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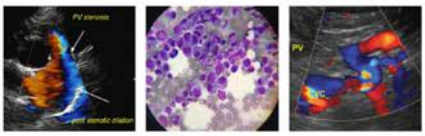
SVS IMAGING



SonoPath
Clinical Sonography & Telecytology
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PATIENT

Kodi Bronowiecki

SPECIES

Canine

BREED

Labrador Retriever

SEX

Neutered Male

AGE

11 Years

WEIGHT

64.2 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VET

Mukwonago AH – Dr. Sherrod

INVOICE

39107

DATE

6/29/22

PRESENTING CLINICAL SIGNS

Patient presented on 6/23/22 for trouble breathing, lump on neck, weight loss. 30# weight loss since 9/9/21
Abnormal PE/Chem/CBC/UA Results: PE: BAR, alert/active, mm tacky, crt about 2 sec, neck large sq mass FNA fat/lipoma H/L increased respiration rate and effort. Abd NSF, CBC: RBC (7.35), WBC (5.97), PLT (224), CHEM: WNL, Chest rads- VHS II, Abd, Increased gas throughout GI tract, ProBNP elevated (1360), CPL WNL (30), decreased cobalamine (less than 150), folate WNL (7.8)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra exhibited normal tone. Mild nonuniform thickening of the urinary bladder wall was present. Ventral apical urinary bladder wall measured 1.0 cm. Hyperechoic focal echogenicities with distal acoustic shadowing were present in the dependent lumen. The urethra was normal to a depth of 4.0 cm.

The area of the aortic trifurcation was free of pathology.

The residual prostate was symmetrically normal in size with uniform parenchyma and slight coarse echotexture. The prostate measured 1.5 cm diameter.

Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 7.0 cm. The right kidney measured 6.4 cm.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.49 cm at the cranial pole and 0.53 cm at the caudal pole.

The right adrenal gland was mildly prominent, yet technically within normal size, measuring 0.81 cm at the cranial pole and 0.82 cm at the caudal pole. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia.

Spleen

The spleen exhibited primarily finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Multifocal, well-defined, symmetrical, echogenic nodules were present throughout the cranial to caudal parenchyma. Example of splenic nodule measured 0.47 cm in diameter. Areas of mild asymmetrical hyperechoic splenic capsule noted. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory or neoplastic changes were not noted. The echogenic nodules tend to trend benign and are most consistent with benign hyperplasia or myelolipomas.

Liver

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to benign parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non distended in size with mild, echogenic, nonmineralized biliary sludge. The cystic duct and common bile ducts were normal without evidence of dilation.

Gastrointestinal

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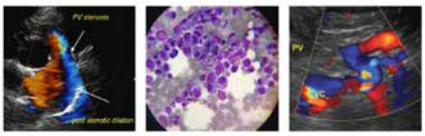

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The visualized gastric walls were sonographically normal, exhibiting intact wall layering. Subjective moderate variably echogenic to shadowing gastric ingesta present. Ventral gastric body wall measured 0.43 cm.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. Segmental areas of potential retained small intestinal non-shadowing chyme. No overt evidence of mechanical obstruction (i.e., intestinal masses, foreign body, etc.).

Normal visible colon wall layers were present with subjective formed feces.

Pancreas

The pancreas was indistinctly visualized, yet the left limb of the pancreas appeared to exhibit mild prominent size, symmetrical contour, with mild hypoechoic to non-homogeneous parenchyma compared to adjacent omentum.

Free Abdomen

No visualized intraabdominal masses, lymphadenopathy, or evidence of peritoneal free fluid.

ULTRASONOGRAPHIC FINDINGS

- Cystitis pattern
- Intact, overtly normal gastrointestinal walls with gastric and segmental small intestinal ingesta/chyme
- Subjective mildly prominent to hypoechoic left pancreas – potential for low-grade to chronic active pancreatitis.
- Mild hepatic parenchymal remodeling – benign.
- Mild gallbladder debris (non-mucocele)
- Benign splenic nodules with probable areas of medial splenic capsule fibrosis
- Mild age related kidneys

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Although no evidence of gastrointestinal mural changes, the decreased cobalamin level in this patient is consistent with distal small intestinal disease. The presence of gastric and segmental small intestinal ingesta/chyme may indicate post-prandial presentation. However, if documented NPO, some degree of possible gastric hypomotility or inefficient peristalsis may be possible.

Empirically, cobalamin supplementation, hydrolyzed diet trial, with as needed gastrointestinal support, with monitoring of cobalamin levels and assessment of clinical response would be reasonable. Assessment of caloric plane may be indicated. 3-view chest radiographs suggested to rule out occult thoracic pathology as a contributing factor to the weight loss. If documented NPO prior to the ultrasound, monitoring for evidence of gatric emptying following documtented 12-24 hour fast is suggested.

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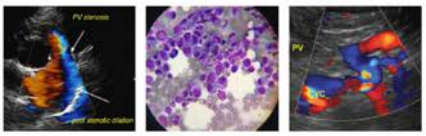

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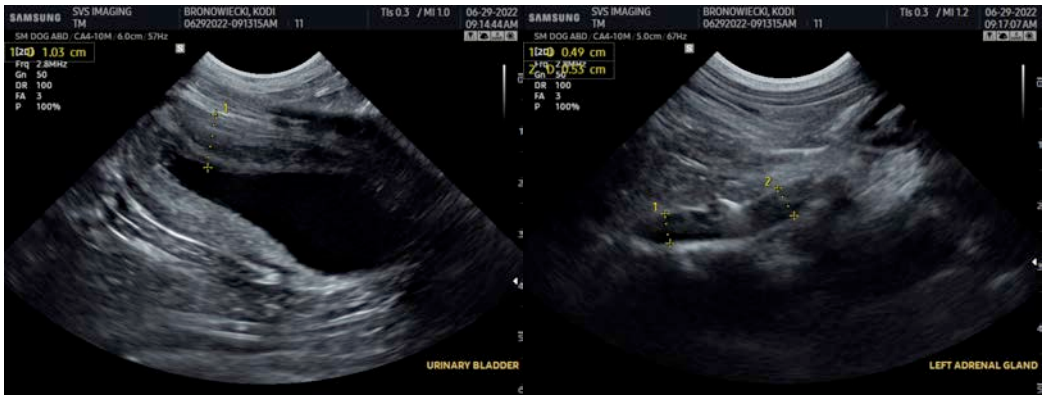

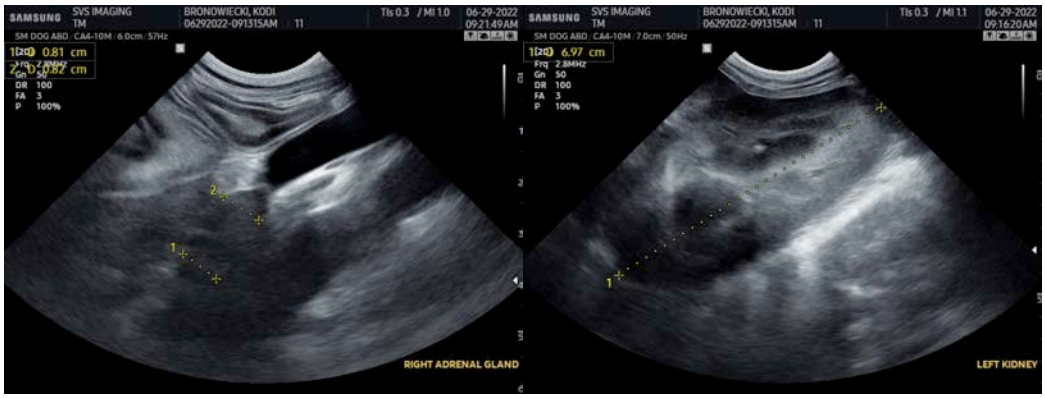

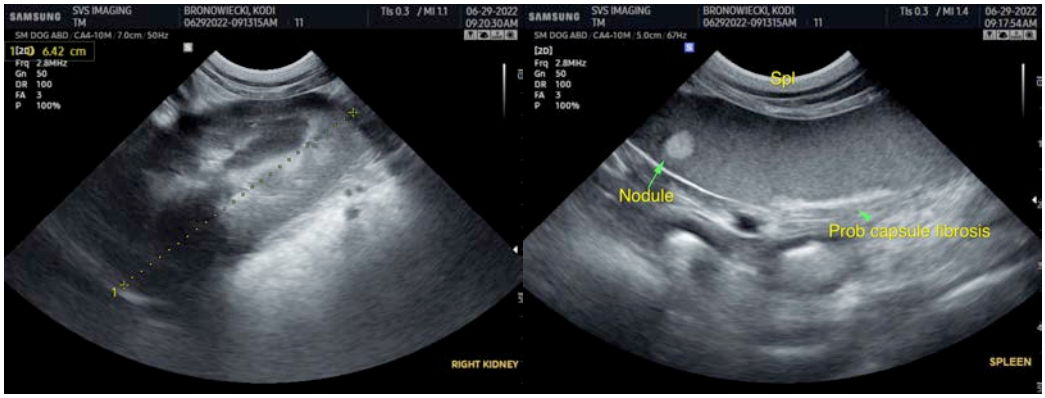

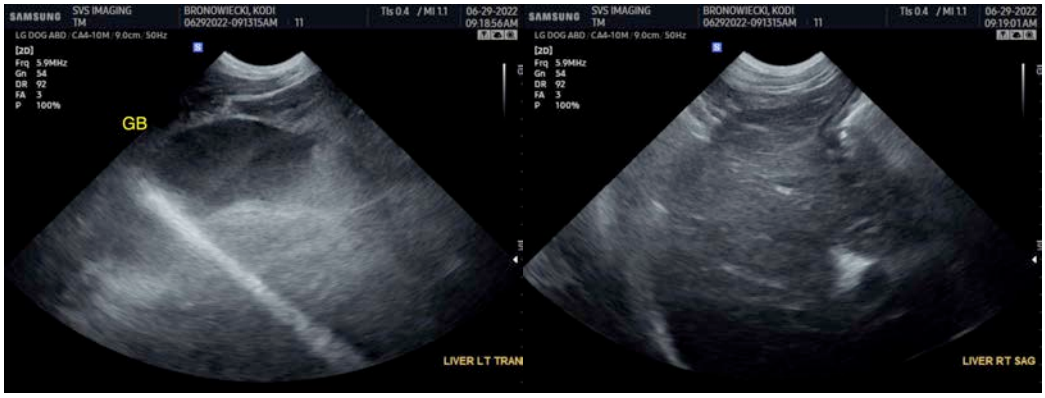

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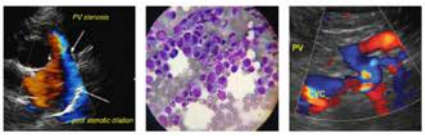

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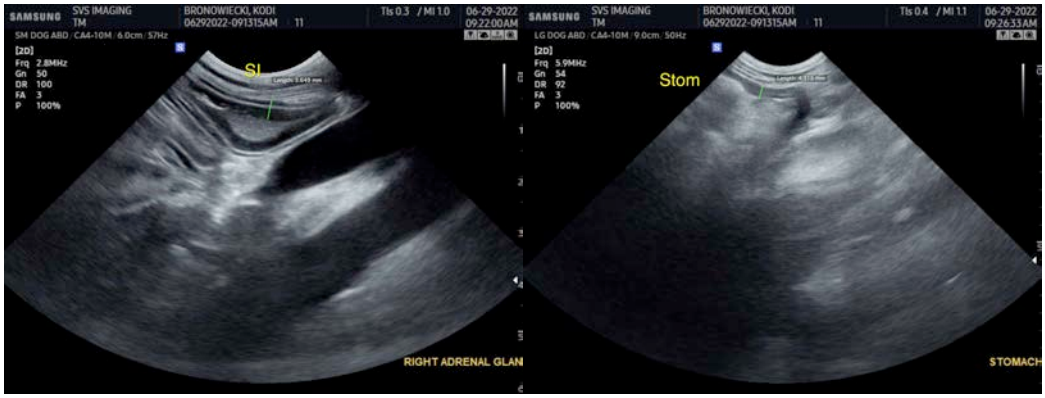

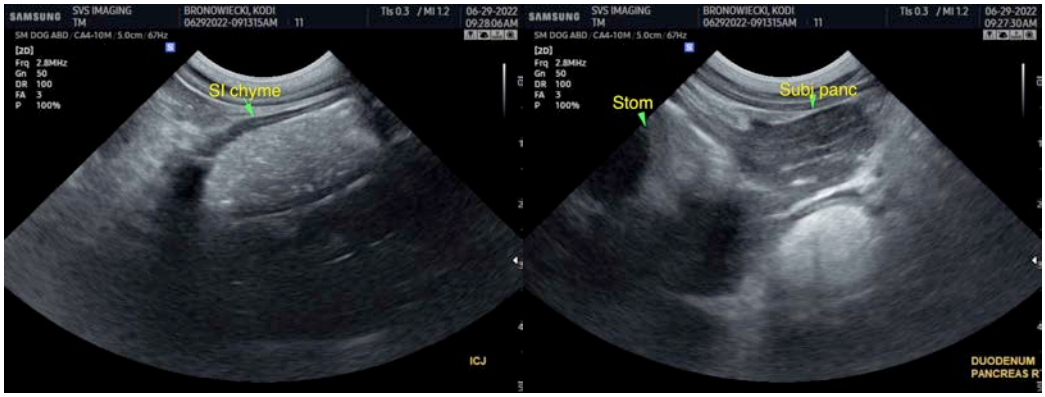

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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