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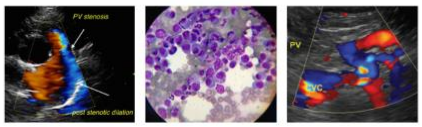
svsimaging.net 309-737-3070



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

PATIENT

Dallas Miller

SPECIES

Canine

BREED

Shih Tzu

SEX

Neutered Male

AGE

3 Years

WEIGHT

13 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Sarah Pender, CVT

HOSPITAL NAME

SVS Imaging QC

REFERRING VET

Dr. Stacy Kula

INVOICE

20939

DATE

2/2/23

PRESENTING CLINICAL SIGNS

History: Patient has had diarrhea since mid-December. Was seen at local emergency clinic on 1/1/2023 for a rectal prolapse and was treated with Fenbendazole and Proviable. Was told to recheck in 7 days and owner did not go back. Came to me on 1/24 for continued diarrhea that is now bloody. Owner cut out the purse string at home on the 19th. Sent home 7 days of Metronidazole and rechecked on 2/1. No improvement in diarrhea and he has lost 1 pound in the last 7 days. Firm circular mass palpable within the central abdomen.

Abnormal PE/Chem/CBC/UA Results: Chemistry: ALKP: 20 (23-212), all other values normal. electrolytes: all values wnl, Na/k: 44. CBC: RBC: 7.42 (5.65-8.87), MCH: 21.1 (21.2-25.9), WBC: 30.76 (5.05-16.76), NEU: 25.38(2.95-11.64), MONO: 3.43 (0.16-1.12), PLT: 270 (148-484), MPV: 14.3 (8.7-13.2). Right lateral abdomen radiograph: circular mass in the central abdomen. Not clearly attached to the liver, stomach, spleen or kidneys.

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 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 were noted.

The area of the residual prostate was overtly free of pathology.

Normal size and margination were present in the right kidney. A mild to moderate loss of corticomedullary border demarcation was present with maintained 1:3 cortex to medulla ratio and overall discernable corticomedullary architecture. The right kidney measured 4.8 cm in length.

An expansive, well demarcated mildly nonuniform hypoechoic left kidney mass was present, measuring approximately 4.1 cm in diameter. The mass obliterated regional left kidney corticomedullary architecture, with secondary distortion of the renal capsule without evidence of parenchymal escape. No evidence of left retroperitoneal effusion. The overall left kidney measured 4.9 cm.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 1.7 cm length x 0.51 cm width at the caudal pole.

The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 1.8 cm length x 0.38 cm width at the caudal pole.

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical 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, neoplastic, or benign parenchyma changes were not noted.

Liver

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion.

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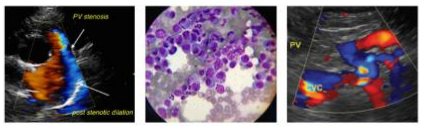

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The gallbladder was non distended in size with mild echogenic, nonmineralized debris, likely secondary to fasting. The cystic duct and common bile ducts were normal without evidence of dilation.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with luminal gas.

The small intestine presented primarily intact wall layering with maintained 1:3 muscularis/mucosa ratio. A focal to mild segmental jejunal mural mass was present, exhibiting focal to segmental jejunal mural hypertrophy, decreased mural echogenicity and loss of discernable wall layering, measuring approximately 2-3 cm in diameter in the mid to caudal abdomen.

The distal descending colon and colorectum exhibited irregular mural hypertrophy with decreased to nonhomogenous mural echogenicity and loss of discernable descending colon to colorectal wall layering. The descending colon wall measured up to 0.82 cm in width.

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

Several enlarged medial iliac lymph nodes were present. These lymph nodes were homogenous, mildly hypoechoic and smoothly marginated. A normal width: length ratio was maintained (<0.5). Evidence of perilymphatic inflammation was evident. An example of lymph node size measured 1.2 cm x 0.57 cm. NO evidence of peritoneal free fluid.

ULTRASONOGRAPHIC FINDINGS

- Irregularly thickened distal descending colon/colorectal walls, indistinct to irregular distal descending colon/colorectal mural mass
- Focal to segmental concurrent jejunal mural mass
- Left kidney mass
- Nonspecific loss of right kidney corticomedullary border distinction
- Mild nonhomogenous medial iliac lymphadenopathy

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Although sampling is required for further assessment, multicentric round cell neoplasia, such as lymphoma or other, involving the left kidney, focal to segmental jejunum and distal descending colon to colorectum is suspected.

Assuming normal clotting status, FNA cytology of the left kidney mass +/- jejunocolic mural FNA cytology for additional staging and further clarification, with potential for oncology consult is recommended.

Potential for early medial iliac lymphatic metastasis or involvement is possible, although not definitive.

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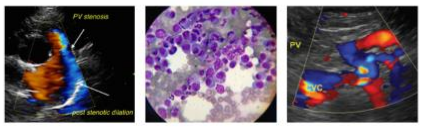

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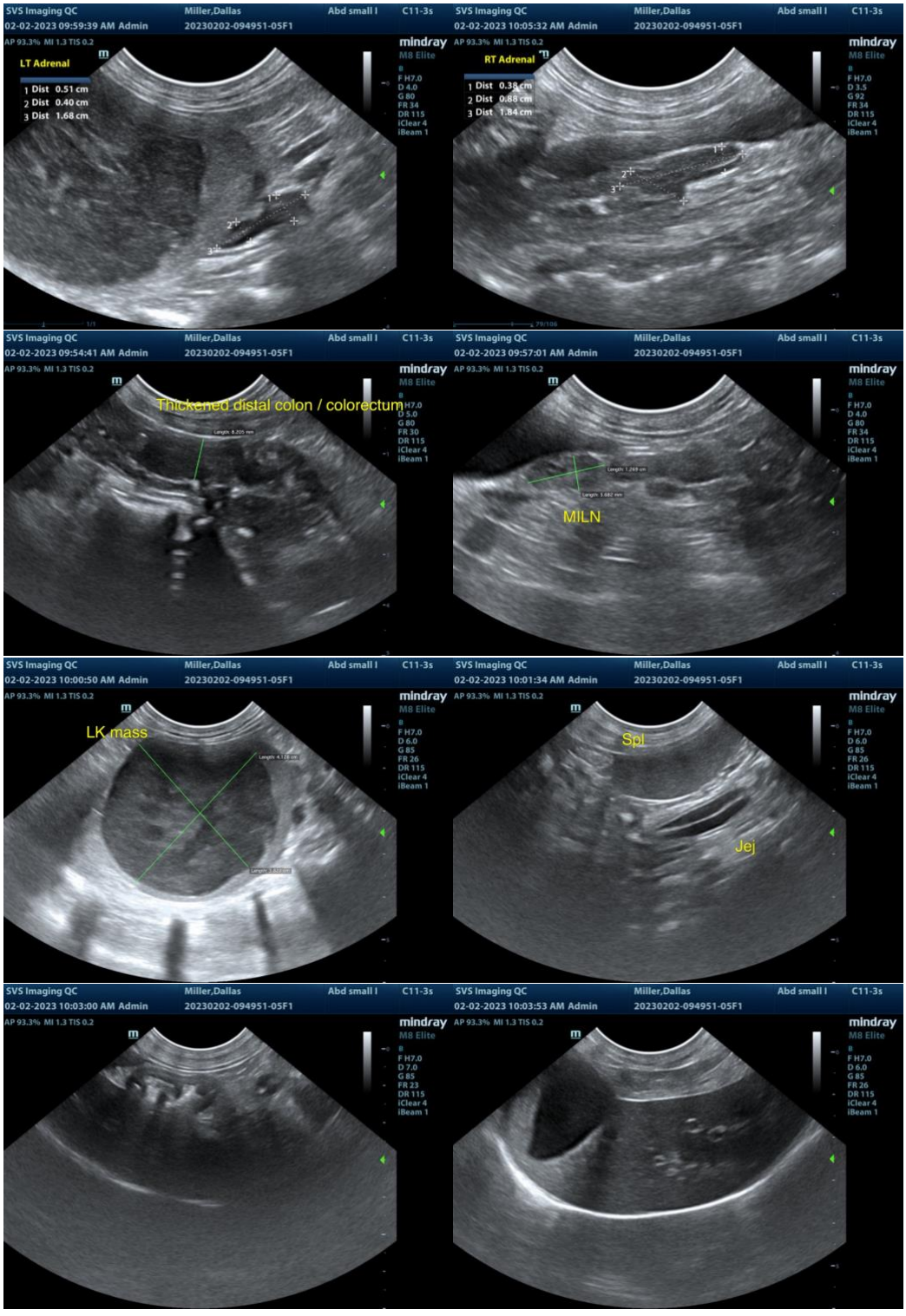

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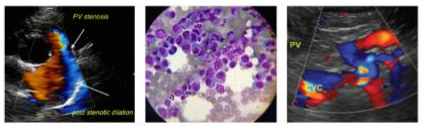

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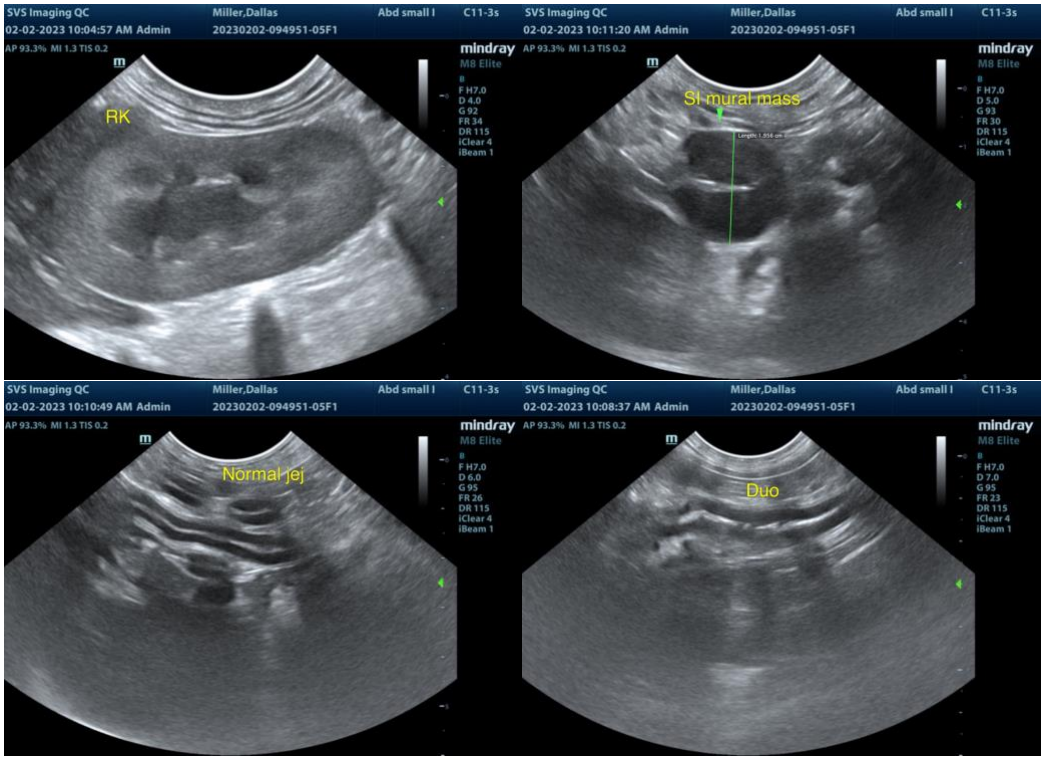

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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