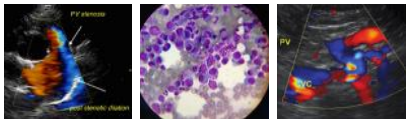
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
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DATE

6.20.2022

PATIENT

Jupiter Stocki

SPECIES

Canine

BREED

Pitbull

SEX

Spayed Female

AGE

1/1/2016

WEIGHT

51.4 lbs

INTERPRETED BY

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

HOSPITAL NAME

Animal Emergency Hospital

REFERRING VET

Dr. Thompson

INVOICE

11114

PRESENTING CLINICAL SIGNS

Jupiter is a 6 y/o FS pitbull who was referred for continued care - has been showing signs of heat 3 times in the last 5 months - dx with UTI at RDVM, concern for uterine horn remnant/stump pyometra, vs pyelonephritis - lethargic - waxing waning appetite, eating every other day - trying to vomit with no production - hard time keeping eyes open, more red - 4-5 days history, worse since first noticed - vomited breakfast and bone broth, mostly non-productive - was on supplement for yeast, stopped 3 days ago - no know FB ingestion or toxin, mammary mass noticed Wednesday and has grown rapidly
- recent CXR, AXR, at RDVM, BW showed mild elevation in ALT 146, Leu 18k Neutrophils 16k Medications:
- none, preventatives none

Current Medications: Metoclopramide, Ampicillin, Cerenia, Buprenorphine.
Radiographs: bone material in pylorus, mild gas/ fluid distension of stomach, otherwise no obvious foreign material or obstructive pattern. AFAST- no obvious free fluid in abdomen
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: STAT requested.
Imaging Performed By: Rachel Brilhart, 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 and the visible portion of the proximal urethra are normal.

There is no obvious evidence of ovarian remnant.

The left kidney is normal size (6.67 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 (6.58 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 (0.59 cm at cranial pole) (0.56 cm at caudal pole) (2.49 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 (0.94 cm at cranial pole) (0.71 cm at caudal pole) (2.89 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 to slightly prominent in size (2.23 cm in width at the level of the hilus) with normal

curvilinear peripheral contours. The parenchyma is subtly mottled in appearance. No focal lesions are observed. 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 to caudal vena cava ratio is approximately 1: 1.

The gall bladder lumen is moderately distended. The wall is thin and smooth. A small amount of aggregated, echogenic, suspended debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is moderately to severely fluid distended and hypomotile. 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. There is no evidence of an obstructive pattern.

Pancreas

The right limb is prominent in size with minimal deviation from the normal peripheral contours. The parenchyma is slightly hypoechoic relative to surrounding omental fat and subtly mottled in appearance. No distinct focal lesions are observed. The pancreatic duct is not overtly dilated. There is no evidence of peripancreatic effusion.

Free Abdomen

There is no evidence of free fluid.

Two to three sublumbar lymph nodes are visualized, the largest measuring 3.78 cm in length. In addition, a few prominent mesenteric nodes are seen, the largest measuring 2.00 cm in length.

Other

A uterine stump is visible (0.75 cm in width). No obvious pathology is seen.

In the region of the caudal mammary chain, a 3.63 x 2.42 cm irregular, heterogenous, vascular, subcutaneous is visualized. Surrounding tissue is hyperechoic.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Gastric ileus (etiology unknown)
- The pancreatic changes could be consistent with mild pancreatitis. Alternatively, minor, age-related remodeling may be present without active inflammation.
- Visible uterine stump, without obvious evidence of pathology

Secondary Findings

- The splenic parenchymal changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis, splenitis or antigenic stimulation with a low possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).

- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

- Subcutaneous mass in the region of the caudal mammary chain. Differentials include neoplasia, hyperplasia, inflammatory disease, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

To further evaluate for stump pyometra/ovarian remnant syndrome, consider the following:

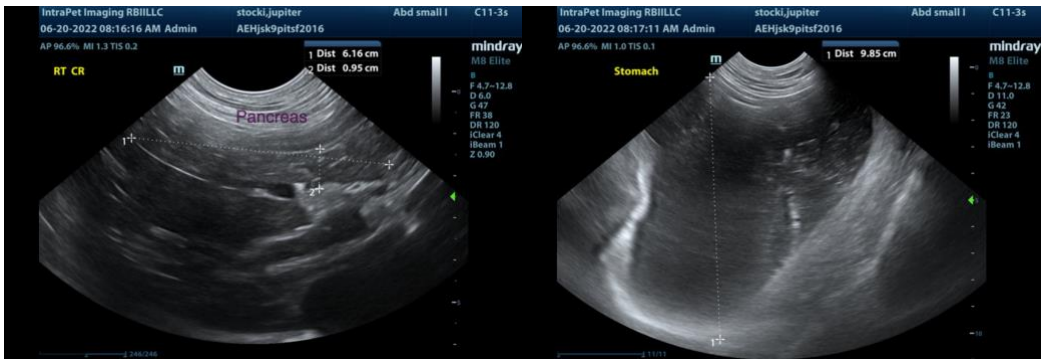
1. Vaginal cytology
2. Progesterone and Anti-Mullerian levels during signs of estrus

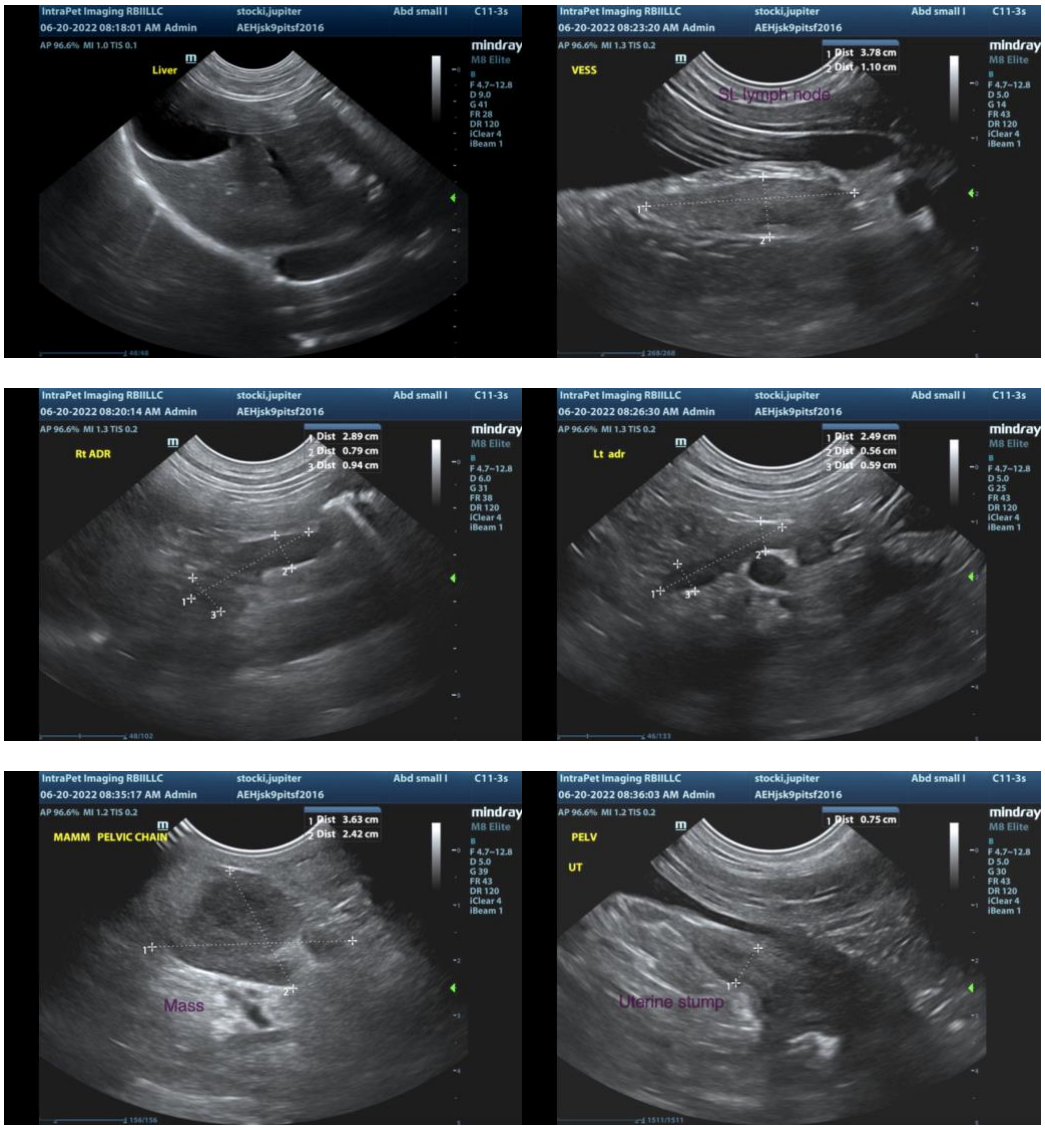
Regarding the subcutaneous mass, consider a fine-needle aspirate or biopsy/removal with submission for histopathology. Three-view thoracic radiographs are recommended prior to anesthesia (if not already performed) to assess for pulmonary metastatic disease as well as esophageal pathology.

A urine culture and sensitivity is also recommended, particularly 5-7 days following the last dose of antibiotics.

To further investigate for possible causes of the gastrointestinal signs, consider the following:

1. Fecal evaluation for ova and Giardia
2. Resting cortisol level to screen for atypical hypoadrenocorticism
3. Malabsorption panel, including serum cobalamin and folate, TLI and PLI
4. A barium esophagram (i.e., preferably thoracoscopy) would be useful to evaluate for esophageal dysfunction. However, there is a risk of aspiration barium with this procedure.
5. An upper GI endoscopic with GI biopsies can also be considered.
6. Regarding the gastric ileus, consider initiation of a promotility agent (i.e., metoclopramide). A proton pump inhibitor is also recommended as empirical treatment for gastric reflux.





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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