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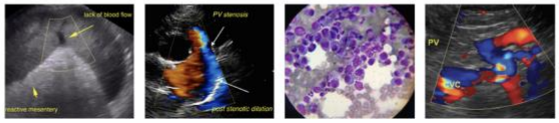


Charleston Mobile Veterinary Services
IMAGING PERFORMED BY
CharlestonMobile.Net 800.403.5408

PATIENT

Lolo Shuppy

SPECIES

Canine

BREED

Pitbull Terrier

SEX

Spayed Female

AGE

10 years

WEIGHT

27 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

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

HOSPITAL NAME

Blue Pearl Vet. Spec. ER

REFERRING VET

Dr. Huggins

INVOICE

10592

DATE

3/21/22

PRESENTING CLINICAL SIGNS

History: P had a mast cell removed from her right side over Thanksgiving - suspect low grade mast cell so took large margins when removed but no cytology sent off. 4 weeks ago P had another mast cell removed from under her right arm. Cytology confirmed it was a high-grade mast cell tumor. P was on cefalexin and gabapentin for 2 weeks - finished last Monday. Thoracic radiographs and bw were wnl 4 weeks ago prior to surgery. Friday P stopped eating and had fluid accumulating at the incision site so O took to an rdvm that sent her home with rimadyl and instructed O to warm compress the area. Saturday night P started vomiting and having soft stool. P will not eat her normal food she will only take a few bites of chicken and rice but then vomits it up a few hours later. O feels the fluid pocket is larger than it was on Friday. UTD on vax/prevention. Takes fluoxitine PRN. No allergies.

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. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal size (6.23 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (7.39 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of 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 (0.61 cm at cranial pole) (0.68 cm at caudal pole) (2.83 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.

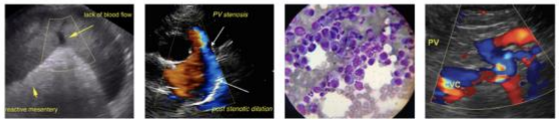
The right adrenal gland is normal size (1.13 cm at cranial pole) (0.76 cm at caudal pole) (3.00 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is subjectively enlarged with swollen peripheral contours and rounding at the poles. The parenchyma is subtly mottled in appearance. No distinct focal lesions are observed. 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



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of congestion. No pathological hepatic lymphadenopathy observed. The portal vein to caudal vena cava ratio is approximately 1: 1.

The gall bladder lumen is moderately distended. The wall is mildly thickened (0.50 cm), and edematous with a "double-walled" effect. A small amount of aggregated, echogenic to mineralized, gravity dependent debris/sludge 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 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 or overt infiltrative 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. The abdominal lymph nodes are normal/not visible.

Other

A brief echocardiogram reveals no evidence of pericardial effusion or obvious right atrial/auricular mass.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The splenic changes could be consistent with infiltrative neoplasia (i.e., mast cell tumor), extramedullary hematopoiesis, lymphoid hyperplasia, antigenic stimulation, splenitis, other. Given the patient's clinical history, nfiltrative neoplasia and extramedullary hematopoiesis are the top differentials.
- The gall bladder wall changes could be secondary to immune-mediated disease, anaphylaxis, cholecystitis, low oncotic pressure (if applicable), other. Right-sided congestive heart failure can also cause an edematous gall bladder. However, there is no evidence of right-sided chamber enlargement in this patient.
- The trace ascites may be secondary to increased vascular permeability (i.e., due to autoimmune disease), low oncotic pressure, or less likely, increased hydrostatic pressure.

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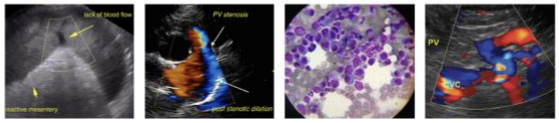

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for metastatic disease.
- A splenic aspirate can be considered if the platelet count is > 50,000. If pursued, consider a PT/PTT and buccal mucosal bleeding time prior to aspiration prior to aspiration. A 25-gauge needle should be used for the aspirate and the patient should be pre-treated with diphenhydramine (2.2 mg/kg subcutaneously 15 minutes prior to the procedure). The patient should also be closely monitored sonographically for hemorrhage for 5-10 minutes post-aspiration.
- Consultation with a board-certified oncologist is recommended for further treatment options. In the meantime, given the recent diagnosis of a high-grade mast cell tumor on the forelimb, consider initiation of an H-2 blocker and diphenhydramine along with symptomatic GI treatment and blood transfusions as needed.

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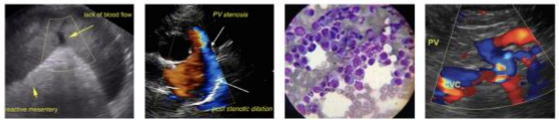

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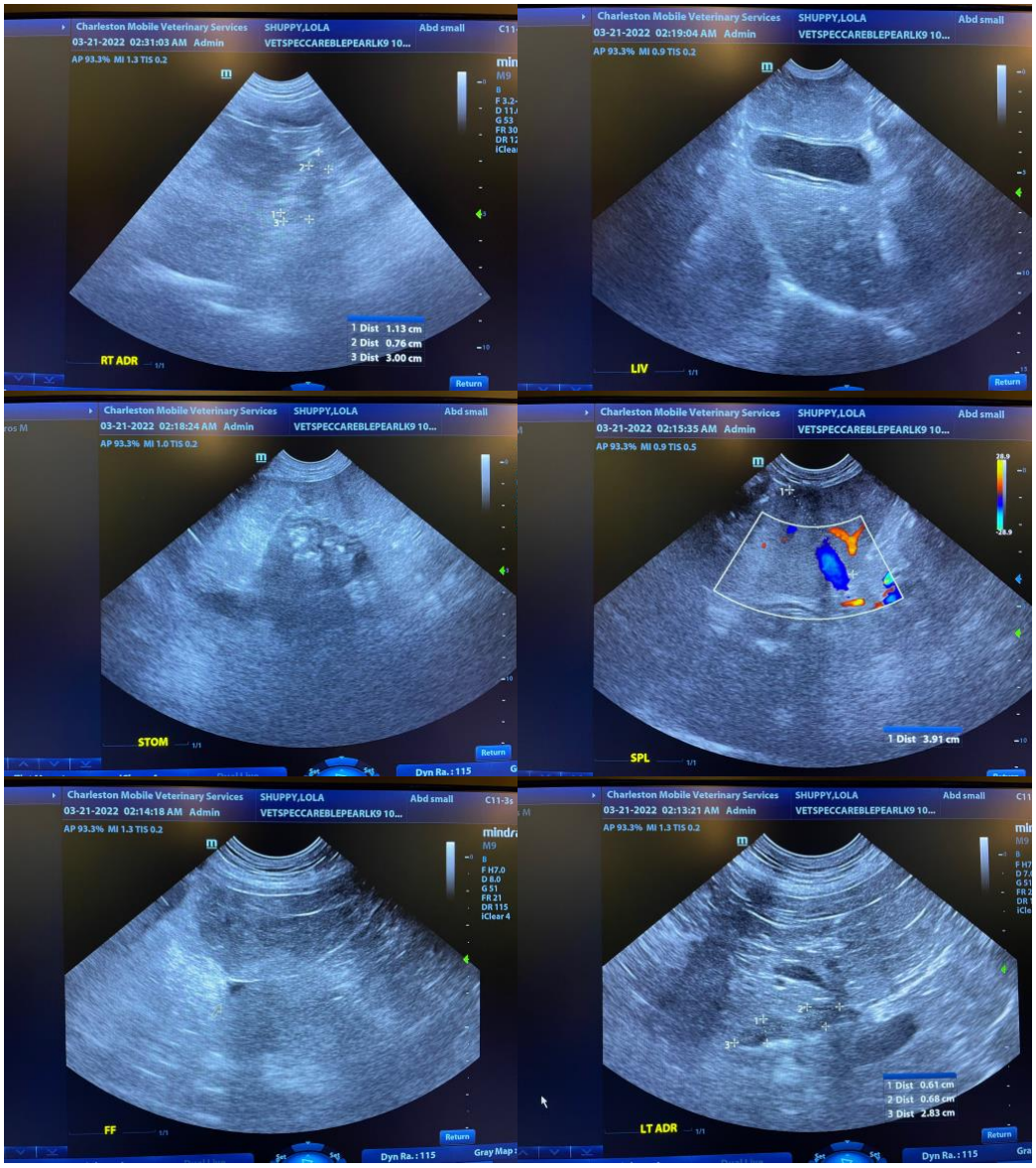

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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