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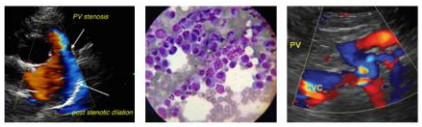


SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

PATIENT

Mayhem Bratcher

SPECIES

Canine

BREED

Cane Corso

SEX

MN

AGE

7 yr

WEIGHT

173 lb

INTERPRETED BY

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

IMAGING PERFORMED BY

Sarah Pender CVT

HOSPITAL NAME

SVS Imaging QC

REFERRING VET

Dr. John Glispie

INVOICE

10633ag

DATE

05/16/2022

PRESENTING CLINICAL SIGNS

History: V/D since last Thursday/Friday. Vomiting brown bile today multiple times. Hx of eating socks. NPO since yesterday

Abnormal PE/Chem/CBC/UA Results: Xray findings possible mass/FB. Painful abdomen ALKP-977 CHOL-362 WBC-17.04

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 4 cm 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. The left kidney measured 8.0 cm in length. The right kidney measured 9.6 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 exhibited potential for mild subnormal size with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.44 cm width at the caudal pole and 2.2 cm length. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.80 cm width at the caudal pole and 2.8 cm in length.

Spleen

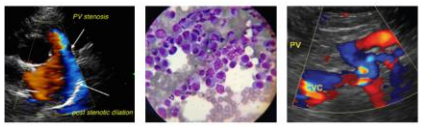
The spleen exhibited primarily finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was primarily smooth and regular without apparent expansion. A mildly expansive caudal nodule with associated capsule distortion was present measuring 2.0 cm. Possible indistinct to subtle hypoechoic nodules possible yet not definitive. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis.

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 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 contained a mild to moderate amount of retained echogenic nonshadowing ingesta/chyme with focal to



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intermittent small shadowing echoes noted within the retained ingesta. An example of the small shadowing echo measured 1.5 cm in diameter. The gastric body wall measured 0.72 cm in width.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The small intestine exhibited segments of empty small intestine without evidence of mechanical/metabolic ileus along with segments of mild retained nonshadowing digesta/chyme within the duodenum and jejunum. Definitive areas of mechanical obstruction were not overtly evident. The duodenum wall measured 0.66 cm in width. The jejunum wall measured 0.47 cm in width.

The colon walls presented intact yet prominent wall layering with mild thickened to echogenic submucosa. Semi-formed fecal matter was present in the colon lumen with lumen dilation.

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

No peritoneal effusion was present.

Multiple focally enlarged mid abdominal mesenteric root 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 5.8 cm x 3.3 cm.

ULTRASONOGRAPHIC FINDINGS

- Acute gastroenterocolitis pattern with mild retained focally shadowing gastric and segmental small intestinal ingesta/chyme
- Hypoechoic to swollen mesenteric root lymph nodes with associated regional omental reactivity/inflammation-reactive lymphadenitis secondary to inflammatory bowel episode, potential for emerging neoplastic criteria
- Hepatopathy-nonspecific yet subjectively benign, suggestive of vacuolar hepatopathy pattern, potential for nonspecific hepatitis or neoplasia possible
- Nonspecific yet suspicious, mildly expansive splenic nodule – multiple etiologies possible ie hyperplasia, hematopoiesis, granuloma, inflammation, emerging primary or metastatic neoplasia

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

An obvious or definitive area of mechanical GI obstruction was not overtly evident in this study, rather the GI presentation was suggestive of acute inflammatory episode. The intermittent small gastric shadowing echoes could represent medication if clinically applicable although small amounts of nonobstructive foreign material with concurrent potential for nonobvious small bowel foreign material and segmental metabolic vs partial obstructive pattern given the patient history is certainly possible. Given the patients clinical signs and reported abdominal pain (positive Murphy sign), exploratory laparotomy with GI and lymphatic biopsies considered essential and with strong consideration for concurrent splenectomy despite exploratory findings could be considered assuming no signs of thoracic pathology and normal cardiopulmonary status on 3 view chest rads. However, there is potential for occult GI, lymphatic, focal splenic +/- hepatic multicentric neoplasia which cannot be excluded and should be considered prior to potential surgery. Alternatively, ultrasound guided FNA of

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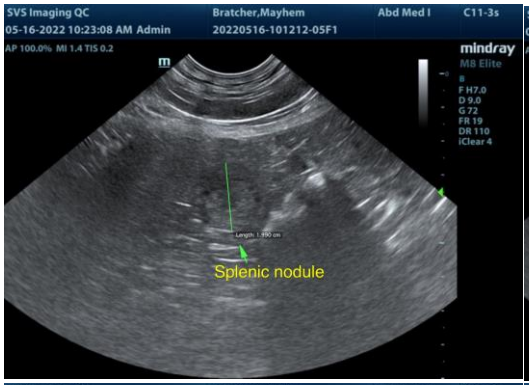
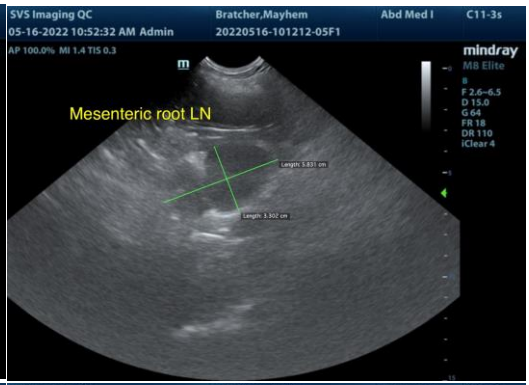
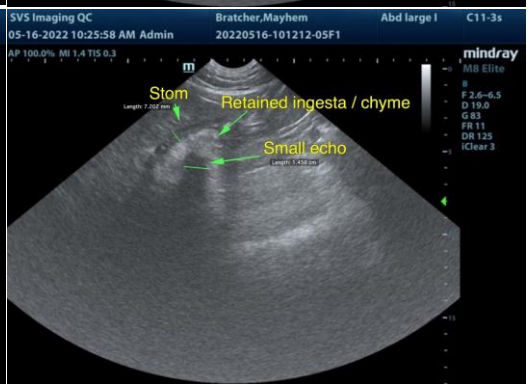
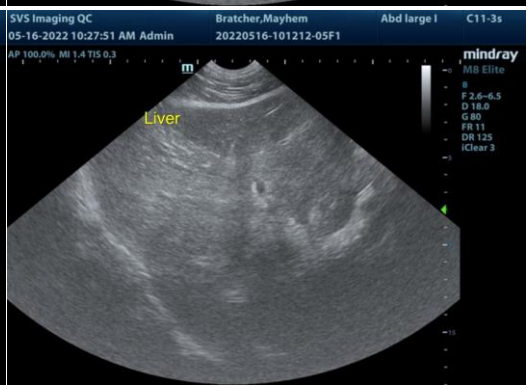
an enlarged mesenteric root LN, splenic nodule, if accessible, and liver could be considered with 24 hour hospitalization including IV fluid and GI support as well as antibiotics given potential mesenteric root lymphadenitis and sonographic monitoring as a more conservative approach. However, with the size of the patient and depth of the mesenteric lymph nodes, FNA of the lymph nodes and splenic nodule may not be possible.









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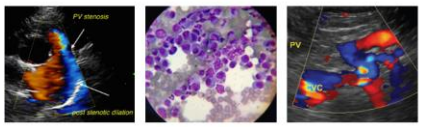

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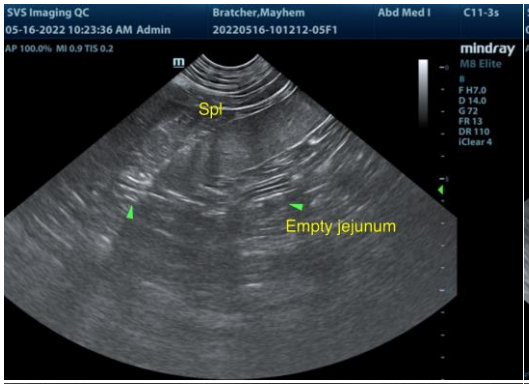

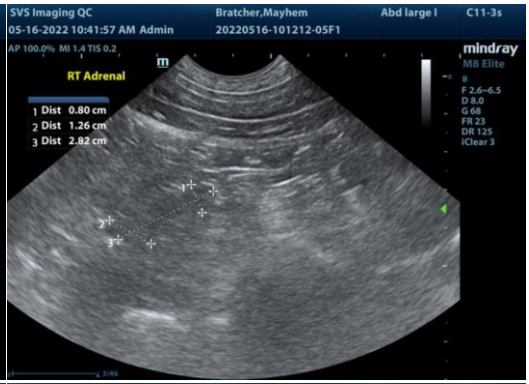

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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