SonoPath
Clinical Sonography & Telecytology
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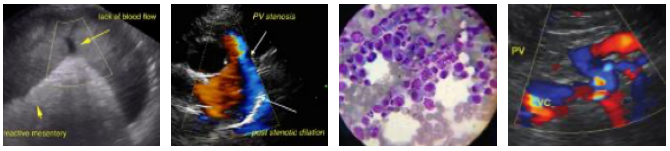

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1-800-838-4268 info@sonopath.com

PATIENT
Emma Llorens

SPECIES
Canine

BREED
Mixed cocker spaniel

SEX
Female

AGE
12 months

WEIGHT
16.1 lbs.

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

IMAGING PERFORMED BY
Dr. Ferrer

HOSPITAL NAME
Paseos VC

REFERRING VET
Dr. Ortiz

INVOICE
12958

DATE
2/7/22

PRESENTING CLINICAL SIGNS

History: Presented for an abdominal ultrasound due to recent vomiting and inappetence. PT was recently hospitalized at an Emergency clinic from 1-28-22 to 2-3-22, due to possible pneumonia, and treatment was started including antibiotics medications (metronidazole and doxycycline) and nebulization. Pt also gave birth to several puppies, but they were all dead (oxytocin was given at the EC). Pt vomited this morning and that's why the evaluation for vomiting. The entire colon is full of gas on abdominal radiographs.
Abnormal PE/Chem/CBC/UA Results: BW: done on 2-3-22 CBC: HCT: 26 (37-61) RDW: 21.9 (13-21.7) Retic 156 (10-110) PLT: 98 (148- 484) Suspect NRBC

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 mostly anechoic urine. 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 is normal size (5.14 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.

The right kidney is normal size (5.01 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 (0.34 cm at cranial pole) (0.45 cm at caudal pole) (2.09 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.

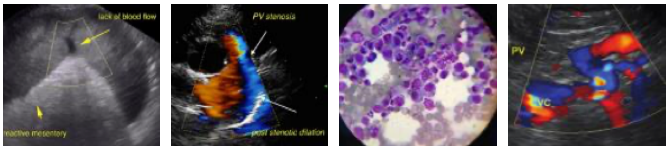
The right adrenal gland is normal size (0.42 cm at cranial pole) (0.42 cm at caudal pole) (1.63 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (1.38 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A 0.25 cm hypoechoic nodule is observed near the medial aspect. Splenic vasculature is normal.

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. The portal vein: caudal vena cava ratio is approximately 1:1. 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.



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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. No obstructive disease is noted.

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

Trace free fluid is observed. A few prominent sublumbar lymph nodes are visualized, the largest measuring 2.57 cm in length. In addition, a few mesenteric nodes are seen, the largest measuring 0.94 cm in length. A few prominent medial iliac lymph nodes are also observed.

Other

The uterine wall is diffusely thickened (up to 0.94 cm) with a normal layering pattern. Some echogenic fluid appears to be present within the lumen.

ULTRASONOGRAPHIC FINDINGS

- The uterine changes could be secondary to recent parturition. However, a developing pyometra cannot be excluded.
- The trace ascites is likely secondary to the uterine changes. However, other potential causes (i.e., increased hydrostatic pressure, low oncotic pressure or increased vascular permeability are also possible.
- The abdominal lymphadenopathy is most consistent with immunologic immaturity and/or reactive change. Infiltrative neoplasia (i.e., lymphoma) is possible but considered less likely.
- The trace pyelectasia bilaterally may be secondary to IV fluid therapy, PU/PD (if applicable) or pyelonephritis.

*An obvious cause for the patient's GI signs is not identified in this study.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given the CBC changes, a repeat CBC (send to a diagnostic lab) with reticulocyte count is recommended to confirm the anemia/thrombocytopenia. Also consider a slide agglutination test to assess for hemolysis.
- Vaginal cytology is recommended to further assess for pyometra. If cytology is consistent with pyometra, an ovariohysterectomy is may be warranted, as long as the patient's clotting status is appropriate.
- Also consider a cPLI to further assess for occult pancreatitis.

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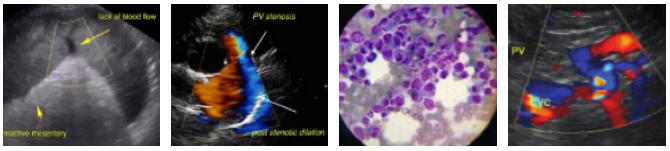

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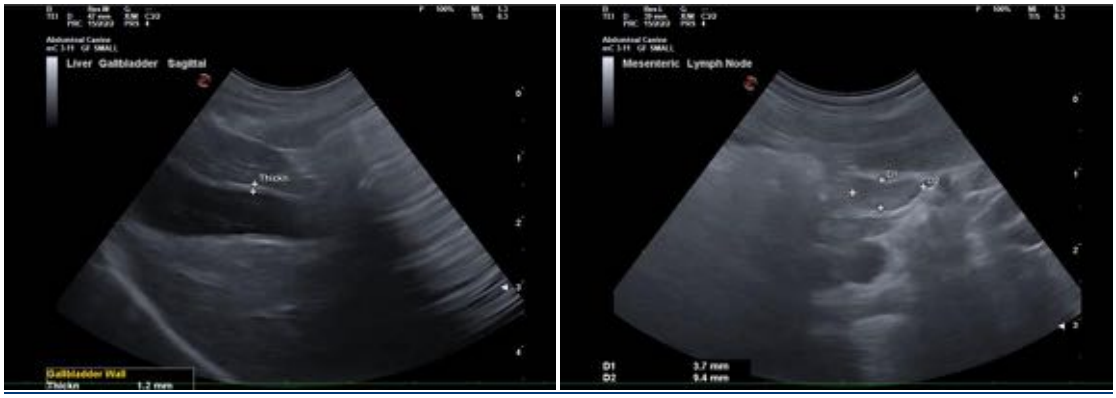

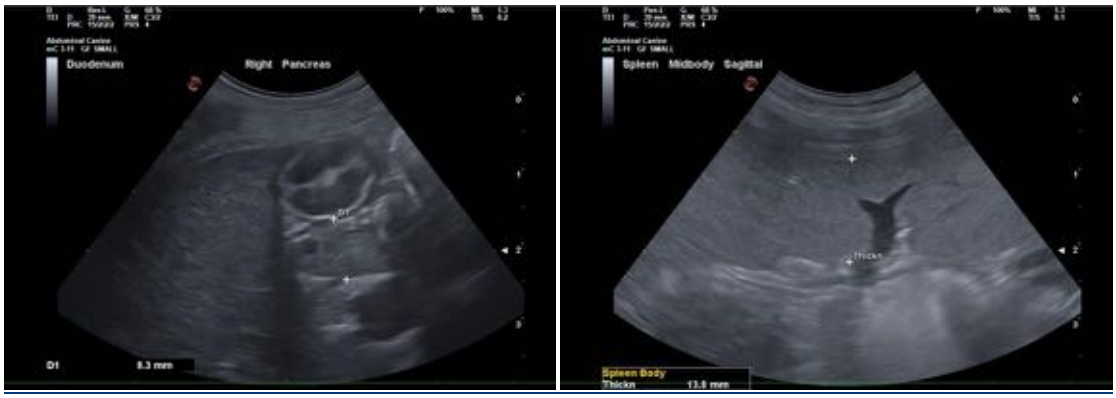

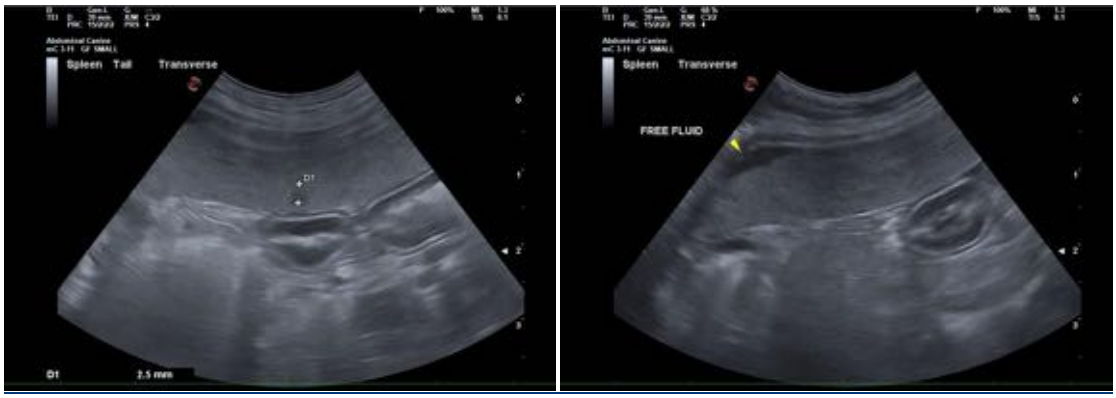

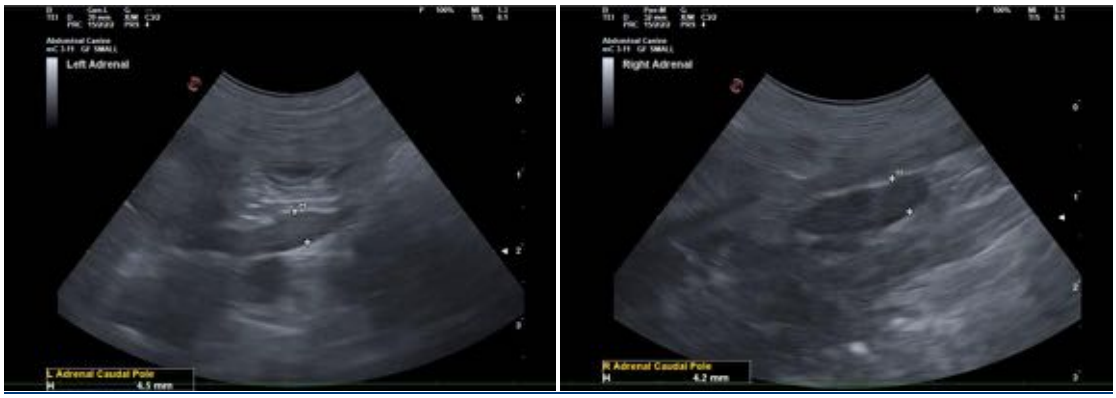

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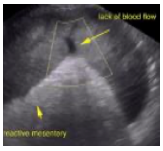
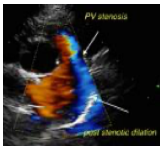
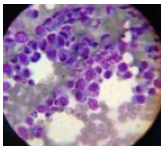
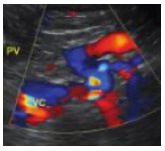

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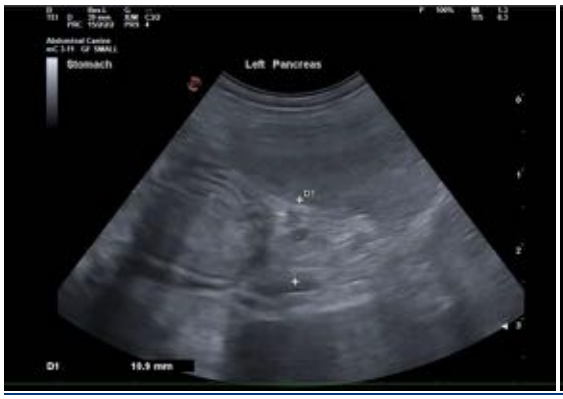

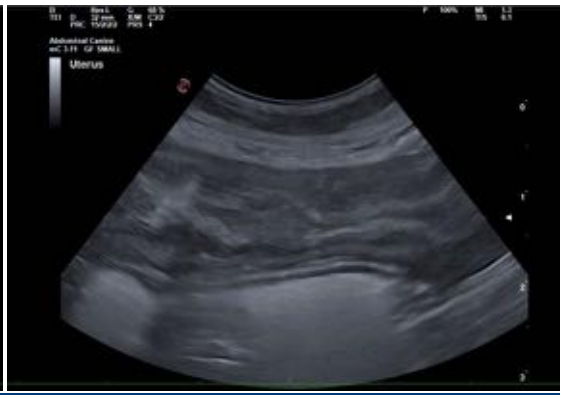

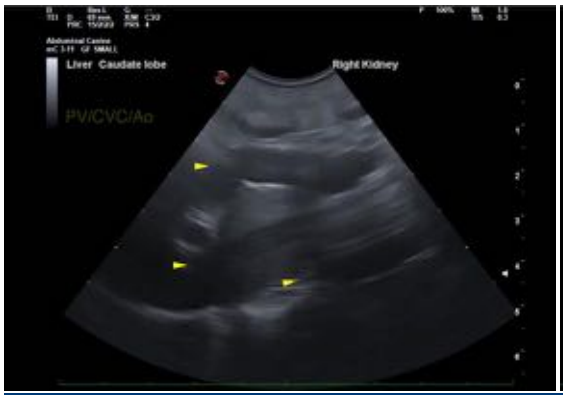

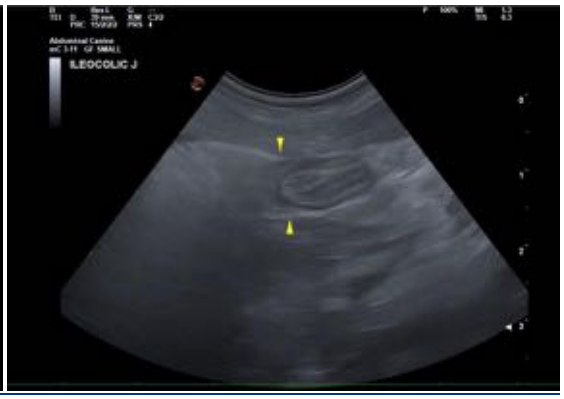

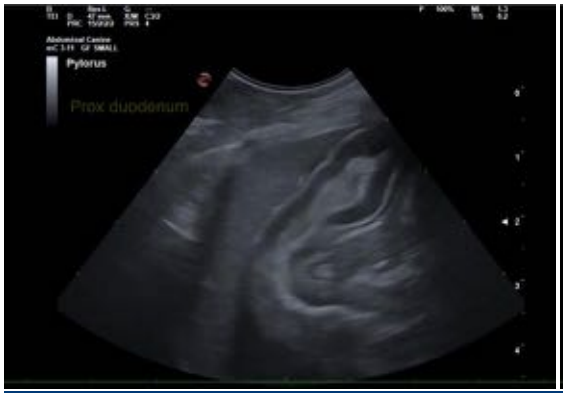

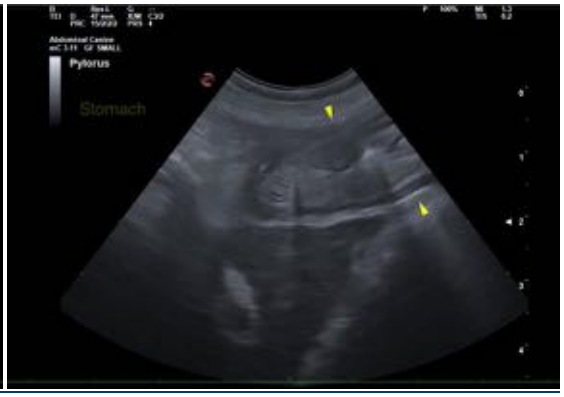

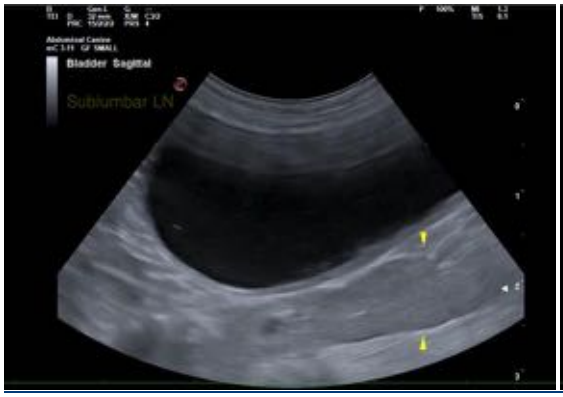

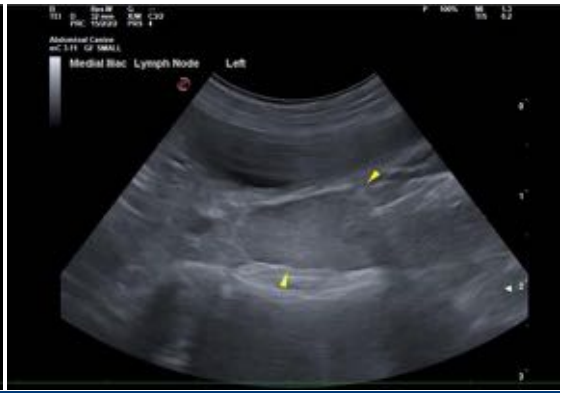

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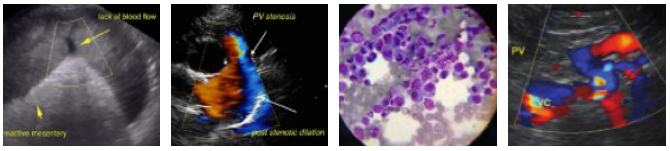

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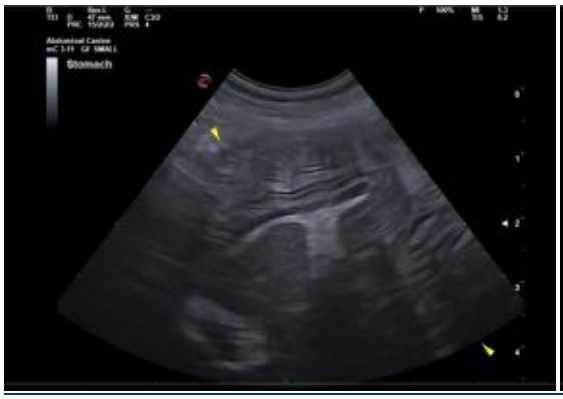

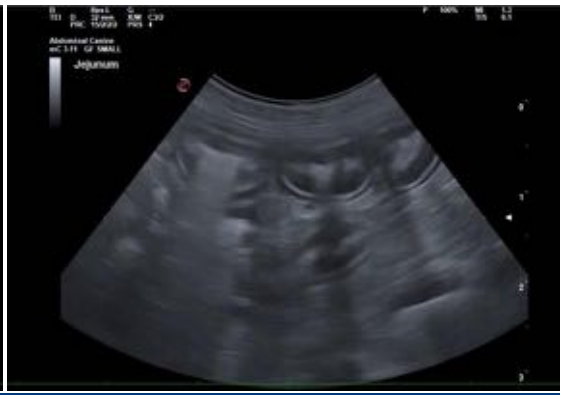

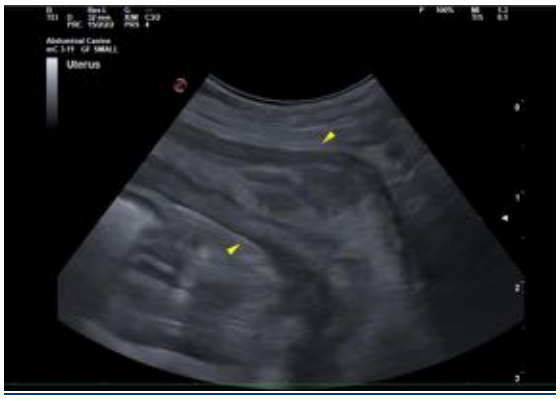

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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