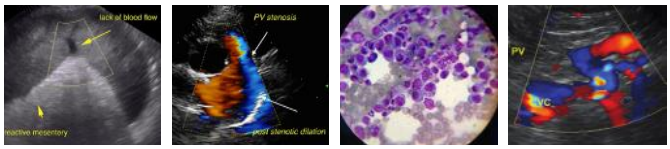
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Che Allen

SPECIES

Canine

BREED

Rottweiler

SEX

MN

AGE

6.5 yr

WEIGHT

1110.6 lb

INTERPRETED BY

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

IMAGING PERFORMED BY

Amanda Lacey-Crook

HOSPITAL NAME

Rivers Edge Pet Medical Center

REFERRING VET

Dr. Travis Gibson

INVOICE

10638ag

DATE

05/16/2022

PRESENTING CLINICAL SIGNS

History: 4/25 P has had a history of puking after eating grass. Went to Willamete Veterinary Hospital and they found a tumor that they removed. P was fine for 4 months then started vomiting again. Their veterinary cousin suggested pancreatitis and recommended a bland diet. P did well for 2 weeks then began to have decreased bowel movements with mucous and blood. Vet friend then suggested Colitis? They went to Animal Health Vet in Baja Mexico that did radiographs and blood work. They noticed a white spot in the radiographs that they thought was gas so they recommended feeding a high fiber diet. That was about 2 weeks ago. P hasn't had a bowel movement in 10 days and is dribbling blood. P hasn't had a very big appetite, eating about every other day. P has been being fed lean raw meat and raw tuna. ("Frozen so there isn't any parasites") 5/16 Pet has been waxing and waning, but has been eating better. Trial of Prednisone was attempted with article of Idiopathic eosinophilic masses of the gastrointestinal track referenced. Owner called and scheduled ultrasound for progression vs reduction. weight loss of over 9 pounds. Current Medications: Prednisone 20mg- 3 tablets by mouth in the morning and 2 tablets by mouth in the evening Metaclopamide

Abnormal PE/Chem/CBC/UA Results: 4/25 CBC- Monocytosis 1.40 K/uL , EOS 3.58 K/uL Chem- BUN 4mg/dL 5/16 Not at this time See attached previous US report

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN-RECHECK

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.

Normal size and margination were present in the kidneys. 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. A solitary indistinct mixed echogenic nonexpansive nodule noted in the caudal lateral left kidney cortex measuring 0.82 cm in diameter.

The left kidney measured 6.3 cm in length. The right kidney measured 7.3 cm in length.

The area of the aortic trifurcation was free of pathology.

No overt pathology in the area of the residual prostate.

Adrenal Glands

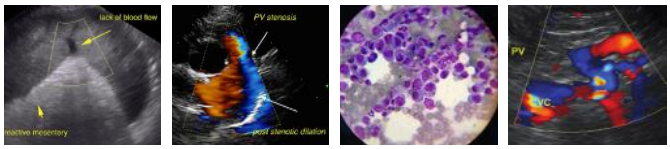
The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 2.4 cm length and 0.68 cm width at the caudal pole. The right adrenal gland was not definitively visualized.

Spleen

The spleen was not visualized owing to previous splenectomy. No evidence of pathology in the area of the previous spleen.

Liver

The liver presented enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The



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hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction 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 colon exhibited persistent to mildly progressive wall thickening and decreased mural echogenicity and loss of wall layer detail subjectively and primarily involving the upper, mid and distal descending colon into the colorectum. A solitary nodular to mixed echogenic mural lesion was noted in the area of the mid to distal descending colon measuring approximately 2 cm x 1.8 cm. This nodular to mixed echogenic mural lesion appeared to impinge somewhat on adjacent jejunal segments. Mild peri colonic reactive mesentery was present. The colon wall measured up to 1.1 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

Multiple static yet persistently enlarged medial iliac to hypogastric 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 was 3.9 cm x 0.85 cm.

ULTRASONOGRAPHIC FINDINGS

- Persistent to mildly progressive thickened colon walls exhibiting decreased mural echogenicity and loss of wall layer detail, primarily descending colon to colorectum
- Persistent yet subjectively static medial iliac to hypogastric lymphadenopathy
- Overtly normal stomach and small bowel
- Hepatomegaly-consistent with benign vacuolar to steroid hepatopathy/hepatomegaly secondary to corticosteroid administration
- Nonspecific indistinct left kidney cortical nodule

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The persistent to mildly progressive thickened descending colon and colorectal walls may indicate chronic colitis i.e. ulcerative, granulomatous or infectious colitis, neoplasia or other. Concurrent associated to secondary medial iliac to hypogastric lymphoid hyperplasia or reactive lymphadenitis with potential for early neoplastic lymphadenopathy potentially suppressed owing to corticosteroid use are possible. Colonoscopy with biopsies as well as FISH strongly recommended and would be ideal for definitive diagnosis. Empirically enrofloxacin trial 10 mg/kg PO SID +/- concurrent metronidazole and/or amoxicillin with sonographic monitoring of the colon and as needed dietary therapy would be reasonable. However, endoscopic biopsies are strongly suggested if possible.

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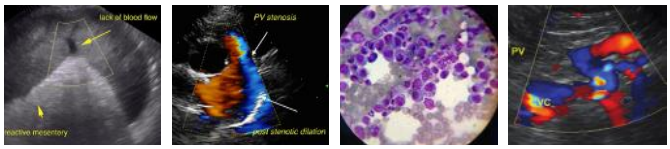

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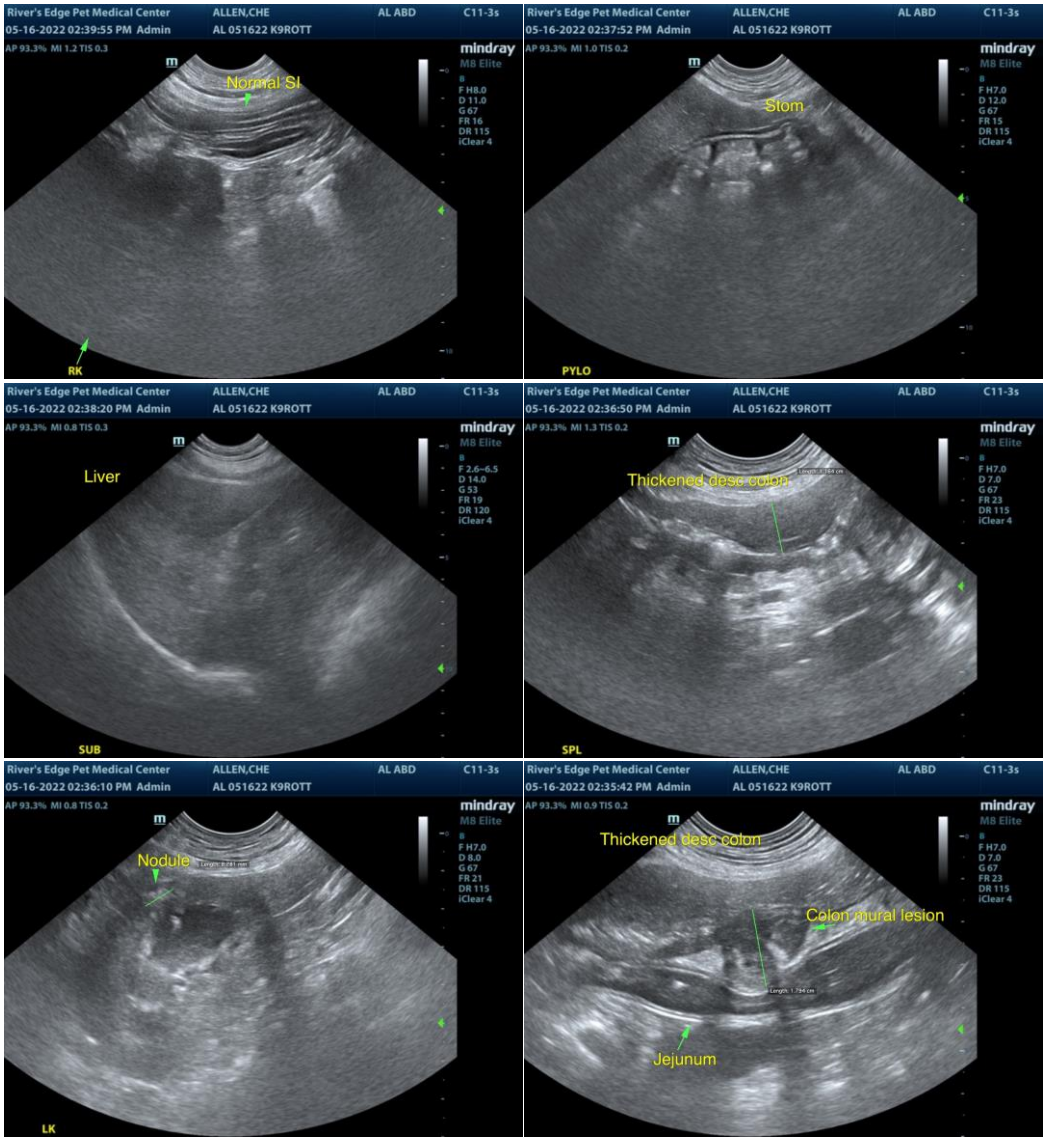
Sonographic monitoring of the indistinct left kidney nodule with recheck in 4 weeks is suggested.



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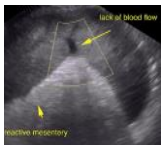
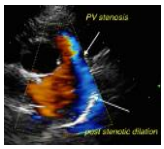
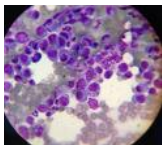
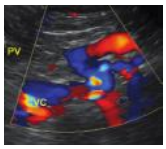

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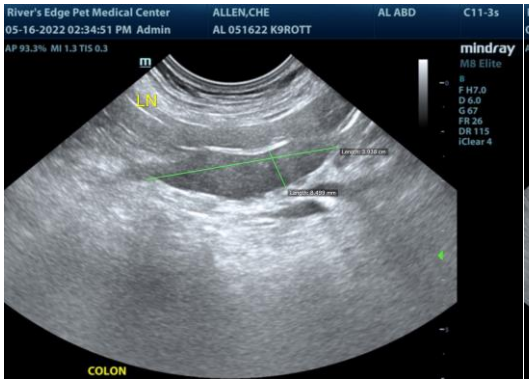

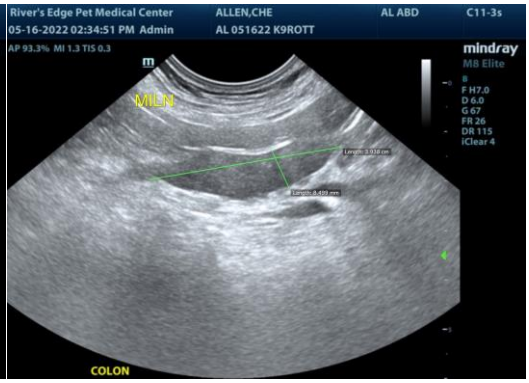

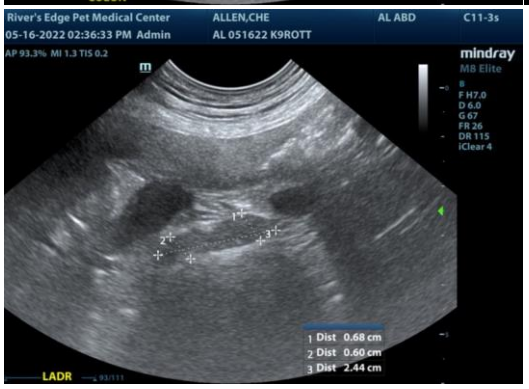

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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