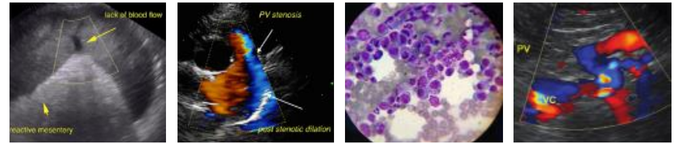
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Rudy Cashman

SPECIES
Canine

BREED
Boxer

SEX
MN

AGE
10yr

WEIGHT
35.6lb

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

IMAGING PERFORMED BY
Kelly Vazquez

HOSPITAL NAME
Bergen County Vet Center

REFERRING VET
Dr. Jill Shiffman

INVOICE
11555ag

DATE
09/07/2022

PRESENTING CLINICAL SIGNS

Patient with history of aortic stenosis presented for GI signs May 2022. Ultrasound at that time showed mildly inflamed lymph nodes and thickened area of the ileum. Treated empirically on Pred which the patient responded to well initially for approx. 2 months. The past 2 months patient's condition gradually worsened (intermittent diarrhea), started Atopica 10 days ago. Patient presents today for acute vomiting and diarrhea; painful abdomen. R/O severe IBD vs. neoplasia with possible rupture vs. pancreatitis vs. other

Abnormal PE/Chem/CBC/UA Results: ALT 535, GGT 26, Cl. 106, RBC 5.35, MCV 79.6, MCH 27.1, WBC 29.69, NEU 26.37, MONO 1.65

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 4 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 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 mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 5.6 cm in length. The right kidney measured 5.2 cm in length.

The area of the aortic trifurcation was free of pathology.

The residual prostate was free of pathology.

Adrenal Glands

The bilateral adrenal glands were normal in size. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The left adrenal gland measured 1.7 cm length and 0.37 cm width in the caudal pole. The right adrenal gland measured 1.9 cm length and 0.61 cm width in the caudal pole.

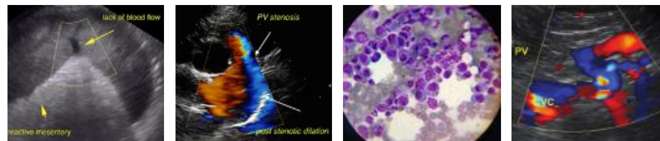
Spleen

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

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 and mild hyperechoic debris along the lumen. The cystic and common bile ducts were normal.



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Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained gastric ingesta with no signs of ileus, obstruction or foreign material. The gastric body wall measured 0.39 cm in width.

The duodenum and jejunum to the level of the ileum presented intact wall layering with generalized prominent mucosa layer including mild mucosal speckling. Moderately thickened ileum to the level of the ileocolic junction exhibiting intact yet mildly indistinct wall layering was present. The ileocolic wall measured 0.40 cm in width. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material. The duodenum measured 0.43 cm in width. The jejunum measured 0.39 cm in width.

Mildly thickened proximal to transverse colon wall exhibiting intact to indistinct wall layering and containing semi formed feces was present. The proximal colon wall measured 0.43 cm in width.

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.

Free Abdomen

Regional peri-ileocolic hyperechoic reactive to mild inflamed mesentery was present.

Intermittent, mildly prominent to enlarged colic lymph nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). An example of a colic lymph node measured 0.32 cm width.

ULTRASONOGRAPHIC FINDINGS

Primary

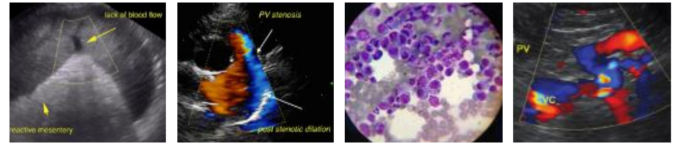
- Enteropathy with duodenojejunal mucosal speckling
- Thickened ileum/ileocolic junction and proximal/descending colon walls
- Associated primary peri-ileocolic hyperechoic mesentery with intermittent colic lymphadenopathy
- Gastric ingesta/chyme
- Non-specific subjectively benign hepatopathy
- Gallbladder debris (non-mucocele)

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The overall presentation may indicate chronic inflammatory enterocolopathy with moderate ileitis and colitis. The colic lymphadenopathy is not overtly consistent with neoplastic criteria. Potential for neoplastic infiltrative enterocolic disease cannot be definitively excluded given this presentation.

Ideally enterocolic biopsies for histopathology and definitive diagnosis is recommended. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended.

Empirically, a limited antigen or hydrolyzed diet trial, +/- prophylactic deworming (Panacur 50 mg/kg SID x 5 consecutive days with repeat protocol in 3 weeks even if fecal testing is negative), high colony count probiotic (Proviable or Visbiome) and as needed gastrointestinal support with assessment of clinical response may prove beneficial.



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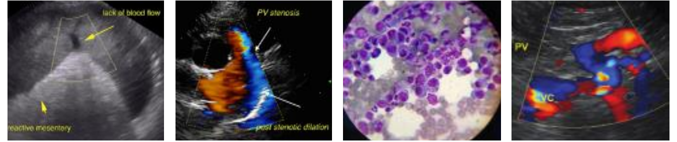

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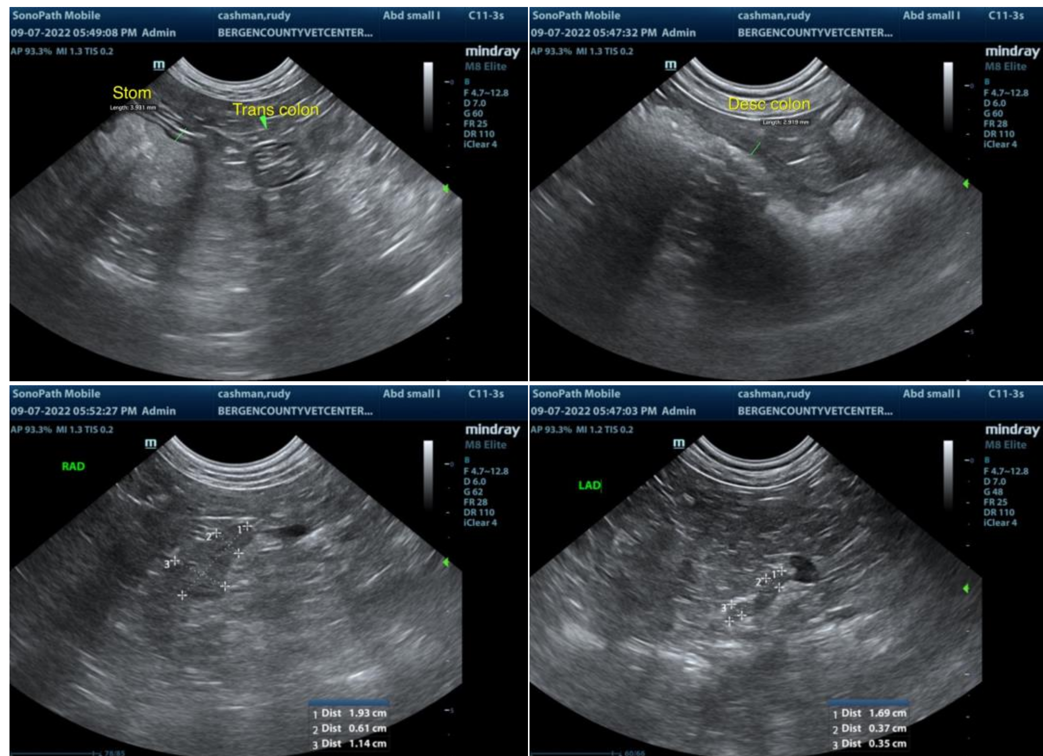

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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