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Clinical Sonography & Telecytology
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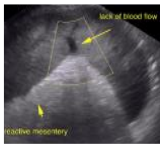
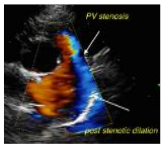
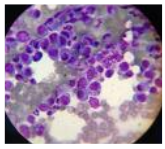
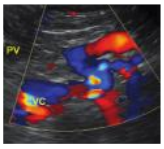

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1-800-838-4268 info@sonopath.com

PATIENT

Haze Garcia

SPECIES

Canine

BREED

Belgian Malinois

SEX

Intact Male

AGE

9 years

WEIGHT

71.2 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. G. Ferrer, DVM

HOSPITAL NAME

Paseos VC

REFERRING VET

Dr. F. Ortiz Vidal, DVM

INVOICE

10515

DATE

3/9/22

PRESENTING CLINICAL SIGNS

History: History: Patient presented on shock and painful panting and has difficulty breathing on 2-22-22. A pericardial tap was performed, and non-clotting blood was removed. The patient became more comfortable. Abdominal tap removed clear fluid - declined culture and fluid analysis for now, IV fluids - - furosemide spironolactone cefazolin cbc - ok chem - electrolyte in balance. -Radiographs: Globoid heart and severe pulmonary edema - severe ascites 4dx - positive ehrlichia but most likely this is a not active dz - once stable and with a cardiac dx will place dog on doxy prophylactically. An echo was done and showed: The cause of the clinical signs is hemorrhagic pericardial effusion. The cardiac structure and function are largely normal in this patient, ruling out CHF as a risk. The patient was in active tamponade with development of ascites, which was reportedly relieved through a pericardiocentesis.

Abnormal PE/Chem/CBC/UA Results: BW of 3-9-22: Hematocrit 34.8 (37.3 - 61.7 %) Hemoglobin 12.9 (13.1 - 20.5 g/dL) MCV 60.8 (61.6 - 73.5 fL) WBC 18.88 (5.05 - 16.76 K/µL) Neutrophils 15.46 (2.95 - 11.64 K/µL) Lymphocytes 1.69 (1.05 - 5.10 K/µL) Monocytes 1.54 (0.16 - 1.12 K/µL) Eosinophils 0.01 (0.06 - 1.23 K/µL) Basophils 0.18 (0.00 - 0.10 K/µL) Platelets 435 (148 - 484 K/µL) CHEM: Glucose 187 (70 - 143 mg/dL) BUN 49 (7 - 27 mg/dL) Sodium 132 (144 - 160 mmol/L) Potassium 7.0 (3.5 - 5.8 mmol/L) Chloride 107 (109 - 122 mmol/L)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder and visible portion of the pelvic urethra are normal for the degree of luminal distension. The urine is anechoic with no evidence of debris. The mucosal surface is slightly irregular. Cystic calculi and discrete masses are not observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The prostate is enlarged (3.42 cm in width), with a slightly irregular shape. The parenchyma is hyperechoic relative to surrounding omental fat and slightly heterogenous in appearance. No distinct focal lesions are observed. The prostatic urethra is not overtly dilated.

The left kidney is normal size (7.07 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.

The right kidney is normal size (6.96 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.

Adrenal Glands

The caudal pole of the left adrenal gland is well visualized and is normal size (0.74 cm in width), with a normal shape, glandular echogenicity and detail. The phrenicoabdominal vein and surrounding vasculature are normal.

The caudal pole of the right adrenal gland is visualized and is mildly enlarged (0.97 cm in width) with a normal shape, glandular echogenicity and detail. Surrounding vasculature appears normal.

Spleen

The spleen is normal in size (1.48 cm in width 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.

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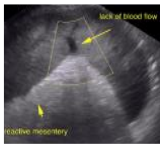
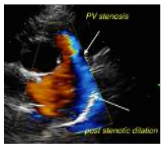
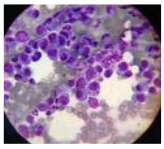
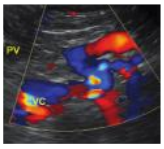

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Liver
The liver is subjectively prominent in size with slightly swollen peripheral contours. The parenchyma is isoechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion. The gall bladder lumen is moderately distended. The wall is thin and smooth. A small amount of aggregated echogenic partially dependent debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

The gall bladder lumen is moderately distended. The wall is mildly thickened (up to 0.17 cm), and hyperechoic. A small amount of mostly gravity dependent echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal
The gastric lumen is mildly distended with ingesta. The gastric wall is 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
A moderate amount of slightly echogenic free fluid is observed. The mesentery throughout the abdomen is mildly hyperechoic. One to two prominent sublumbar lymph nodes are visualized, the largest measuring 2.93 cm in length.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- An obvious cause for the ascites is not identified in the abdomen. The top differential is ascites secondary to cardiac tamponade/pericardial effusion, although other causes (i.e., increased vascular permeability or low oncotic pressure (if applicable)) should also be considered.

Secondary Findings

- Minor age-related renal changes.
- Mild right adrenomegaly.
- Suspected benign diffuse hepatopathy (i.e., vacuolar hepatopathy, regenerative nodular hyperplasia and/or passive congestion).
- The gall bladder wall changes could be consistent with cholecystitis and/or benign age-related hyperplasia. Correlation with clinical findings is recommended.
- The prominent sublumbar lymph nodes are likely reactive.
- The prostate changes are most consistent with benign prostatic hyperplasia. Bacterial prostatitis is also a differential but considered unlikely in the absence of lower urinary tract signs.

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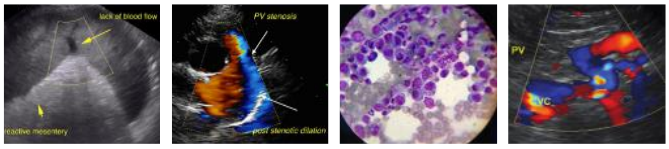

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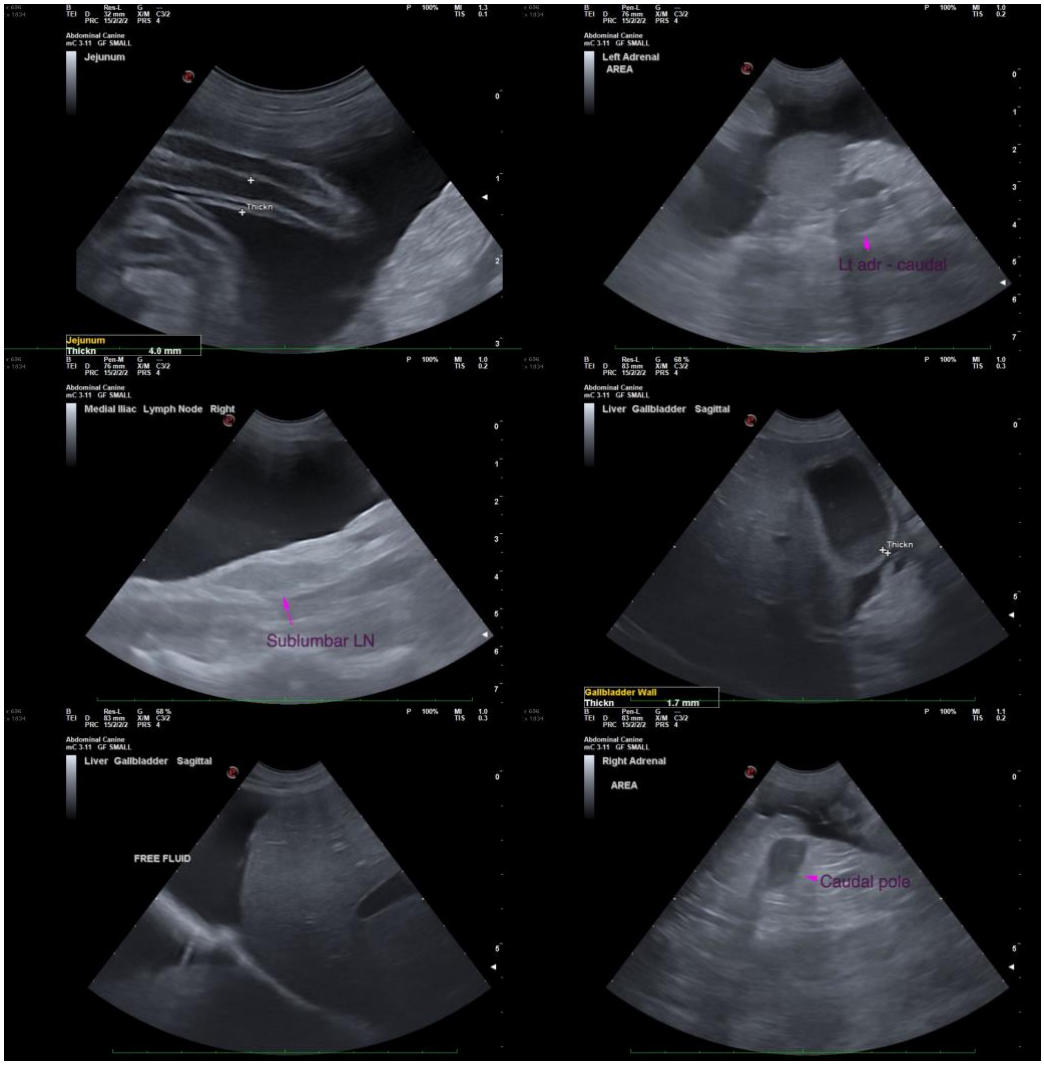
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- A recheck abdominal ultrasound is recommended at the time of a recheck echocardiogram (see cardiologist report) to determine if the ascites has resolved.
- Given the electrolyte derangements, repeat bloodwork is recommended to determine if these changes are persistent.



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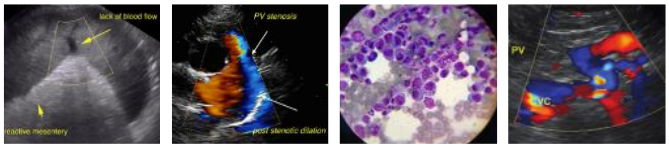

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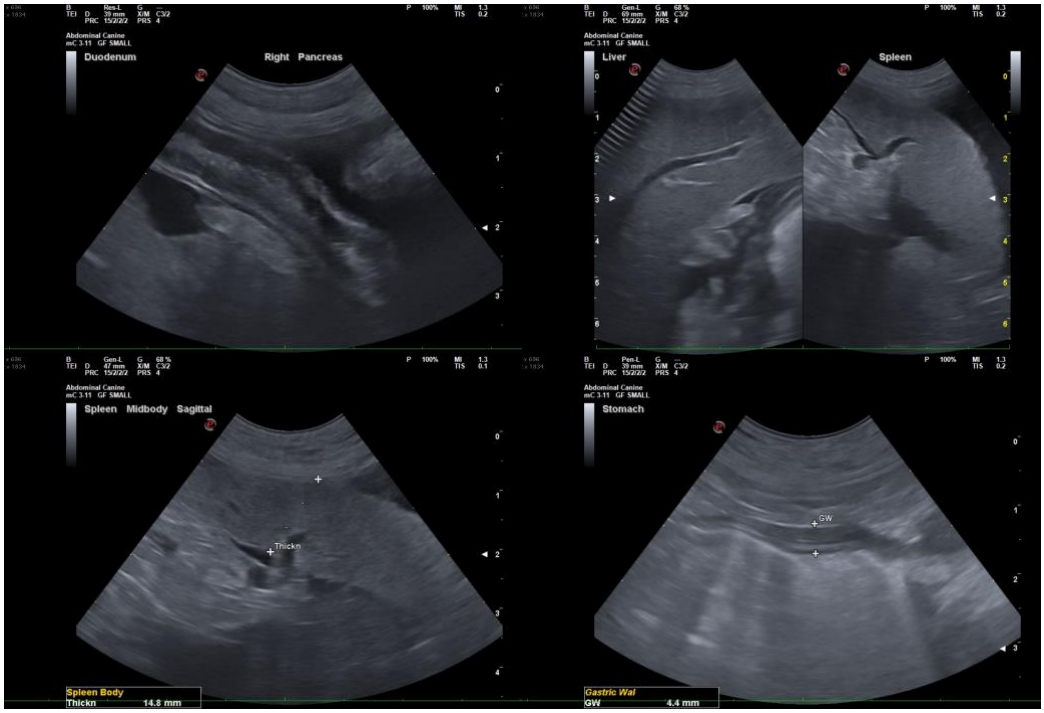

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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