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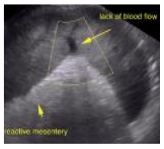
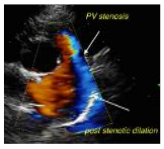
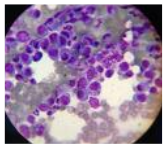
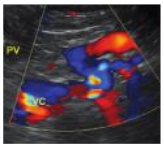





SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Teddy Janes

SPECIES

Canine

BREED

Chesapeake Bay Retriever

SEX

Neutered Male

AGE

4 Years 4 Months

WEIGHT

60 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Emma Herdener

HOSPITAL NAME

Eastgate VC

REFERRING VET

Josiah Moses

INVOICE

14693

DATE

4/11/22

PRESENTING CLINICAL SIGNS

History: Waxing and waning GI signs starting early march (vomiting and intermittent diarrhea). Workup for blockage, not noted on rads. Treat symptomatically for gastroenteritis. Possible mild pallor. Labs from intial visit showed some very mild anemia with signif regeneration. P not greatly improving over a few days and hospitalized for pancreatitis treatment, labs showed elevated PSL. ACTH stim test negative. Case discuss with internist rec abdo ultrasound and or treat for possible gastric ulcer. Abnormal PE/Chem/CBC/UA Results: Complete Blood Count 3/15 3/7 Neutrophilia: 11,6K 27K Eosinophila 6.4K Monos wnl 1944 Basos 400 HCT 34% 35% Retic 215K Chem Mild PSL elevation otherwise NSF on Chem Polychrom no polychrom, no retic counted Anisocytosis

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction 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 proximal urethra exhibited overt normal structure and tone to depth of 4.0 cm.

No overt pathology in the area of the residual prostate.

Normal size and margination were present in the left kidney. 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 6.3 cm in length.

The right kidney exhibited focal asymmetrical lateral capsule margination with maintained 1:3 cortex to medulla ratio. 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 right kidney measured 6.3 cm in length.

Adrenal Glands

The left and right adrenal glands were not definitively visualized.

Spleen

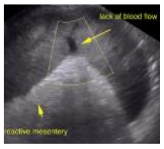
The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

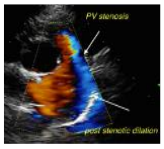
Liver

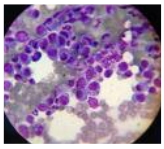
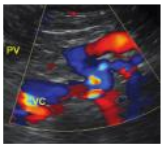
The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion.

The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal





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The gastric fundus and subjective left to mid gastric body exhibited intact wall layering. The fundus wall measuring 0.38 cm in width. A large complex, expansive mass was present, appearing to involve the upper gastrointestinal tract, specifically portions of the gastric body, antrum and pylorus, suspected to extend to involve the upper duodenum and potential additional segments of the gastrointestinal tract, primarily in the mid to cranial abdomen. Portions of gastric and intestinal lumen were noted within the mass, exhibiting mild gas artifact. The mass measured at least 7-8 cm in diameter, although definitive size of the mass was difficult to ascertain given expansive presentation of the mass. Associated regional reactive mesentery, exhibited by increased omental echogenicity.

Segments of small intestine, exhibiting intact wall layering with potential altered muscularis to mucosa ratio present in the mid to cranial abdomen, as well as adjacent to the mass. Intact small intestinal wall measured 0.45 cm.

Associated, regional, enlarged, hypoechoic mid to cranial mesenteric lymph nodes were present. 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 lymph node size measured 1.7 cm in diameter.

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

Pancreas

Sonographic assessment of the pancreas was limited, owing to peripancreatic pathology. Potential involvement of the pancreas within the mass cannot be excluded.

Free Abdomen

A focally enlarged medial iliac lymph node was present. The lymph node was homogenous, mildly hypoechoic and smoothly marginated. A normal width: length ratio was maintained (<0.5). Evidence of perilymphatic inflammation was evident. The lymph node measured 1.0 cm in diameter.

No overt evidence of free fluid.

ULTRASONOGRAPHIC FINDINGS

- Large complex to expansive mass, subjectively involving the upper gastrointestinal tract
- Hypoechoic to swollen mesenteric and focal medial iliac lymph nodes
- Associated regional reactive mesentery

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Although sampling is required for further clarification, the complex to expansive mass, involving the upper gastrointestinal tract is consistent with neoplastic criteria with potential for multicentric neoplasia. Assuming normal clotting status, ultrasound guided FNA of the mass +/- accessible lymph node recommended for further assessment and staging with potential for oncology consult. Three-view chest radiographs and empirical continued gastrointestinal support recommended pending cytology.

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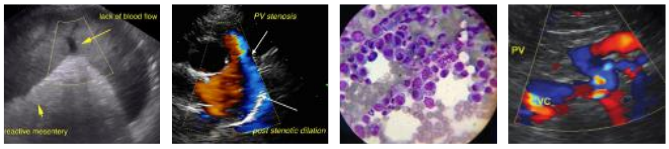

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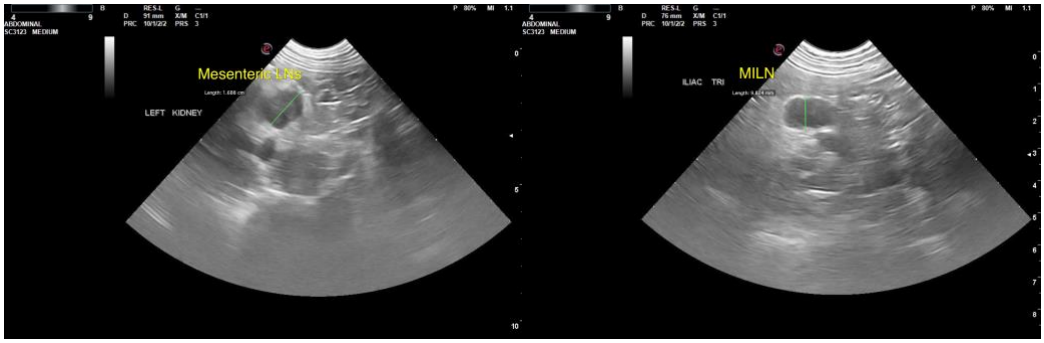

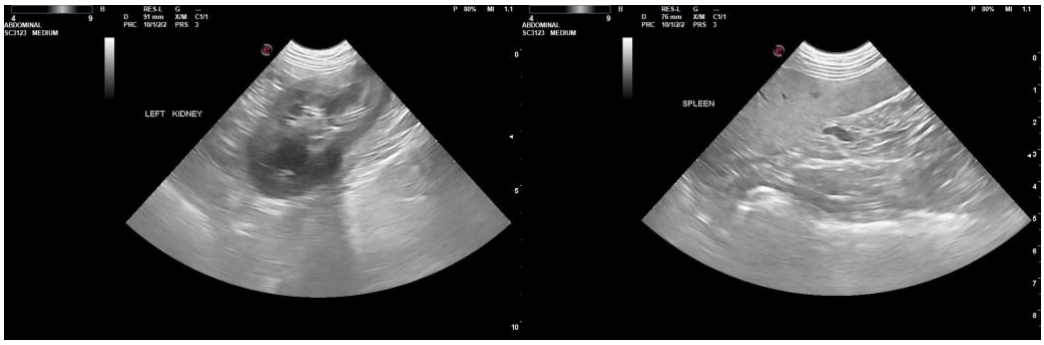

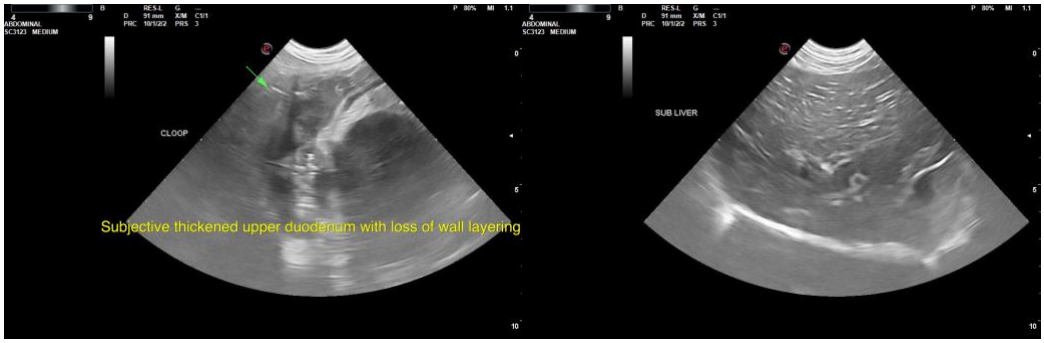

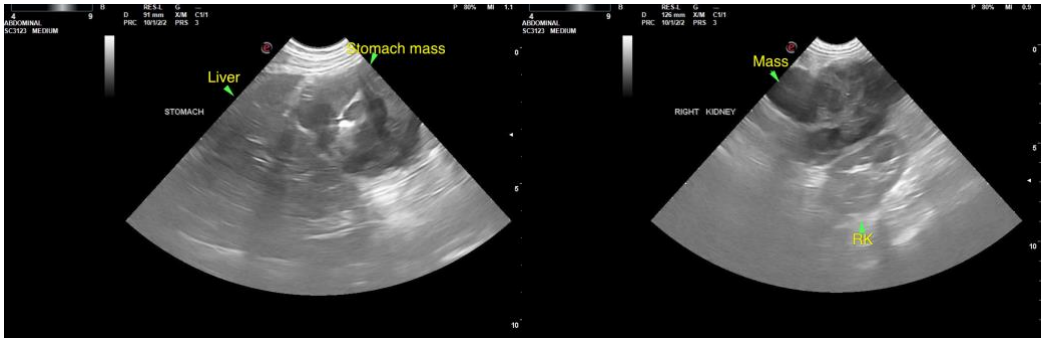

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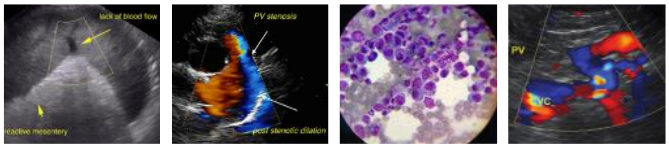

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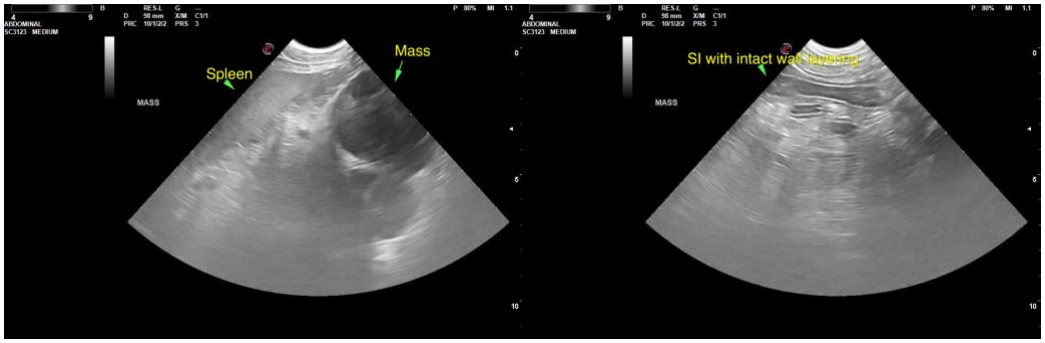

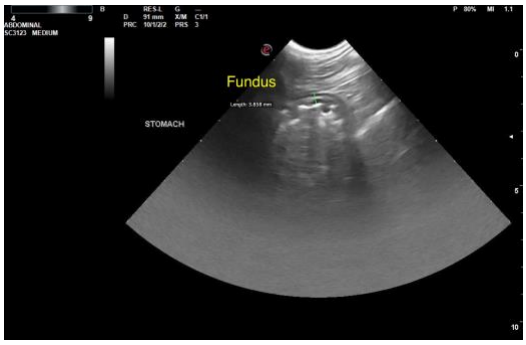

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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