



PATIENT

Onyx Baird

SPECIES

Canine

BREED

Shih Tzu Mix

SEX

FS

AGE

12 years

WEIGHT

10.34 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Hannah Fearing

HOSPITAL NAME

Lanier AH

REFERRING VET

Dr. Hannah Fearing

INVOICE

12466

DATE

10/27/21

PRESENTING CLINICAL SIGNS

Hx of vomiting and bloody diarrhea for 2 days. Physical exam showed dental disease, severe chronic skin problems (allergies suspected). Has been on long-term ketoconazole per O (from previous foster/vet).

Abnormal PE/Chem/CBC/UA Results: CBC/Chem/T4 today showed mild leukocytosis characterized by neutrophilia and monocytosis, slightly elevated SDMA (15).

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder was normal in size and overall tone containing anechoic urine without evidence of calculi. A small, nonhomogeneous yet nonmineralized mass lesion was noted in the area of the urinary bladder neck, measuring 0.77 cm x 0.44 cm. The urethra was normal to a depth of 2.0 cm.

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 mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 3.9 cm in length. The right kidney measured 4.2 cm in length.

Adrenal Glands

A small, yet mildly expansive nodule was present in the cranial left adrenal gland resulting in subtle symmetrical distortion of the adrenal capsule yet without evidence of parenchymal escape or mineralization. The nodule measured 0.68 cm x 0.62 cm. The overall left adrenal gland measured 0.84 cm width at the cranial pole and 0.49 cm width at the caudal pole.

The right adrenal gland was not definitively visualized.

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/ Gallbladder

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. Intermittent, variably sized, mildly hypoechoic, non-expansive parenchymal nodules were present. An example measured 1.1 cm in diameter. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended



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in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach exhibited primarily intact yet regionally thickened wall layering subjectively within the area of the gastric body. The ventral gastric body wall width measured up to 0.64 cm. The stomach was empty with mild luminal gas and was without evidence of retained ingesta, fluid, or foreign material.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction, or foreign material. The jejunum wall width measured 0.29 cm.

The colon walls presented intact yet prominent wall layering with mild thickened to echogenic submucosa. The colon was primarily empty with mild, non-formed feces present.

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 were evident.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Small mass lesion in area of urinary bladder neck
- Bilateral mild chronic renal changes
- Nonspecific left adrenal nodule - suspect adenoma
- Nonspecific hypoechoic hepatic parenchymal nodules - areas of nodular to regenerative hyperplasia or hematopoiesis suspected, minor potential for emerging neoplastic nodules
- Mildly thickened stomach with concurrent mild colitis

Secondary Findings

-

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The small mass lesion is concerning for potential emerging urinary bladder neoplasia, although not definitive. The small mass lesion did not appear to be subjectively mobile as with congealed urinary bladder sediment, yet this possibility cannot be definitively excluded. Screening BRAF Assay, as well as cytospin cytology on a free catch urine sample to assess for atypical epithelial cells may be considered.

A minor potential for emerging left adrenal primary vs. metastatic neoplasia i.e., pheochromocytoma, adenocarcinoma, or other cannot be definitively excluded. Screening blood pressure is recommended.



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Screening ultrasound guided hepatic FNA, assuming normal clotting status, could be considered for screening cytology. Conservatively, sonographic monitoring of the urinary bladder neck mass lesion, left adrenal nodule, as well as the hepatic nodules for evidence of progression, would be ideal.

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The regional gastric thickening may indicate gastritis, although the potential for early infiltrative gastropathy cannot be definitively excluded. Some or all of the following protocol may be considered with as-needed gastrointestinal support and empirical therapy for colitis.

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A clinical trial of **Zithromax (Dogs: 5-10 mg/kg p.o. q24h. May increase dosing interval to q48h after 3-5 days of treatment)**, **Metronidazole (10-20 mg/kg p.o. b.i.d.)**, **Pepcid (0.5-1 mg/kg s.i.d.)** and **Sucralfate (0.5-2 g/dog PO)** or **Omeprazole (1 mg/kg p.o. s.i.d.)** over the next 3 weeks along with a **novel-protein or hydrolyzed diet** with slurry feeding b.i.d./t.i.d. over the next 2-4 days and then increase to canned diet bid. Dry food should be avoided over the next 4 weeks. A recheck sonogram to assess GI improvement or progression would be ideal in 4 weeks.

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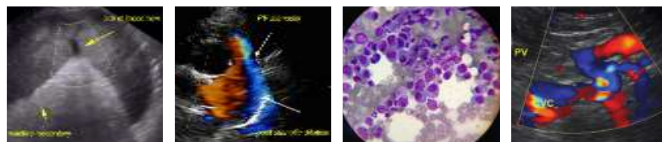
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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