

**DATE PRESENTING CLINICAL SIGNS**

5/11/22

**PATIENT**

Pepper Vittek

**SPECIES**

Canine

**BREED**

Golden retriever

**SEX**

Female, spayed

**AGE**

4/15/2012

**WEIGHT**

79.7 lbs.

**INTERPRETED BY**

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

**HOSPITAL NAME**

Animal Emergency  
Hospital

**REFERRING VET**

Dr. Thompson

**INVOICE**

13362

History from ER Express: Pepper was seen at Fallston vet on Monday 5/2 for a suspicious sore on her front leg. A needle biopsy was inconclusive. On Fri 5/6 she started to become lethargic and listless. Sunday she slept most of the day, didn't eat her evening meal, but was drinking. Monday 5/9 took her to Dr Lomax again. Temp was 103.1, physical exam otherwise unremarkable. Vet offered her some canned dog food which she ate a small amount of reluctantly. Blood was drawn and results were normal. However, Pepper remains listless, seems weak. Won't jump up onto sofa which is wear she often sleeps. Temp at 130 pm was 104.5. Spoke to vet at Fallston who recommended she get an X-ray. However, their machine is not working. Suggested we bring her to pet er. Continues to drink, but will only eat a tablespoon or two of food. Date: 05-10-2022 Notes: Pepper is a 10 y/o FS Golden Retriever who presents for fever and anorexia - had an FNA of skin mass on 5/3 which was inconclusive - 2-3 days ago stopped eating, acting more lethargic - no C/S/V/D - Eye discharge started today

Current Medications: Buprenorphine, Cerenia, Triple Antibiotic Ophthalmic Ointment.

Lab Results: USG 1.010, no proteinuria, inactive sediment, normal PCV, 4DX negative

Radiographs: Xray Thorax 3 view- subjectively normal heart, no overt pathology, unremarkable thorax. Xray Abdomen 2 View- no overt FB or obstructive pattern, no overt masses, loss of detail mid abdomen, large full urinary bladder.

Date of Previous IntraPet Ultrasound: No previous.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

Imaging Performed By: Andi Parkinson, RDMS.

**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 is normal.

The left kidney is normal size (7.82 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney is normal size (7.43 cm in length) with a slightly irregular shape. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths or hydroureter.

**Adrenal Glands**

The left adrenal gland is normal size (0.79 cm at cranial pole) (0.69 cm at caudal pole) (2.41 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 (0.90 cm at cranial pole) (0.75 cm at caudal pole) (2.81 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 (1.93 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.

### *Liver*

The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen and homogeneous in appearance. There is an increase in portal markings. 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. Luminal contents are anechoic. 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 minimally fluid 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*

An approximately 5 cm ill-defined area of reactive mesentery is observed in the sublumbar region. There is no evidence of free fluid. A few prominent jejunal lymph nodes are visualized, the largest measuring 2.81 cm in length. The nodes are normal in shape and echogenicity. Surrounding mesentery is hyperechoic.

### *Other*

A brief echocardiogram reveals no evidence of pericardial effusion.

## **ULTRASONOGRAPHIC FINDINGS**

### **Primary Findings:**

- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- The significance of the reactive mesentery in the caudal abdomen is unclear. It is suggestive of a focal peritonitis, albeit of unknown cause.

### **Secondary Findings:**

- Bilateral, age-related renal changes.
- The increase in hepatic portal markings could be consistent with an inflammatory hepatopathy or may be a normal variant for this patient. Correlation with the patient's bloodwork is recommended.

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

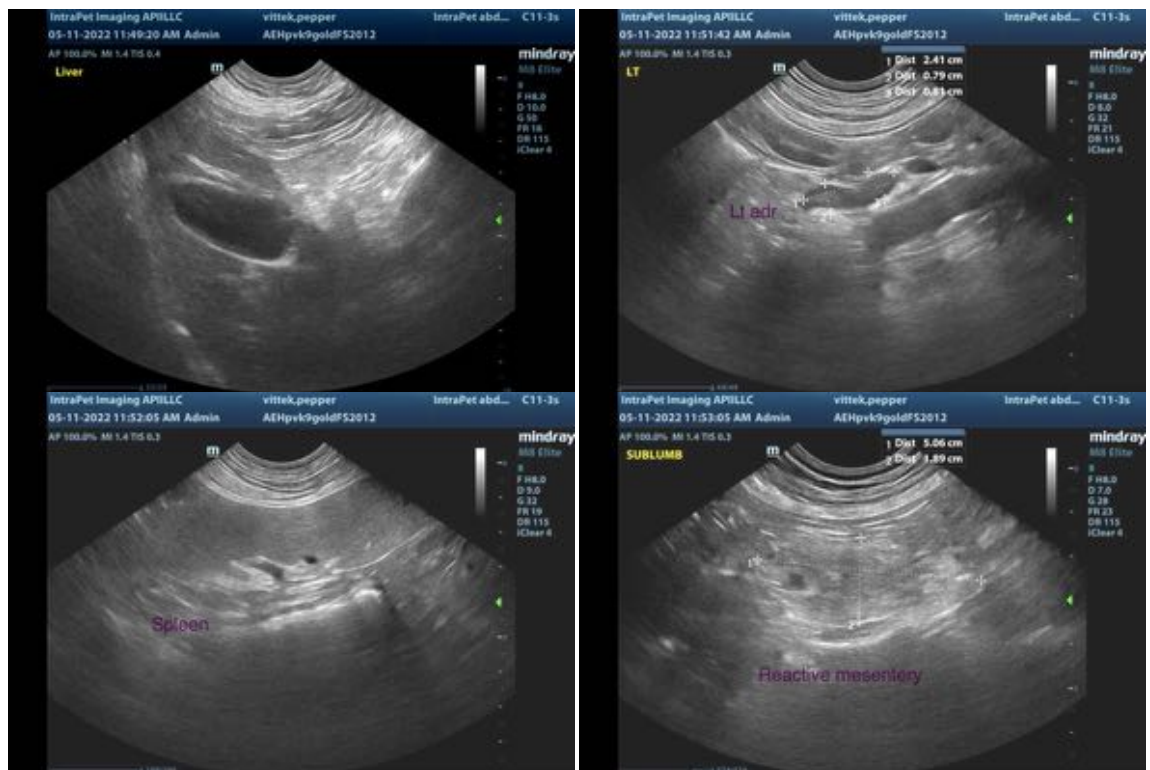
## **INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

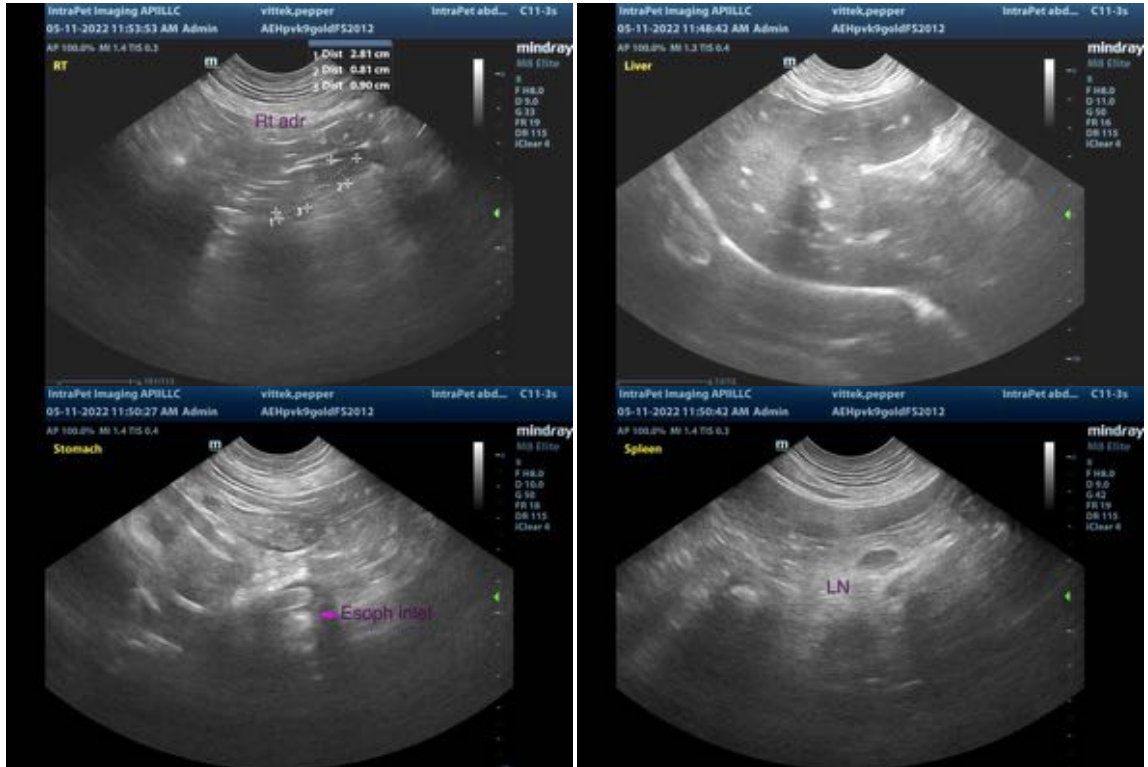
Further workup for fever of unknown origin could include the following:

- Urine culture and sensitivity.
- Full echocardiogram to assess for valvular endocarditis.
- Further testing for tick-borne disease (send to NC State Vector Borne Disease Lab).
- Thorough orthopedic and neurologic evaluations are recommended to assess for non-metabolic causes for the patient's clinical signs.
- If the above diagnostics are inconclusive, joint +/- spinal taps may be warranted to assess for immune mediated polyarthritis and meningitis, respectively.

Regarding the reactive mesentery in the caudal abdomen, consider a recheck ultrasound in 2-3 weeks to assess for resolution/progression.

If the skin lesion on the leg is still present, consider biopsy.





The information and recommendations provided are based on the images presented by the referring veterinarian. 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 ACVIM (*Small Animal Internal Medicine*)  
Andrea.nicastro@sonopath.com