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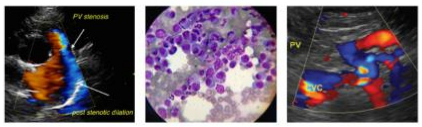


SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

PATIENT

Henry Woodham

SPECIES

Canine

BREED

Lab Mix

SEX

Neutered Male

AGE

8 Years

WEIGHT

94 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. Hartmann

INVOICE

15058

DATE

5/6/22

PRESENTING CLINICAL SIGNS

History: Decreased appetite, ate yesterday afternoon and only a small treat this morning, Vomiting, recent weight loss (13# since January), Still acting normal, Has eaten socks in the past. Normal stools. No vomiting today
Abnormal PE/Chem/CBC/UA Results: Obese, tense cranial abdomen CPL - abnormal WBC 16.89 Neu 12.64 BUN 5 Rads - suspicious of soft tissue mass in cranial

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone and 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. Aortic trifurcation was normal.

No overt pathology in the area of the residual prostate.

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 7.3 cm in length. The right kidney measured 6.8 cm in length.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.50 cm width at the caudal pole and 0.74 cm width at the cranial pole.

The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.39 cm width at the caudal pole and 0.74 cm width at the cranial 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.

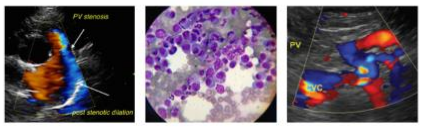
Liver

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.

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

Gastrointestinal

The stomach presented wall thickening secondary to echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. Mild to moderate retained anechoic fluid and minor echogenic chyme was present. Subjective prominent pyloric mucosa in the area of the pyloric outflow yet not overtly indicative of mechanical pyloric outflow obstruction. No overt evidence of gastric foreign



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material. The ventral gastric body wall measured 0.72 cm. The pylorus wall measured 0.86cm, up to 1.2 cm in the area of the pyloric outflow.

The small intestine presented intact wall layering and primarily maintained 1:3 muscularis/mucosa ratio with segmental propensity for mildly prominent duodenojejunal mucosa. Generalized duodenal and segmental jejunal ileus were present without overt evidence of definitive obstructive pattern or overt foreign material. The duodenum wall measured 0.47 cm. The jejunum wall measured up to 0.54 cm.

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

Pancreas

The pancreas base and proximal right pancreatic limb were enlarged with capsule asymmetry and presented hypoechoic to heterogeneous echogenicity compared to adjacent omental fat. Mild asymmetrical capsule margination was present with mild variable parenchymal swelling and mild peripancreatic reactivity / inflammation. No overt evidence of neoplasia.

Free Abdomen

Solitary, mildly prominent to enlarged gastric or pancreaticoduodenal lymph node was present adjacent to the pylorus and pancreas base. The lymph node was essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). The lymph node measured 1.2 cm x 2.5 cm width.

No overt free fluid was present.

ULTRASONOGRAPHIC FINDINGS

- Moderate gastroduodenitis and segmental jejunitis pattern with duodenal and segmental jejunal ileus
- Active to chronic active pancreatitis pattern in the area of the pancreas base and proximal right pancreatic limb
- Associated perigastric regional periintestinal and peripancreatic reactive mesentery, solitary visualized nonspecific yet subjectively reactive gastric versus pancreaticoduodenal lymph node

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The gastrointestinal and pancreatic presentation may indicate either active to chronic active pancreatitis with secondary upper gastrointestinal and segmental jejunal inflammation or primary gastroenteropathy with concurrent low-grade to chronic active pancreatitis without overt evidence of mechanical obstructive pattern, definitive foreign body and suspect gastroduodenal and segmental jejunal metabolic ileus. The possibility of early infiltrative gastroenteropathy with round cells (i.e., lymphoma or similar), as the possibility of early pancreatic neoplastic criteria cannot be definitively excluded.

Assuming normal clotting status, using a 25-gauge needle, ultrasound guided FNA in the area of the pancreas base (if accessible) could be considered for screening cytology. Empirically, aggressive therapy for gastroduodenitis and pancreatitis, which may include hospitalization, gastrointestinal support and therapy for pancreatitis could be considered. Chronic gastroenteropathy and concurrent pancreatitis, given the patients weight loss, is of concern. A GI panel to include PLI/TLI/Cobalamin/Folate is suggeted.

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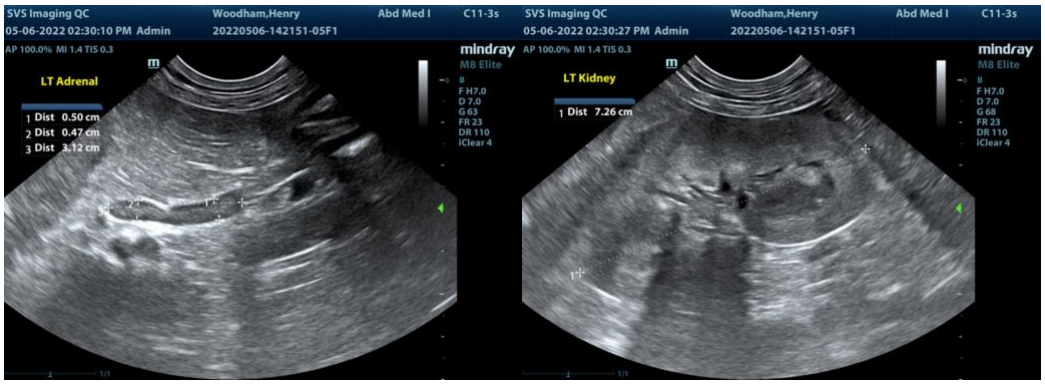
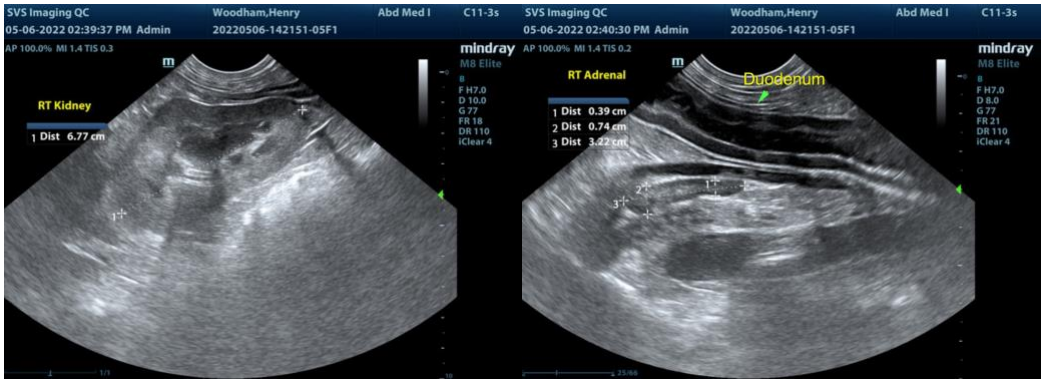
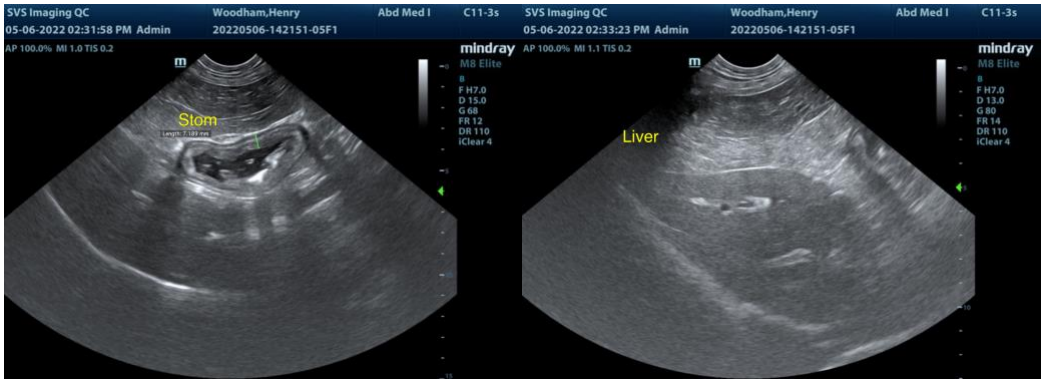
Ultimately, endoscopic upper gastrointestinal biopsies may be indicated for biopsies and histopathology.







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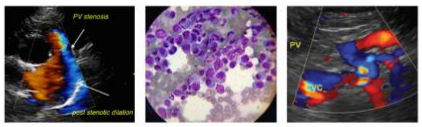

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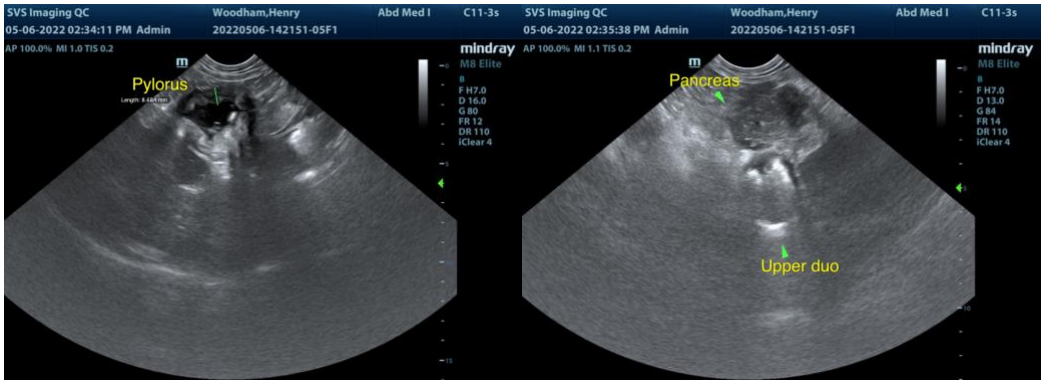

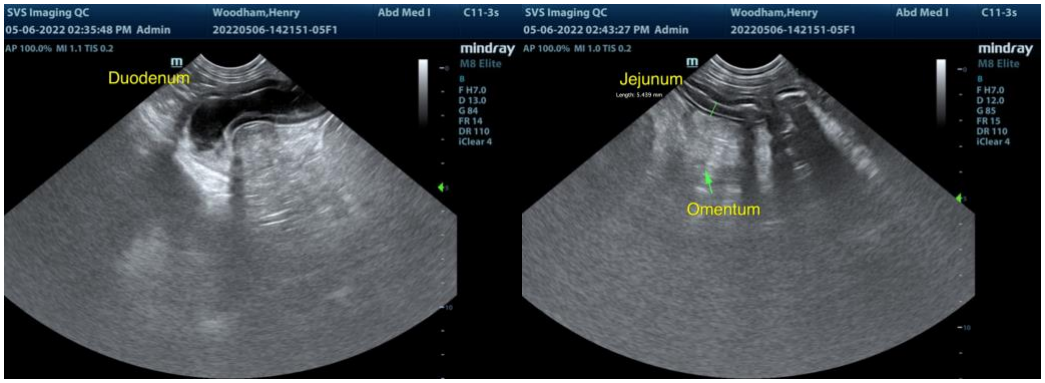

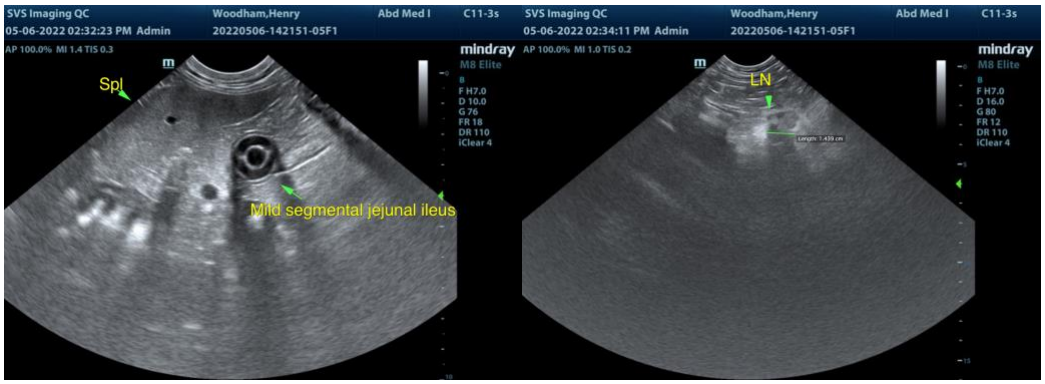

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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