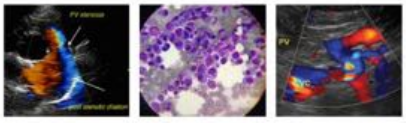


PATIENT

Obrack Cunningham
51439A

SPECIES

Canine

BREED

Labradoodle

SEX

Neutered Male

AGE

10 years, 4 mos

WEIGHT

21.2 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VET

Madison Vet Spec
Dr. McKelvey

INVOICE

11944

DATE

11.2.22

PRESENTING CLINICAL SIGNS

History: Obrack presented to the MVS Emergency Service on Nov 01, 2022, at 5:35pm for evaluation of vomiting and bloody diarrhea. Owners went on vacation with Obi to Lake Michigan this past week. Owners said that Obi licked up some seagull feces and ate some things at the lake. They returned Sunday night and Obi started having diarrhea Monday night. Owners stated that it was more blood than stool coming out, he was also straining and going every hour. This morning was when the vomiting started. Obi drank water and immediately vomited.

Abnormal PE/Chem/CBC/UA Results: Rectal: Severe hematochezia; anal sacs unremarkable and easily to express No obvious free fluid on TFAST/AFAST; suspect abnormal architecture associated with area of spleen PCV - 57% (35-55)

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 lumen is moderately distended with anechoic urine. No masses, inflammatory changes or calculi are observed. The region of the trigone and the visible portion of the proximal are normal.

The prostate is difficult to visualized due to its pelvic location. In the visualized portions, it is subjectively normal in size with homogenous parenchyma. The prostatic urethra is not overtly dilated.

The left kidney is normal in size (6.26 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 in size (5.72 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 in size (0.49 cm at cranial pole) (0.58 cm at caudal pole); 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.

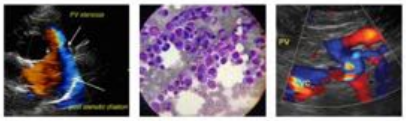
The right adrenal gland is normal in size (0.52 cm at cranial pole) (0.53 cm at caudal pole); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is overall normal in size (1.99 cm in width at the level of the hilus) with a normal capsular contour. Just cranial to the hilus, a 2.30 x 1.27 cm heterogenous mass with anechoic regions, is visualized. The lesion causes mild capsular expansion. A few, smaller, ill-defined hypoechoic nodules are also seen. The remaining parenchyma is mottled in appearance. Splenic vasculature is normal with no evidence of thrombosis.

Liver

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed.



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The gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is not distended. The gastric wall is normal in thickness with a normal layering pattern. The proximal duodenal and ileal lumen are mildly fluid-distended. The remaining small intestinal segments are empty. The small intestinal wall is normal in thickness with a normal layering pattern appropriate mural detail. The submucosal layer appears mildly thickened in some segments. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. The lumen of the descending colon is mildly fluid-distended. There is no obvious evidence of an obstructive pattern.

Pancreas

The region of the pancreas is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional inflammation or effusion.

Free Abdomen

There is no evidence of free fluid. A 0.98 cm lymph node is observed near the aortic trifurcation. A few prominent mesenteric lymph nodes are also observed, the largest measuring 2.44 cm in length. A 1.28 cm gastric lymph node is also seen.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The gastrointestinal changes are most consistent with acute gastroenteritis/colitis.
- The splenic mass is concerning for a neoplastic process (i.e., hemangiosarcoma, hemangioma, round cell tumor) with a lower possibility of benign pathology.

  *An obvious cause for the patient's clinical signs is not identified in this study. Considerations include acute hemorrhagic gastroenteritis, dietary indiscretion, infectious/parasitic disease, underlying metabolic issue, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A fecal evaluation for ova and Giardia is recommended.

Also consider prophylactic deworming with Fenbendazole.

Supportive care for acute hemorrhagic gastroenteritis is recommended, including fluid therapy, gastric protectants, antiemetics, probiotic, +/- fiber supplementation (i.e., Metamucil or Konsyl).

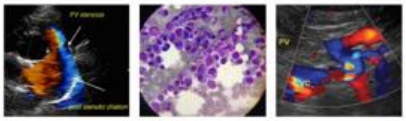
Regarding the splenic mass, consider the following:

1. Three-view thoracic radiographs are recommended to assess for pulmonary metastatic disease.
2. Consider a splenectomy with submission of the spleen for histopathology, once the patient has recovered from the current gastrointestinal episode.

IMAGING PERFORMED BY

svsimagingqc.net 309-737-3070

SVS IMAGING



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Clinical Sonography & Telecytology

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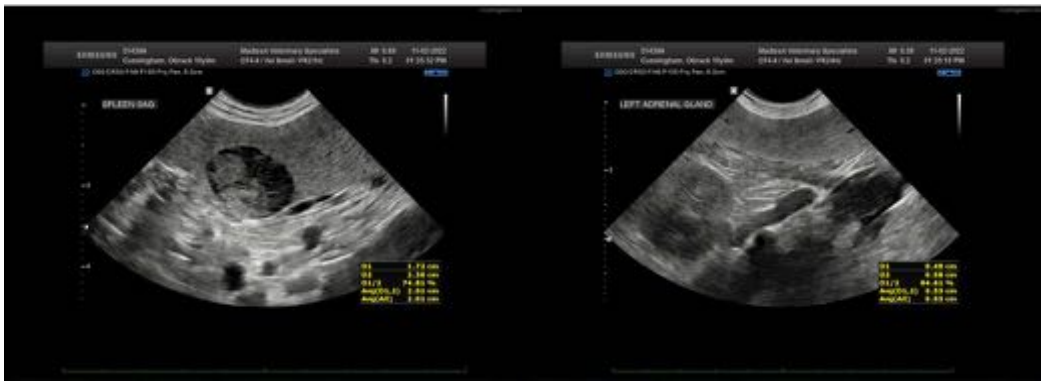
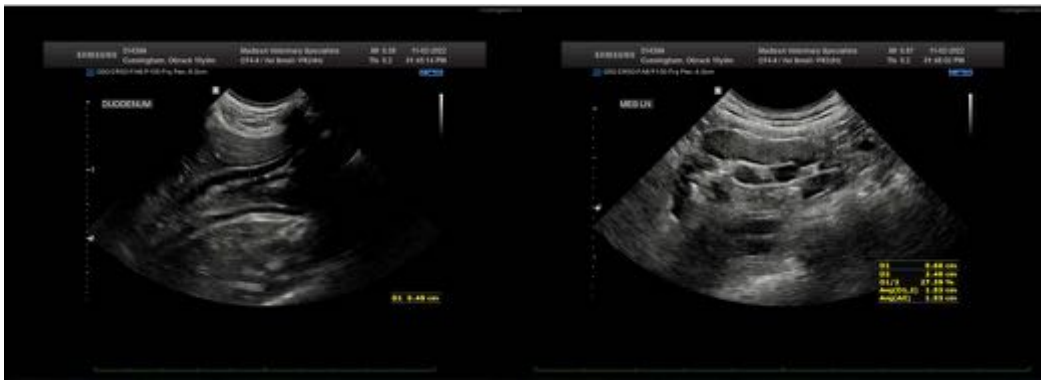
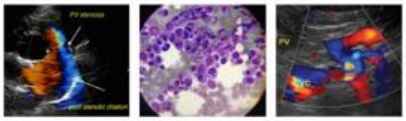




The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not



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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