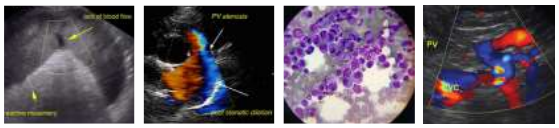

PATIENT

Peyton Barrough

SPECIES

Canine

BREED

Boxer

SEX

Spayed Female

AGE

6 years

WEIGHT

37 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Jenna Walsh

HOSPITAL NAME

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INVOICE

12246

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PRESENTING CLINICAL SIGNS

Presents for: Issues with vomitting starting about 2 months ago, weight loss ever since. O has noticed a more drastic decline in P's weight in the last several weeks. E/D: Sometimes seems interested in food, sometimes not, the most she'll eat is about 1/2 cup per day. Still drinking water but not as much. U/D: Stayed for the most part WNL, but possibly a little less. C/S/V/D: vomitting and diarrhea (O knows diarrhea today, unsure how long it's been going on) Diet: Switch up food types fairly often- Cascade put her on hydrolyzed, ate for a couple weeks and now wants nothing to do with it. Eating wet food okay, not interested in people food, won't even eat boiled chicken Exercise: Lays around a lot, still getting up to go outside and has some energy Prevention:^ Rx: nothing currently, was given meds from Cascade (steroids and anti nausea, was on them 2-3 weeks, has been off now for 2 weeks) QAR, very mellow but friendly EENT: MM pale pink, moist. CRT 2 seconds. Clear OU, Clean AU. Nares free of any discharge. ORAL: Mild tartar and gingivitis present. INTEGUMENT: No external parasites observed. No evidence of skin disease at this time. LYMPH NODES: Lymph nodes are small and of normal texture CIRCULATORY: No murmur or arrhythmia ausculted. Femoral pulses are strong and synchronous. RESPIRATORY: Eupneic. Lungs clear bilaterally. No cough on tracheal palpation. DIGESTIVE: Abdomen soft/benign. No masses palpated. GENITOURINARY: No significant findings. MUSCULOSKELETAL: Ambulatory x all 4. Severely malnourished with diffuse muscle wasting. BCS 2/9 NEURO: No neurologic deficits noted at this time. OTHER: A:P appears severely malnourished. Has lost approx 35# since last seen here. Has been at another vet and seeking second opinion. R/O GI disease (EPI, IBD, PLE, SIBO, Malabsorption/maldigestion, neoplasia), Parasitism, Open B12 injections once weekly for 6 weeks - 0.50cc SQ Lowfat/Low Fiber GI diet (Royal Canin Low Fat, or Purina EN Low Fat) OR possibly Hypoallergenic but these often aren't low enough in fat. Prednisone @ 1mg/kg/day : 20mg PO SID x 2-4 weeks (Taper will be recommended once clinical response is adequate) Metronidazole 250mg - 1 PO BID x 5 days. Proviable Broad spectrum deworming with Panacur

Abnormal PE/Chem/CBC/UA Results: Summary of labs are current treatment recommendations - (Complete labs below:) Elevated at 35. Bun and Crea are normal. Mild decrease in CA, TP/ALB. Decreased Cholesterol Increased Amylase Decrease NaCl Spec cPL a933 0 - 200 µg/L Trypsin-like Immuno-reactivity (TLI) b33.3 5.0 - 35.0 ug/L Cobalamin (B-12) c260 284 - 836 ng/L Folate 5.6 4.8 - 19.0 ug/L

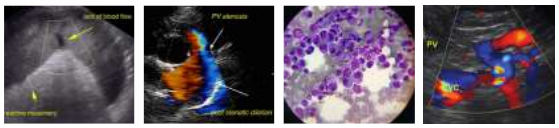
ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 4.0 cm exhibited normal thickness and tone. Primarily anechoic urine was present in the lumen. Minor, particulate, nondependent sediment was present without evidence of calculus formation. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural changes were noted.

The area of the aortic trifurcation was free of pathology.

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



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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 5.6 cm in length. The right kidney measured 5.6 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 2.3 cm length x 0.32 cm width at the caudal pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 1.5 cm length x 0.35 cm width at the caudal pole.

Spleen

The spleen exhibited primarily finely textured parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Mild generalized parenchyma heterogeneity was present without evidence of nodular changes. 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. The parenchymal heterogeneity is likely consistent with benign changes such as extramedullary hematopoiesis or age-related remodeling with minor potential for inflammatory or neoplastic disease.

Liver/ Gallbladder

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 wall thickening secondary to echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. The stomach was primarily empty with mild luminal gas. No evidence of retained ingesta, fluid or foreign material was noted.

The small intestine exhibited generalized intact wall layering with segmental to generalized propensity for mildly prominent small bowel mucosa. Increased mucosa echogenicity to mucosal speckling as well as mild segmental prominent to echogenic submucosa were present. Segmental jejunal nonobstructive ileus pattern was present. The jejunum wall width measured 0.43 cm.

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

Pancreas

The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

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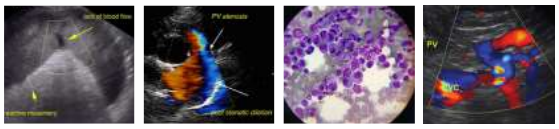

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Free Abdomen

Multifocal, midabdominal, mesenteric and pancreaticoduodenal 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 a mesenteric lymph node size was 5.0 cm x 1.0 cm. An example of a pancreaticoduodenal lymph node size was 3.7 cm x 1.1 cm.

Generalized reactive mesentery along with small pockets of very scant peritoneal free fluid were present.

Hypoechoic to mildly nonhomogeneous primarily ovoid mass lesion was noted in the right cranial abdomen in the area of the caudate liver lobe, pancreas base and adjacent pancreaticoduodenal lymph nodes. This mass lesion measured approximately 6.0 x 4.5 cm.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Chronic gastroenteropathy with small bowel increased mucosa echogenicity and subjective prominent submucosa layer - chronic IBD, PLE, Infiltrative neoplastic enteropathy / gastroenteropathy or other possible
- Hepatomegaly
- Hypoechoic to mild nonhomogeneous mass lesion in right cranial abdomen - hepatic (caudate), pancreatic or lymphatic origin possible
- Multifocal intraabdominal lymphadenopathy - marked reactive hyperplasia, reactive lymphadenitis, or neoplastic lymphadenopathy possible
- Generalized reactive mesentery and scant peritoneal free fluid

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Assuming normal clotting status, an ultrasound-guided FNA of the right cranial abdominal mass lesion as well as hepato-lymphatic FNA are recommended for further clarification.

Intestinal and lymphatic biopsies are likely required for a definitive diagnosis. However, potential recent or current Prednisone may affect cytology or histopathology results. Empirically, continued IBD protocol with a limited antigen or hydrolyzed diet and continued cobalamin supplementation would be appropriate.

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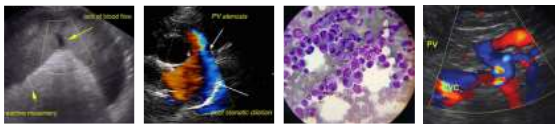

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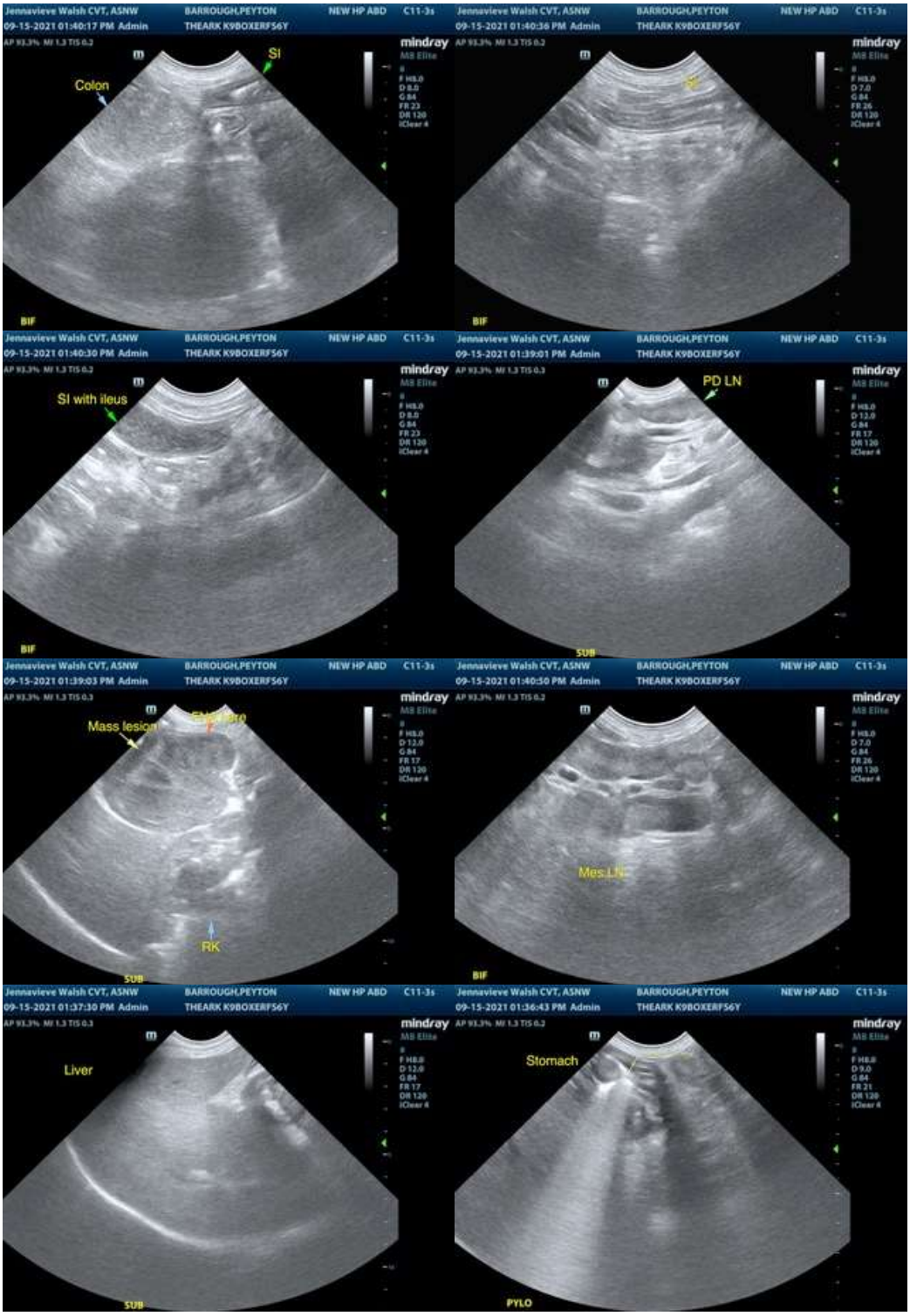

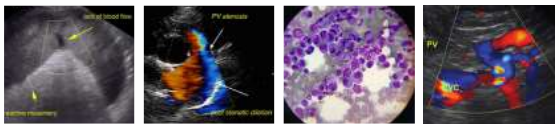

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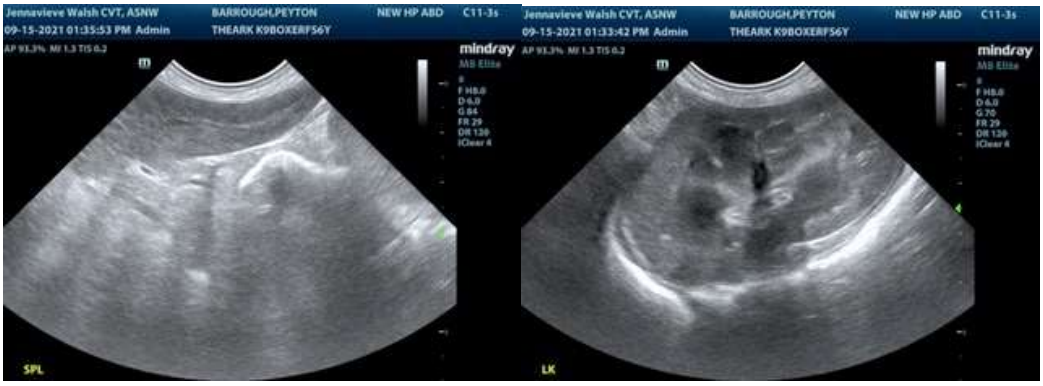

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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