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Clinical Sonography & Telecytology
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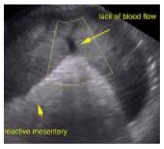
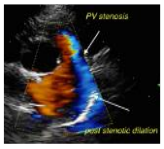
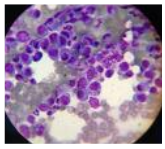
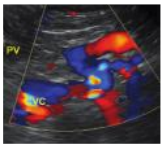

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Shyla Tuscherer

SPECIES
Canine

BREED
Miniature Schnauzer/German Shep Mix

SEX
FS

AGE
10 years

WEIGHT
43.5 lbs.

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

IMAGING PERFORMED BY
Mack

HOSPITAL NAME
Northside Veterinary Clinic

REFERRING VET
Mack

INVOICE
14762

DATE
8/2/23

PRESENTING CLINICAL SIGNS

Patient presented for lethargy x 2 days and vomiting dark liquid.
Abnormal PE/Chem/CBC/UA Results: CBC: Elevated WBC Xray: Round, soft tissue mass noted in cranial abdomen.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder and urethra were not definitively visualized.

A solitary kidney exhibited normal size with mild asymmetrical margination and a 1:3 cortex/medulla ratio. Loss corticomedullary border demarcation, expected for age, was present with no evidence of pyelectasia. The kidney measured 6.0 cm in length.

Adrenal Glands

The left and right adrenal glands were not definitively visualized.

Spleen

The spleen exhibited minor cranial enlargement with maintained symmetrical capsule contour and generalized mild splenic parenchyma heterogeneity. A solitary, nondisruptive, cranial splenic myelolipoma was present. The cranial splenic width measured 2.2 cm in diameter.

Liver/ Gallbladder

The liver was mildly enlarged yet maintained symmetrical capsule contour with generalized mild nonhomogeneous hepatic parenchyma exhibiting intermittent, variably sized, subtle to nondisruptive, hypoechoic intraparenchymal nodules. An example of a liver nodule measured 2.1 cm in diameter. The gallbladder and common bile duct were not definitively visualized.

Gastrointestinal

The visualized stomach exhibited intact, sonographically unremarkable wall layering and an empty lumen without evidence of retained ingesta, fluid, or foreign material.

Segmental, mildly expansive, irregular, nonhomogeneous mid-cranial intestinal mass measuring approximately 6.0 cm in diameter was present with a jejunal location considered most probable, given the location within the abdominal cavity. Adjacent intestinal segments exhibited intact, subjective mildly thickened wall layering with mildly thickened intestinal wall measuring 0.37 cm. There was no evidence of an obstructive pattern.

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

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 were evident.

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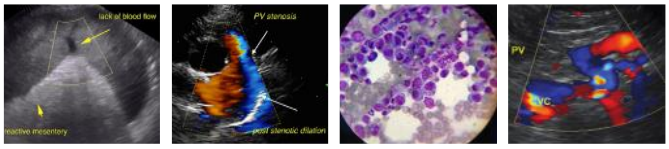

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Free Abdomen

Regional peri intestinal peritonitis and potential scant peri intestinal free fluid around the intestinal mass were present. Definitively visualized or significant omental lymphadenopathy was not obvious, yet mild peri intestinal omental lymphadenopathy is possible.

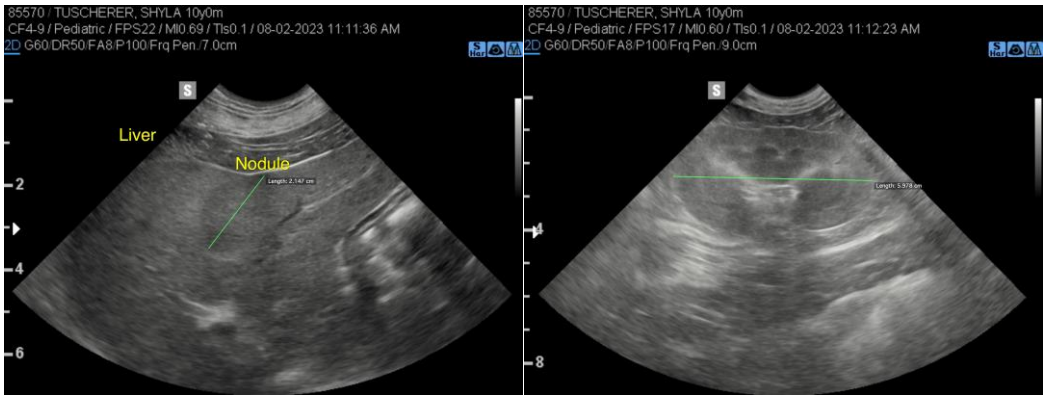
ULTRASONOGRAPHIC FINDINGS

- Small intestinal mass with regional peritonitis
- Minor cranial splenomegaly with probable splenic myelolipoma - subjectively benign
- Mildly enlarged, nonhomogeneous, subtly nodular liver - nonspecific, vacuolar hepatopathy, inflammatory disease, hyperplasia, hematopoiesis, fibrosis, primary or metastatic hepatic neoplasia possible

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Although sampling or histopathology are required for a definitive diagnosis, neoplastic criteria for the intestinal mass with considerations including adenocarcinoma, lymphoma, stromal tumor, leiomyoma / leiomyosarcoma or other, considered likely.

Assuming normal clotting status, FNA cytology of the intestinal mass and screening hepatic FNA cytology could be considered for further clarification. Potential for more generalized to emerging segmental intestinal involvement, as well as potential for regional omental seeding and hepatic metastasis are possible. Although the intestinal mass appears to be amendable to surgical resection, and assuming no evidence of pathology on three view chest radiographs, abdominal CT would be ideal for further clarification, assessment of non-sonographically evident metastasis, and surgical planning.



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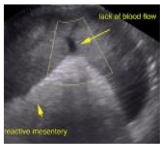
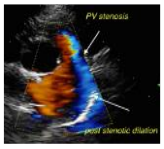
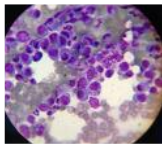
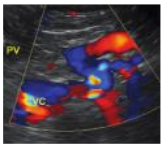

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@sonopath.com