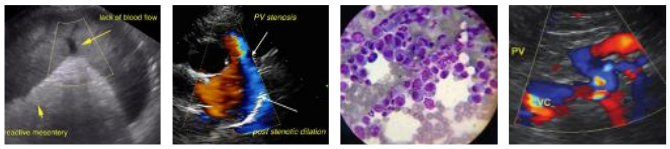
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

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

**PATIENT**

Berta Mazur

**SPECIES**

Canine

**BREED**

Terrier Mix

**SEX**

Spayed Female

**AGE**

8.5 Years

**WEIGHT**

57 Pounds

**INTERPRETED BY**

Andrea Nicastro, DMV, Diplomate DACVIM (Small Animal Internal Medicine)

**IMAGING PERFORMED BY**

Prescott

**HOSPITAL NAME**

Roundout Valley VA

**REFERRING VET**

Prescott

**INVOICE**

14060

**DATE**

10/29/21

## PRESENTING CLINICAL SIGNS

History: Pt presented 10/27 for lethargy and weakness. Was eating and drinking at this time. Pt had a fever of 104.9. In house BW revealed noisy ALT and tbili, normal Hct and low platelets. 4Dx anap +. Disc anap causing thrombocytopenia and fever vs autoimmune disease. Started on doxycycline and prednisone. Sent out anap PCR. Saw the following day for not eating and vomiting. Added cerenia and entyce. Had scheduled BW follow up this morning. Now anemic, septic changes to WBCs, platelet count still very low. ALT back to normal, tbili up to 2.5, but now BUN >130, creatinine not reading on in house machine, and phos 8.2. Saline agglutination slide positive. Definate autoimmune component, underlying cause to be determined. r/o leptospirosis, cancer, other. Anap PCR came back negative.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder, trigone, and pelvic urethra are normal in thickness and the mucosal surface is smooth. The bladder is 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 left kidney presented normal size (5.55 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. Trace pyelectasia is present. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney presented normal size (7.09 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. Renal vasculature is normal.

### *Adrenal Glands*

The left adrenal gland is normal size (0.47 cm at cranial pole) (0.69 cm at caudal pole) (1.67 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 (1.42 cm at cranial pole) (0.54 cm at caudal pole) (2.15 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 normal in size (1.20 cm at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

### *Liver*

The liver is subjectively prominent in size with normal curvilinear peripheral contours. The parenchyma is isoechoic to hyperechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions are observed. Hepatic vascular and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

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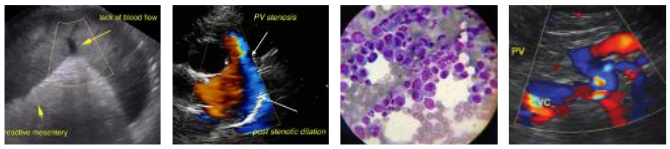

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The gall bladder is of normal contours and contains some gravity dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. The cystic and common bile ducts are normal/not seen.

### *Gastrointestinal*

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is mildly distended with ingesta. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal (xxx cm) with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. No obstructive or overt infiltrative disease is noted.

### *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*

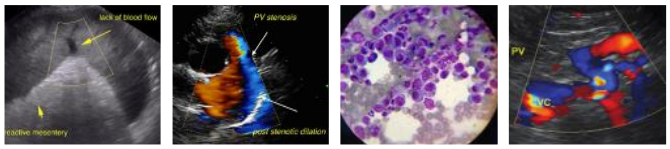
The peritoneal cavity is normal. There is no evidence of inflammation or effusion. The abdominal lymph nodes are normal/not visible.

## ULTRASONOGRAPHIC FINDINGS

- Non-specific diffuse hepatopathy. Differentials include inflammatory/immune mediated disease, hepatotoxicosis, infiltrative neoplasia (less likely), other hepatopathy.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- A comprehensive tick panel, including PCR and serology (submission to North Carolina State University's Vector Borne Disease Diagnostic Lab) is recommended. https://cvm.ncsu.edu/research/labs/clinical-sciences/vector-borne-disease.
- Leptospirosis testing (i.e., blood and urine PCR, serology) is recommended.
- Three-view thoracic radiographs should be considered to assess for occult disease (i.e., neoplasia) in the chest.
- If the patients' platelet count increases above 50,000 and the PT/PTT are normal, consider a fine needle aspirate of the liver. A 25-gauge needle should be used.
- Given the azotemia, a urine culture and sensitivity is also recommended, preferably on a pre-antibiotic sample. Also consider a baseline blood pressure measurement +/- a UPC (if proteinuria is present).
- While awaiting test results, empirical treatment for Leptospirosis (i.e., amoxicillin-clavulanic acid) and tick-borne disease, along with IV fluid diuresis to address the patients' azotemia, is

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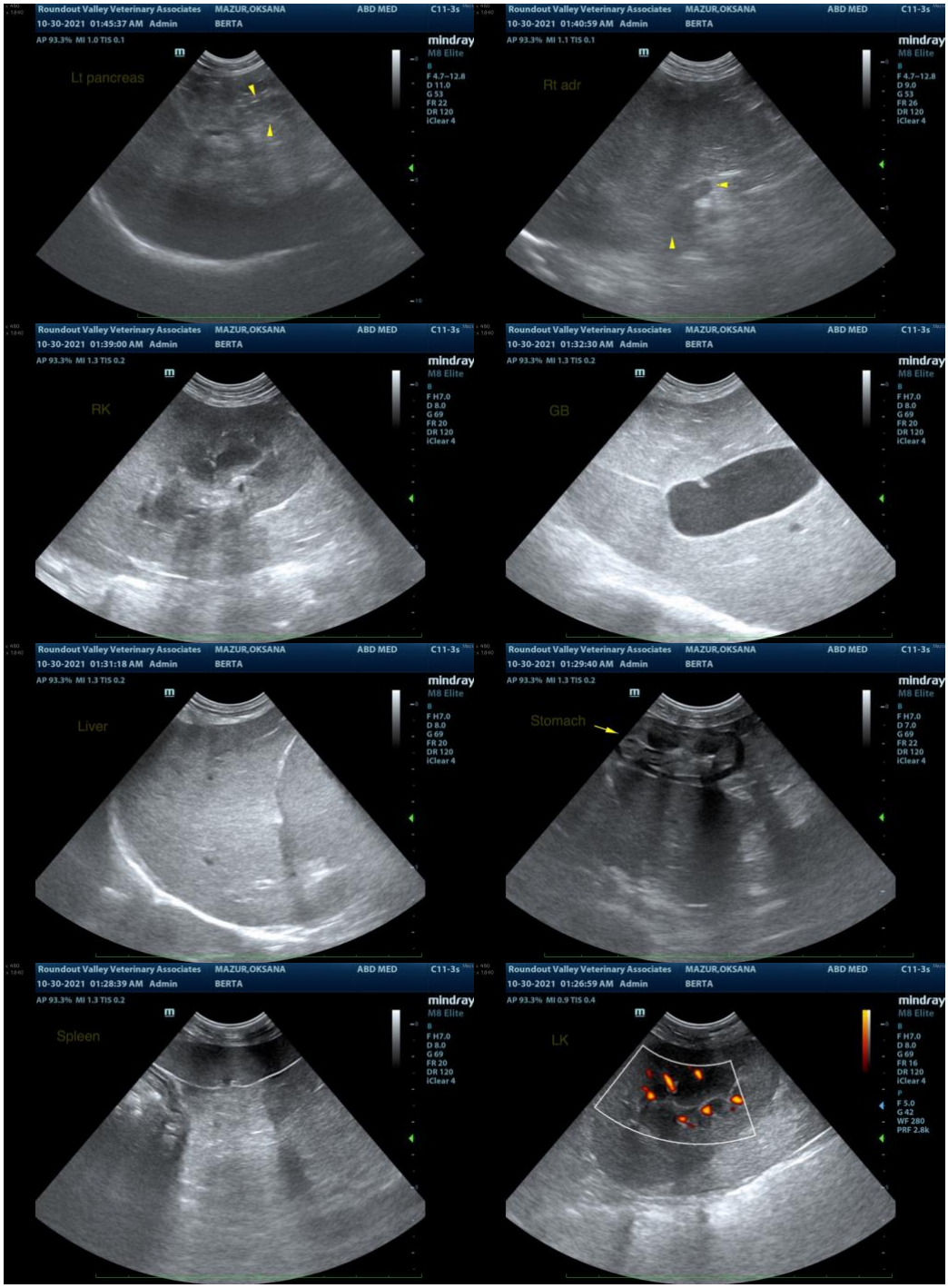
recommended.

- Given the acute onset of azotemia, urine output should be monitored to assess for oliguric and/or anuric renal failure.




**The information and recommendations provided are based on the images presented by the**

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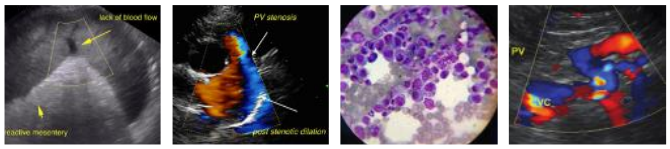


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**referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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.

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