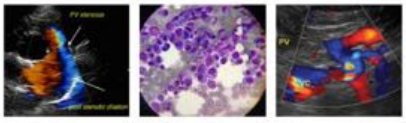




**PATIENT**

Lollipop Kempen

**SPECIES**

Canine

**BREED**

Mixed

**SEX**

Spayed Female

**AGE**

11 years

**WEIGHT**

16.9 lbs

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Kim Liedberg WVRC

**HOSPITAL NAME**

SVS Imaging WI

**REFERRING VET**

Dr. Bianco

**INVOICE**

11913

**DATE**

12.22.22

## PRESENTING CLINICAL SIGNS

History: Lollipop presents for a second opinion. 12/16- OHE performed and mammary masses removed by rDVM. Owner reports she hasn't recovered from the surgery well. The owner reports that her blood counts have been off since surgery. There is concern that she has mammary neoplasia, but the biopsies are not back yet. She has not eaten anything significant since this past Thursday. No v/d/c/s noted. Medical History: - No litters of puppies - Sees Dr. Accola, last check in June 2022: OD keratoconjunctivitis sicca - controlled, punctate cataract, nuclear sclerosis; OS transpalpebral enucleation 8/19/2021 - biopsy declined (OS corneal perforation, retinal detachment - suspect secondary to corneal perforation) Medications: - Eye medications - Oral pain medication Vaccination Status: - UTD Addendum 10am, rDVM record review: 10/20 - Presented for lump check - PE - mammary nodules - CBC - HCT 41.3%(N), MCV 60.6(L), WBC 12.69(H), Plt 333(N) - Chem - ALP 1534(H), Glob 3.7(H), Gluc 122(N) 12/16 - Presented for OHE and mammary mass removal - Pre-med with ace and hydro, induced with propofol, maintained on iso - Carprofen given SQ - Rx Carprofen 12.5mg PO q12hr for 5 days 12/19 - Presented for anorexia - PE - L axillary incison moderately swollen, no discharge/pain on palpatin - PCV/TP - 26%, 7.9 - Given SQF - Rx Entyce, Gabapentin 12/20 - Presented for anorexia and lethargy - PE - NSF - AFAST - no free fluid - CBC - HCT 19.3%(L), Hgb 7.4(L), RBC 3.45(L), , MCV 55.9(L), MCHC 28.3(H), Retic 20.1(L), WBC 30009(H), Neut 15820(H), Lymph 5.65(H), poss bands, mono 8060(H), Plt 360(H), MPV 18.7(H) - Saline agglut - negative - PCV/TP - 22%, 7.0

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder wall is distended. The wall is normal in thickness. A few cystic calculi are visualized (the largest measuring 0.65 cm in length). Luminal contents are otherwise mostly anechoic. The region of the trigone is normal.

The left kidney is normal size (4.08 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. Trace pyelectasia is present is present. A few nonobstructive nephroliths are visualized. There is no evidence of infarcts or hydroureter.

The right kidney is normal size (4.13 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. A few nonobstructive nephroliths are visualized. There is no evidence of infarcts or hydroureter.

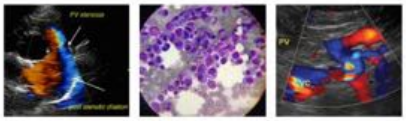
### *Adrenal Glands*

The left adrenal gland is mildly enlarged (0.46 cm at cranial pole) (0.61 cm at caudal pole) with a normal shape and 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 upper limits of normal size (0.39 cm at cranial pole) (0.56 cm at caudal pole) with a normal shape and 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 subjectively normal in size with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.





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***Liver***

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

The gall bladder lumen is moderately distended. The wall is thin and smooth. A scant amount of suspended echogenic debris is observed within the lumen. 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 not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is 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 right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely isoechoic relative to surrounding omental fat and slightly mottled in appearance. The mesentery effacing the serosal surface is mildly hyperechoic. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

***Free Abdomen***

There is no evidence of free fluid. few prominent mesenteric lymph nodes are visualized, the largest measuring 1.20 cm in length.

## ULTRASONOGRAPHIC FINDINGS

### Primary Findings

- An obvious cause for the patient's anemia is not identified in this study. Considerations include blood loss, hemolysis, infection (i.e., tick-borne), bone marrow disease, other.

### Secondary Findings

- Cystic calculi
- Bilateral chronic age-related renal changes with nonobstructive nephrocalcinosis
- Borderline bilateral adrenomegaly. This may be a normal variant for this patient or may represent early hyperplastic change.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The lymph node changes are most consistent with reactive lymphadenitis or lymphoid hyperplasia.
- Suspected benign hepatopathy. Vacuolar hepatopathy (i.e., endocrine, idiopathic) is the top differential.

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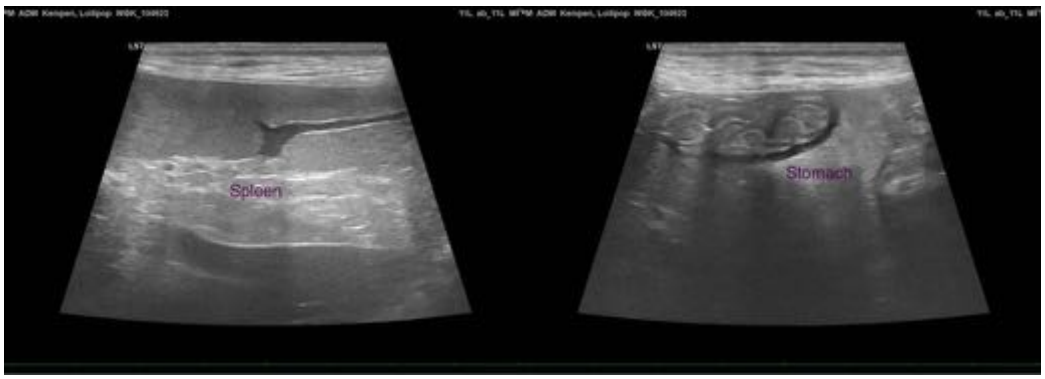
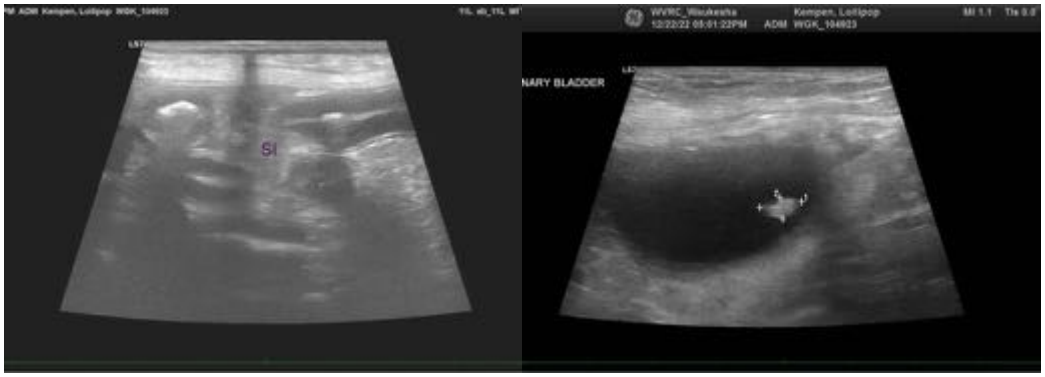
## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Regarding the anemia, a reticulocyte count is recommended to assess for regeneration. If regeneration is present, consider further evaluation for blood loss (i.e., thoracic radiographs, upper GI endoscopy to assess for a bleeding gastroduodenal ulcer).
- Other diagnostic considerations include a comprehensive tick panel +/- a bone marrow aspirate (if the anemia is nonregenerative).
- If all causes of anemia are ruled out, treatment for immune-mediated hemolytic anemia may be warranted.

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Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
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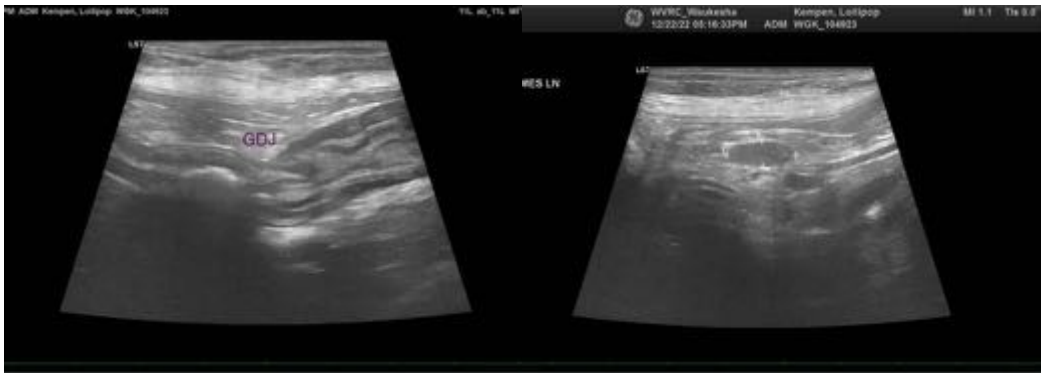


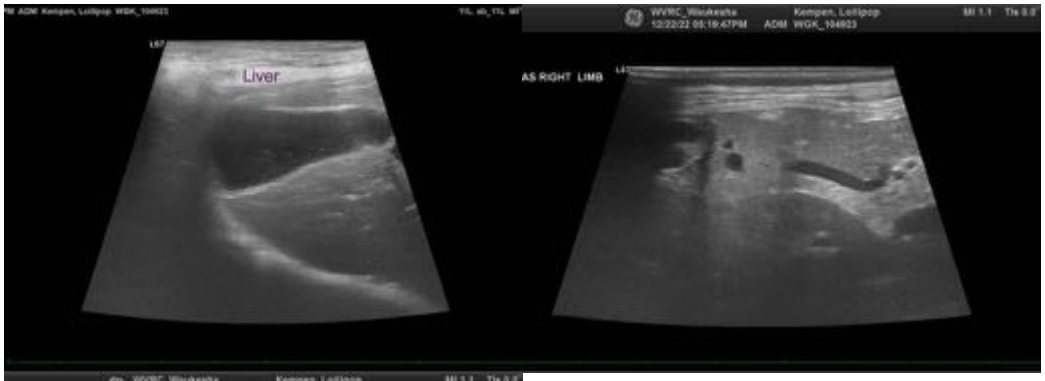


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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