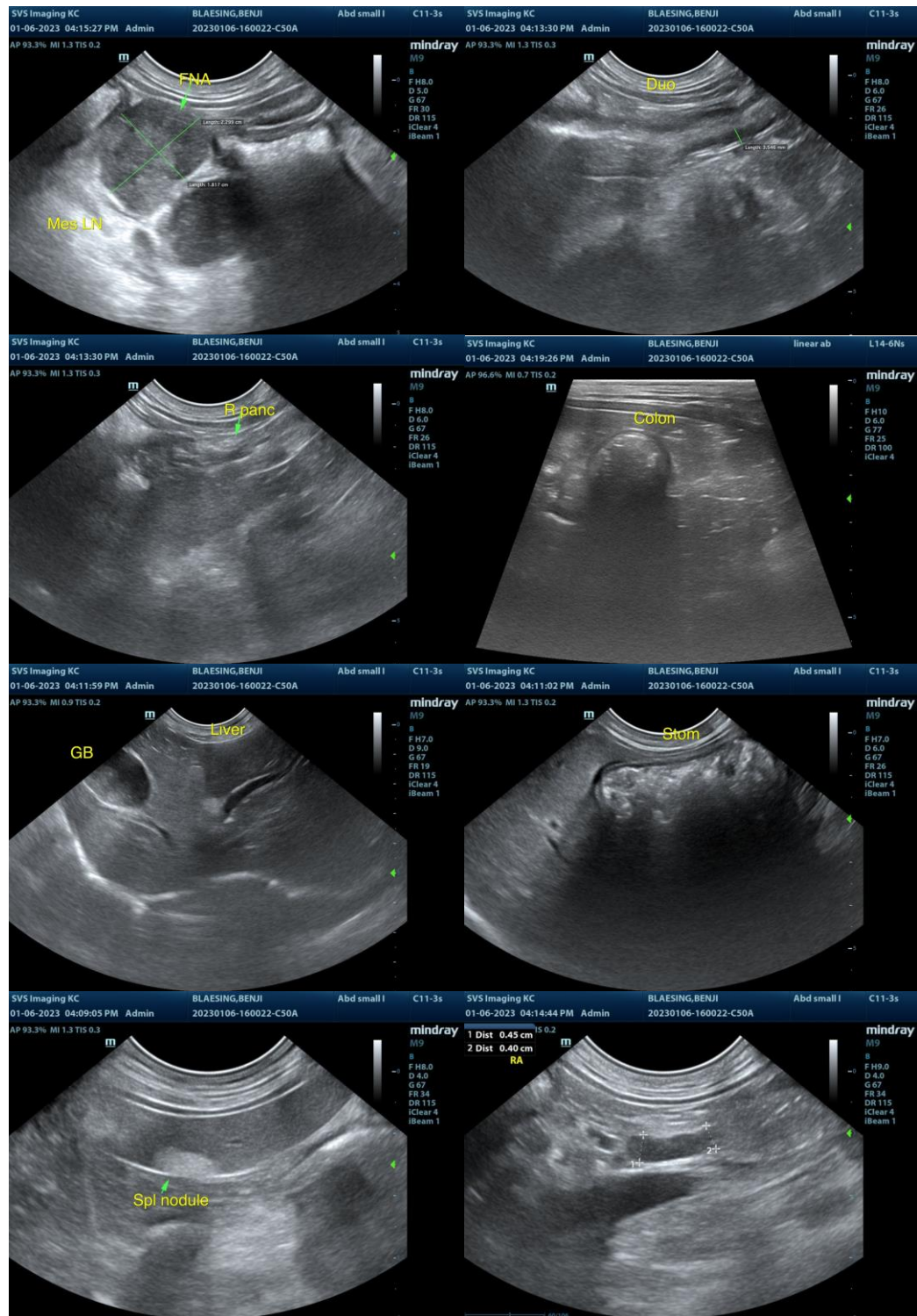
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Clinical Sonography & Telectyology

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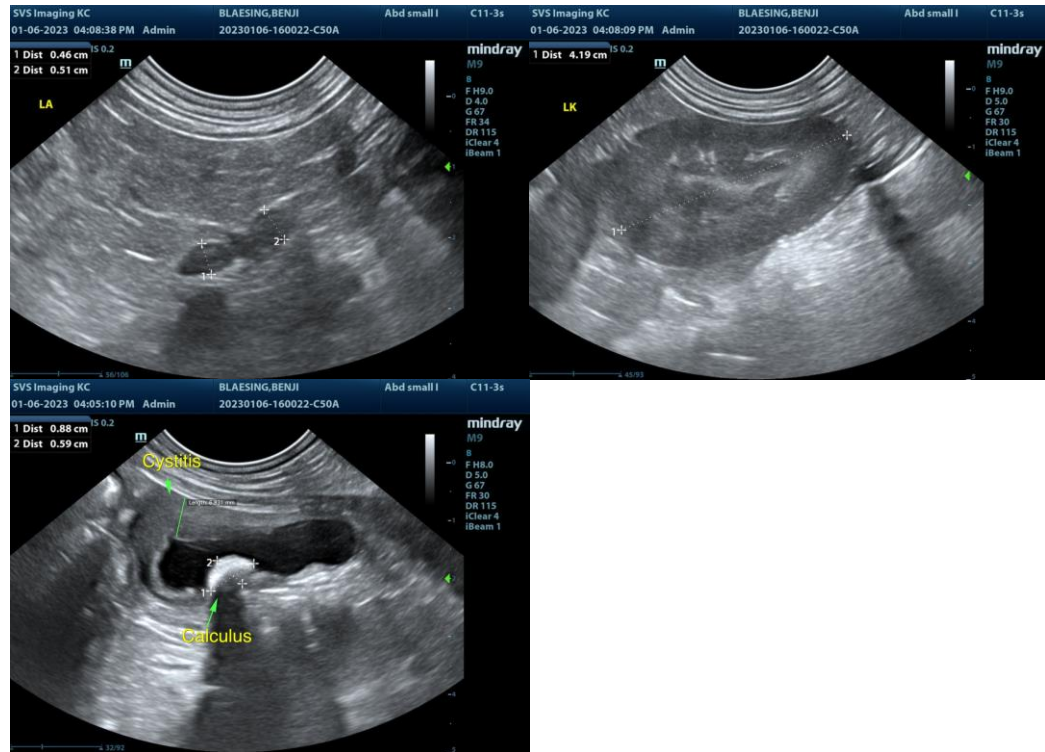
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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