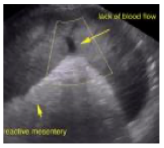
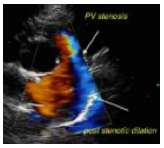
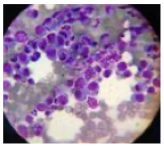
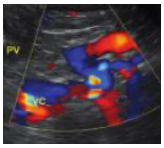
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

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

PATIENT
Pumpkin Langley

SPECIES
Canine

BREED
Pitbull Terrier

SEX
Neutered Male

AGE
4 years

WEIGHT
32 kg

INTERPRETED BY
Andrea Nicastro, DVM, Diplomate ACVIM (*Small Animal Internal Medicine*)

IMAGING PERFORMED BY
Dr Brian Barnes

HOSPITAL NAME
Westview VH

REFERRING VET
Dr Brian Barnes

INVOICE
11918

DATE
10.27.22

PRESENTING CLINICAL SIGNS

History: History of trembling started as a 1yo dog and seems to have gotten progressively worse. At times seems out of it. Dog is lethargic, anorectic, reluctant to get up walking very stiff and sore.

Abnormal PE/Chem/CBC/UA Results: CBC:Hct 35.4 (N 37.3-61.70 RDW 22.0 (N 13.6 - 21.7) WBC 66.64 (N 5.05 - 16.76) Neu 27.26 (N 2.95 - 11.64) *Band suspected Lym 11.09 (N 1.05 - 5.1) Mono 28.11 (N 0.16 - 1.12) Plt 66 (N 148 - 484) Chem:Glu 3.44 (N 4.11 - 7.95) Alkp 1062 (N 23 -212) Cl 108 (n 109-122) TT4 <6 (N 13 - 51) , Lepto negative 1) Pyrexia 2) Bilateral elbow arthritis, much worse on the right, with right elbow synovitis. 3) Subtle right stifle effusion 4) Subtle bilateral coxofemoral arthritis. 5) leukemoid reaction WBC count 6) Low platelet count, Real or clumped? 7) Trembling 8) Ataxia rear end, weak, slight CP deficit rear legs, neuro vs weakness? 9) Regurgitation

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** wall is normal in thickness and the mucosal surface is smooth. The bladder lumen is moderately distended. A scant amount of suspended, echogenic debris is observed within the lumen. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The **prostate** is normal in size (0.94 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The **left kidney** is normal size (7.54 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The **right kidney** is normal size (7.58 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The **left adrenal gland** is normal size (0.46 cm at cranial pole) (0.49 cm at caudal pole) (2.18 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The **right adrenal gland** is normal size (0.36 cm at cranial pole) (0.44 cm at caudal pole) (2.26 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The **spleen** is prominent in size (2.42 cm in width at the level of the hilus) with slightly swollenperipheral contours. The parenchyma is subtly mottled in appearance. No focal lesions are observed. Splenic vasculature is normal.

Liver

The **liver** is subjectively prominent in size with slightly swollen peripheral contours. The parenchyma is hypoechoic relative to the spleen and homogenous in appearance. No focal lesions are observed. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

The **gall bladder** is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The **gastric lumen** is moderately fluid-distended and appears hypomotile. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract appears patent. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. There is no evidence of an obstructive pattern.

Pancreas

The **pancreas** is normal in size with normal peripheral contours. The pancreatic duct is normal. The base and limbs of the pancreas are isoechoic to surrounding omental fat. No focal lesions are observed. There is no evidence of peripancreatic inflammation or effusion.

Free Abdomen

There is no evidence of free fluid. The abdominal **lymph nodes** are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The splenic parenchymal changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis, splenitis, antigenic stimulation or infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).

- Suspected gastric ileus

*An obvious cause for the patient's clinical signs is not identified in this study. Considerations include immune-mediated polyarthritis, discospondylitis, myasthenia gravis, other neurologic or orthopedic disease, occult neoplasia, tick-borne disease, other.

Secondary Findings

- The mild hepatomegaly may be secondary to vacuolar hepatopathy, infiltrative neoplasia (i.e., lymphoma), cholestatic liver disease, inflammatory disease (unlikely), other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

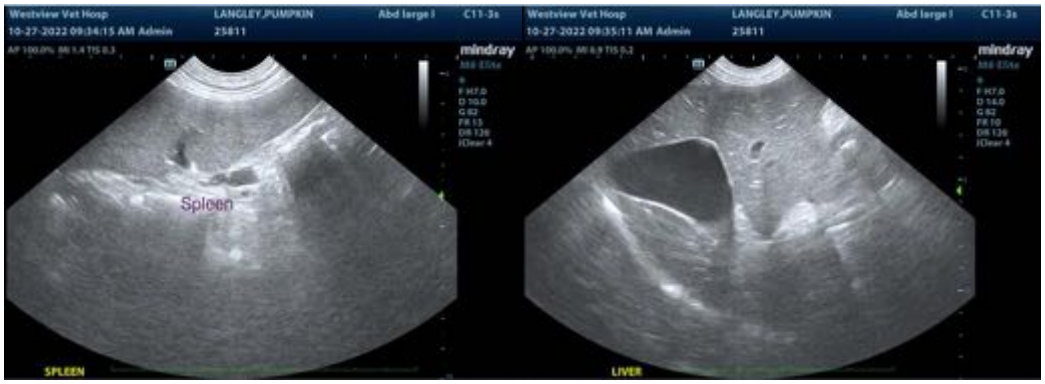
Regarding the severe ALP elevations, consider the following:

1. Pre-and postprandial serum bile acids
2. Additional testing for Leptospirosis (i.e., blood and urine PCR, serology)
3. Hepatic tissue sampling (fine-needle aspirate or surgical biopsy) if clotting status is appropriate

Regarding the fever and clinical signs, consider the following:

1. Comprehensive tick panel
2. Arthrocentesis with cytology and cultures of the joint fluid
3. Radiographs of +/- MRI of the spine
4. Consultation with a board-certified neurologist and/or surgeon
5. Echocardiogram to assess for occult endocarditis, which may be causing showering of bacteria
6. Acetylcholine receptor antibody titers to further assess for myasthenia gravis.

7. Thoracic radiographs to assess for megaesophagus, if not already performed.



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.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com