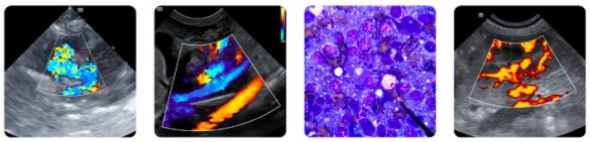


PATIENT

Spark McNeal

SPECIES

Canine

BREED

Jack Russell Terrier

SEX

Neutered Male

AGE

12

WEIGHT

10.5 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Meghan Myers

HOSPITAL NAME

Hershey AEC

REFERRING VET

Dr. Cara Sinopoli

INVOICE

23099

DATE

6-1-26

PRESENTING CLINICAL SIGNS

History: Presented 5/31 for fever, ADR, lethargic, not eating since dental surgery 1 week ago. Dental procedure 1 week ago, 11 extractions. Rescued 2 years ago.
PE: EENT/oral: pale pink moist mm, crt <2s
H/L: Grade IV/VI SHM, No a, ss pulses, clear lung sounds, eupneic
LN: No evidence of lymphadenopathy
Abd: Bloated abdomen, difficult to perform deep palpation, painful on palpation, right inguinal hernia present with suspected intestinal loop - non-painful on palpation
U/G: WNL
Musc: mild muscle wasting hindlimbs, no lameness
Integ: Healthy coat; no abnormalities
Neuro: No CN/CP deficits, normal mentation, mild ataxia/weakness
5/16 RDVM
Fecal: neg,4DX: Neg,CBC: NSF
Chem: ALP 321 H, glob 4.8 H
5/31 HAEC
Rads:
– Transient herniation of a small intestinal segment into the inguinal region
– Mild, diffuse bronchointerstitial pulmonary pattern
– Mild, diffuse hepatomegaly. The hepatomegaly is non-specific; hepatomegaly can be secondary to benign etiologies however malignant etiologies cannot be completely excluded.
– Nonobstructive GI content

Abnormal PE/Chem/CBC/UA Results: EPOC: PO2 139.2, CSO2 99.4, PCO2 24.9, PH 7.482, HCT 32 CBC: 33.5, HGB 12.7, MCV 57.8, LYM 0.72, EOS 0.01, PLT 17, MPV 20.5, PLCRT 0.03 invue: HCT 33.5, %IMM.NEU 8.1, IMM.NEU 0.52, LYM 0.51, PLT <50 K/uL (L) PCV/TS: 35/6.6 (clear) EPOC: HCT 31% L, pH 7.466 H, pCO2 29.2 H blood smear path review: adequate to mild decrease in erythrocyte density, mild inflammatory leukogram with a mild left shift and mild toxic change and lymphopenia, thrombocytopenia plt est. 30-60K PT/PTT: 18.7 H/115.1 N - NSF BP: 197/128 (141), 183/120 (135), 182/124 (137), 174/106 (117), 197/130 (146)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

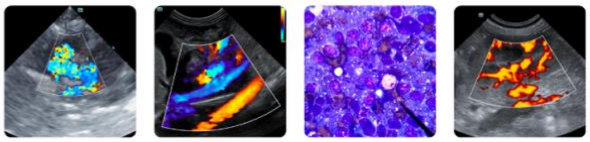
Urinary System

The urinary bladder wall is normal in thickness. The mucosal surface is smooth. The bladder is moderately distended. Luminal contents are mostly anechoic. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The prostate is prominent-in-size (1.54 cm in width) with smooth peripheral contours. The parenchyma is homogenous. The prostatic urethra is mildly dilated. No obvious intraluminal obstructions are seen.

The left kidney is normal in size (5.22 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild- to moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal in size (5.49 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. Trace pyelectasia is present. There is no evidence of infarcts or hydroureter. Renal vasculature is normal.



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Adrenal Glands

The left adrenal gland is normal in size (0.50 cm at cranial pole) (0.57 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 normal in size (0.90 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 normal in size (1.15 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 normal- to slightly prominent-in-size with smooth peripheral contours. The parenchyma is hypoechoic relative to the spleen and heterogenous in appearance, with ill-defined hyperechoic nodules/areas (the largest measuring 3.3 x 2.9 cm (right side)). Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

The gallbladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are mostly anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is moderately-distended with ingesta, consistent with a post-prandial presentation. 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 is normal in thickness 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 base and limbs of the pancreas are visible with normal curvilinear peripheral contours. The parenchyma is largely hyperechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion. (See also “Other” category).

Lymph Nodes

(See “Other” category).

Free Abdomen

Trace free fluid.

Other

In the cranial- to mid-abdomen, just caudal to the stomach, a 1.4 x 0.9 cm hypoechoic oval structure is visualized.

ULTRASONOGRAPHIC FINDINGS

- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

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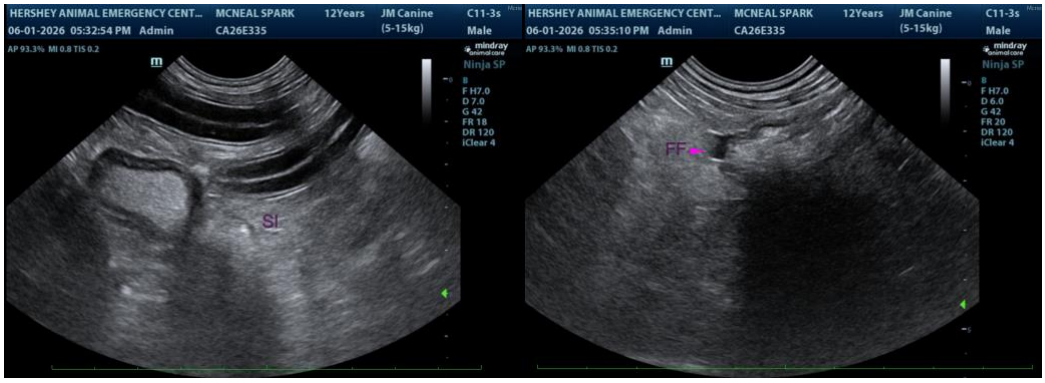
- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory disease, infiltrative neoplasia and other hepatopathies are considered less likely. However, correlation with the patient's liver values is recommended.
- Bilateral nonspecific age-related renal changes with dystrophic mineralization and trace right pyelectasia
- The hypoechoic structure in the cranial- to mid-abdomen may represent a prominent lymph node, nodule within the pancreas, other.
- Trace ascites
- The mild prostatomegaly could be consistent with late-in-life neutering (if applicable), prostatitis, emerging prostatic neoplasia (i.e., adenoma, transitional cell carcinoma), other. Correlation with the patient's clinical history is recommended.

*An obvious cause for the patient's fever and thrombocytopenia is not identified in this study. Considerations include tick-borne disease, autoimmune disease, occult neoplasia, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- A CBC with clinical pathology review is recommended (if not already performed).
- Given the anemia, a reticulocyte count and slide agglutination test should be considered.
- A comprehensive tick panel, including PCR and serology (submission to North Carolina State University's Vector Borne Disease Diagnostic Lab is recommended. https://cvm.ncsu.edu/research/labs/clinical-sciences/vector-borne-disease)
- Depending on the results of the above diagnostics, a bone marrow aspirate may be indicated. In the meantime, symptomatic care is recommended.
- Regarding the prostatomegaly, consider a urine BRAF test for further evaluation, particularly if the suspicion for neoplasia is high.



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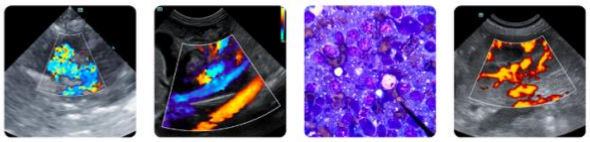

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Educational Teleconsultation Services™

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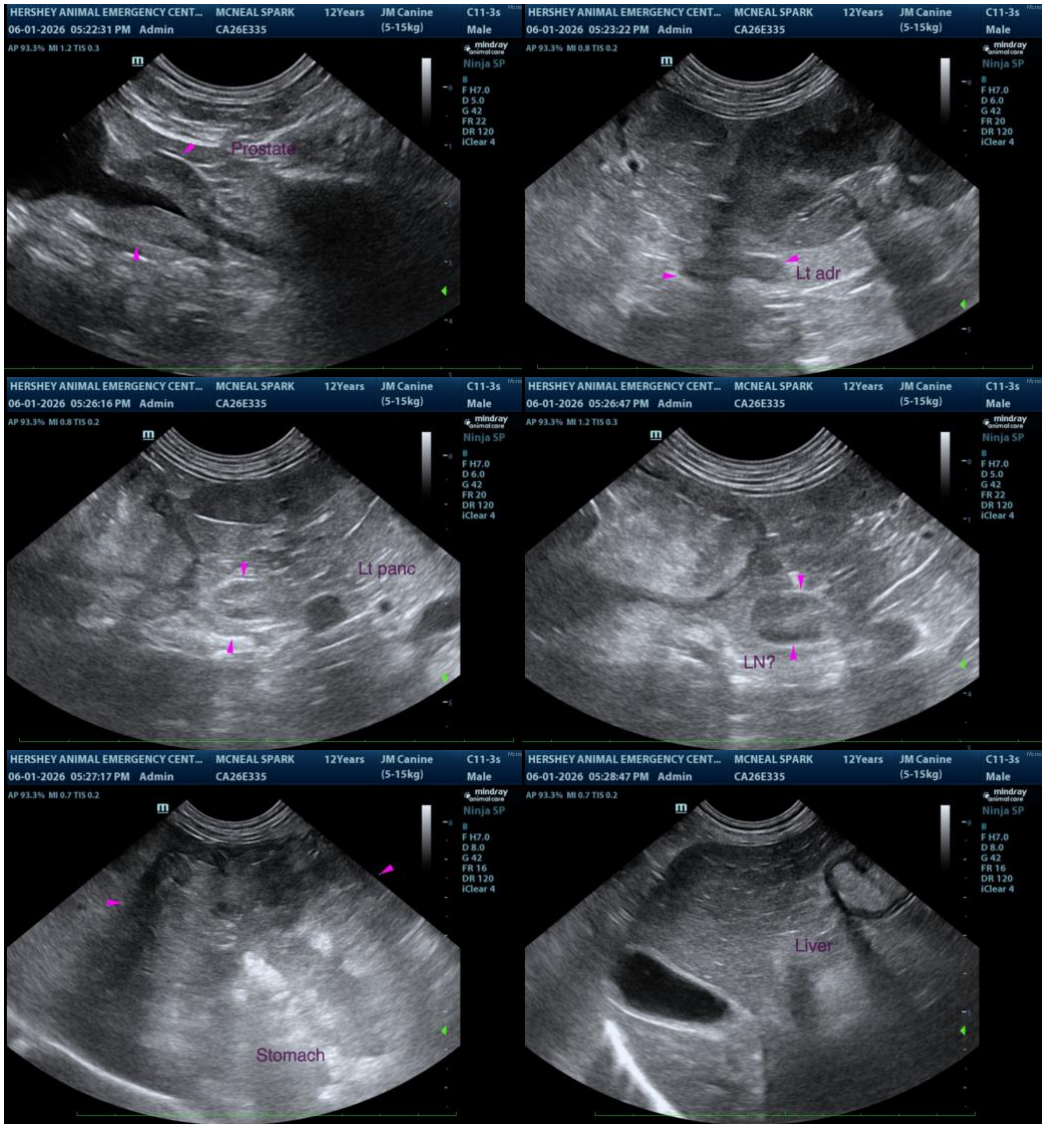

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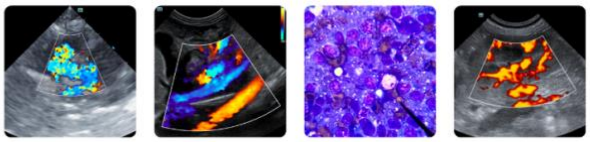

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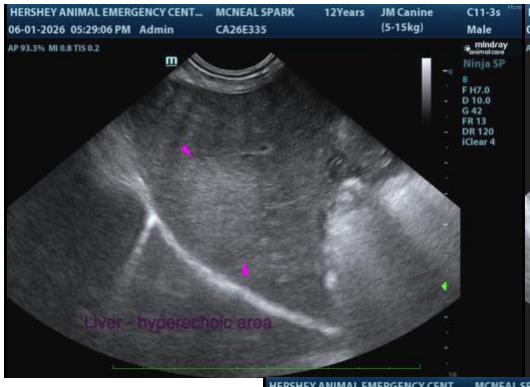

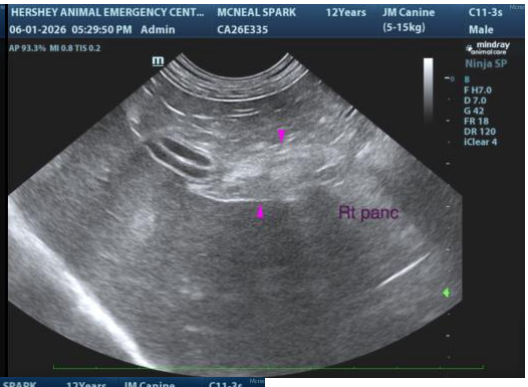

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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