

**PATIENT**

Luna Standen

**SPECIES**

Canine

**BREED**

American Bulldog Mix

**SEX**

FS

**AGE**

7yr

**WEIGHT**

58.1lb

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Michaleen

**HOSPITAL NAME**

DPC Veterinary  
Hospital

**REFERRING VET**

Dr. Ward

**INVOICE**

11158ag

**DATE**

07/24/2022

**PRESENTING CLINICAL SIGNS**

History: 7y 10m old SF Am Bulldog presents for lump on chest. In 2019, lump was described as a 3.5cm soft movable SQ mass on L side of the sternum. An FNA was declined at that time. O states he recently noticed it changed in texture from firm to softer. Pet not bothered by area. Vaccines updated in March of this year. Within the past year pet has had a significant decrease in appetite, O reports pet vomits frequently, typically after every meal. Currently has had diarrhea for 1 week

Abnormal PE/Chem/CBC/UA Results: Hydration: Estimate 5% dehydration Lymph Nodes: Submandibular, prescapular and popliteal lymph nodes normal size, shape and consistency Skin: Heterogenous SQ mass left ventral thorax--golf-ball sized firm irregular portion palpated and fluctuant swelling surrounding this mass. Otherwise healthy hair coat. No ectoparasites seen, skin clean dry and intact. CV/Respiratory: Normal heart rate and rhythm, no murmur, pulses strong and synchronous, normal bronchovesicular sounds. Abd/GI: fluid filled intestines with audible borborygmi on palpation. Soft, non-painful, no fluid wave Low albumin=2.2 (2.3-4.0) Low-normal globulin=2.5 (2.5-4.5) Low total protein=4.7 (5.2-8.2) USG=1.036 with trace protein and quiet sediment

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2 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 6.0 cm in length. The right kidney measured 6.0 cm in length.

The area of the aortic trifurcation was free of pathology.

**Adrenal Glands**

The overt pathology in the area of the left or right adrenal glands although not distinctly 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 stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained echogenic, nonshadowing ingesta without signs of obstruction or foreign material.

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A segment of thickened intestine exhibiting mild to moderate mural hypertrophy, decreased mural echogenicity and loss of discernable wall layering was present in the subjective mid to potential caudal abdomen measuring approximately 5-6 cm in length with wall width up to 1.0 cm. Concurrent segmental to primarily chyme distended bowel was present exhibiting oral/aboral movement of luminal chyme adjacent to the segmentally thickened intestine was present and is suggestive of at least partial obstructive pattern. Concurrent segments of primarily empty SI with mild to moderate luminal gas artifact were present suspected to be distal to the segmentally thickened intestine.

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**Pancreas**

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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**

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Mild volume peritoneal free fluid was present along with mid abdominal hypoechoic to swollen mesenteric lymph nodes and evidence of mild perilymphatic reactive mesentery. An example of a lymph node measured 4.5 cm x 2.3 cm.

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**ULTRASONOGRAPHIC FINDINGS**

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(Canine and Feline)

- Retained gastric ingesta
- Segmental intestinal mural mass
- Moderate to variable chyme distended small intestine-suspect proximal to the intestinal mural mass consistent with some degree of mechanical ileus
- Associated mid abdominal hypoechoic to swollen mesenteric lymphadenopathy-suggestive of lymphatic neoplastic criteria

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

**IMAGING PERFORMED BY**

Michaleen

Assuming normal clotting status an ultrasound guided FNA of an enlarged mesenteric lymph node +/- thickened intestine for screening cytology could be considered. Considerations may include favored neoplastic process such as lymphoma, adenocarcinoma, stromal tumor or other, concern for lymphatic involvement/metastasis is warranted.

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It is suspected that this patient is losing protein through the intestinal tract.

Continued monitoring of ALB/GLOB is suggested.

Three view chest radiographs are recommended if not done. A surgery/oncology consult pending sampling is recommended.

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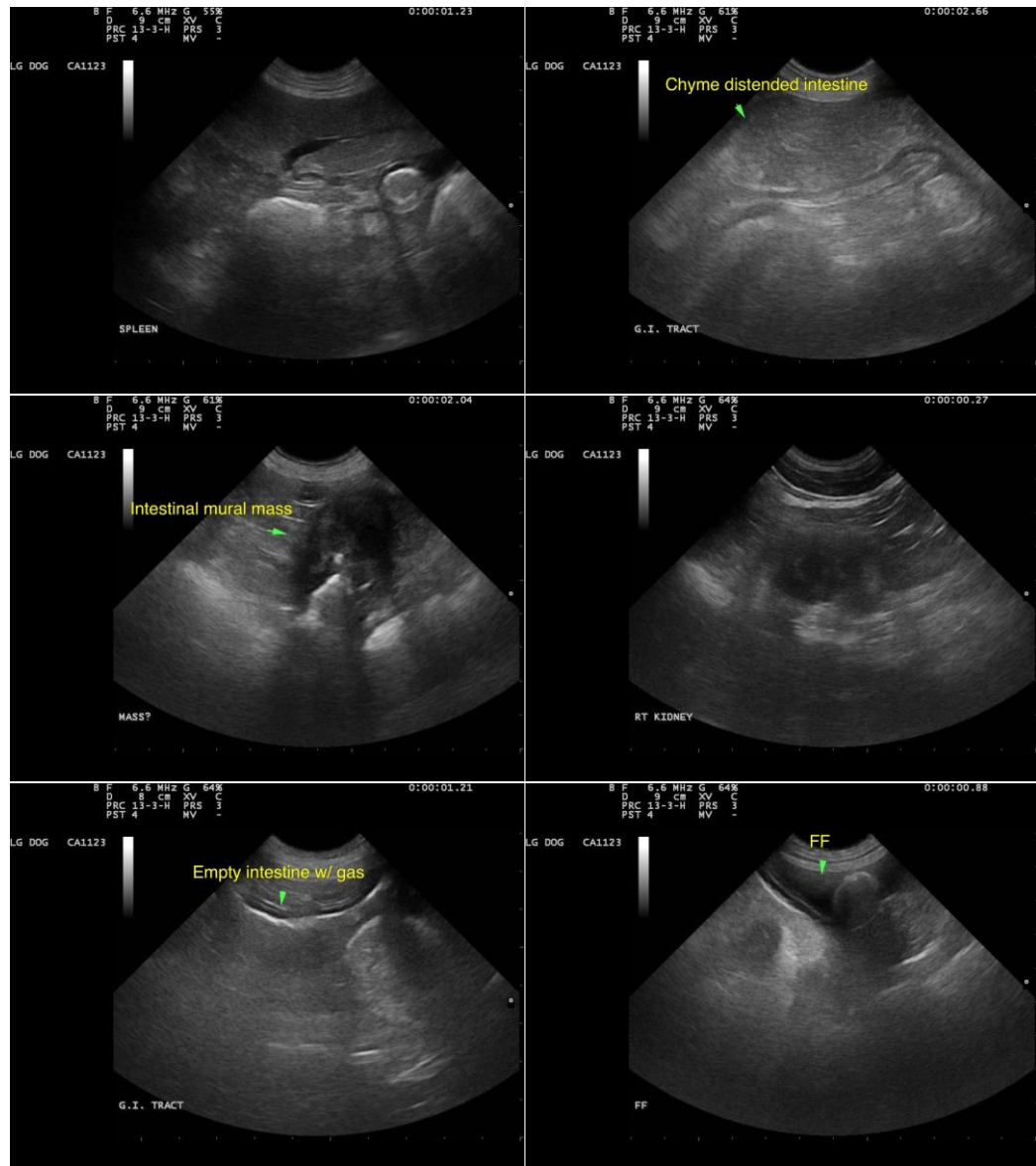
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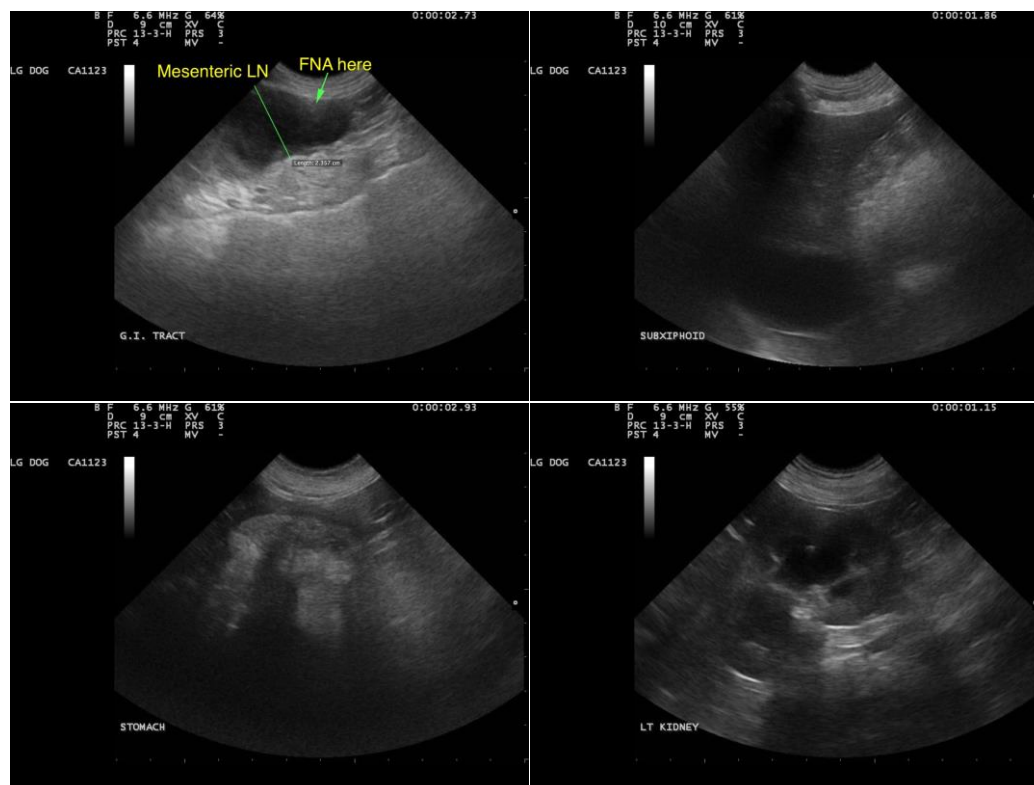
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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info@SonoPath.com

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