

**DATE PRESENTING CLINICAL SIGNS**

8.17.23 Presented to the ER on 8/12 for trouble Walking. O thinks P dislocated leg. P doesn't want to stand up, having difficulty walking and using stairs, P seems to be not using hind legs and they "go out" from under him. Leg is swollen. Began this morning, getting progressively worse throughout the day. On exam - stove pipe swelling from thigh to toes, pitting edema. Edematous prepuce with severe bruising R inguinal region extending to R side of prepuce. Rads did not reveal a fracture but bloodwork has concerns for ITP/IMHA/Evan's Syndrome vs anemia/thrombocytopenia due to neoplasia

SPECIES Current Medications: Started 8/15: Gabapentin 100mg 2 c bid, Pred 20mg 1.5T BID, Doxycycline 100mg 3C sid

Canine Lab Results: HCT- 22.6% (37.3-61.7) with Hgb- 8.3 (13.1-20.5) and RBC 3.44 (5.65-8.87), Plate73 (148-484)

BREED Date of Previous IntraPet Ultrasound: No previous.

Sedation: Not required to complete full diagnostic ultrasound.

Labrador Retriever Stat Report: Not requested.

Imaging Performed By: Rachel Brillhart, RDMS.

SEX

Intact Male

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**Urinary System**

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. Luminal contents are 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 enlarged (<3.80 cm in width) with a normal shape and smooth peripheral contours. Parenchyma is isoechoic to slightly-hyperechoic relative to surrounding omental fat and subtly heterogenous in appearance. No distinct focal lesions are observed. The prostatic urethra is not overtly dilated.

WEIGHT

87.1 lbs

INTERPRETED BY

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The left kidney is normal in size (7.67 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

HOSPITAL NAME

Fullerton AH

The right kidney is normal in size (7.13 cm in length) with a normal shape, architecture and 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. Renal vasculature is normal.

REFERRING VET

Dr. Unger

Adrenal Glands

The left adrenal gland is normal in size (0.66 cm at cranial pole) (0.61 cm at caudal pole) (2.60 cm in length) 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.

INVOICE

14157

The right adrenal gland is in normal size (0.68 cm at cranial pole) (0.65 cm at caudal pole) (2.27 cm in length) 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 (2.23 cm in width at the level of the hilus) with a normal capsular contour. 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 curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen and slightly mottled in appearance. No distinct focal lesions are observed. Hepatic vasculature and intrahepatic 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 scant amount of gravity-dependent echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is moderately distended with ingesta. 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

A portion of the pancreas is obscured by the gastric distention. In the visualized portion of the right limb, the pancreas is visible/prominent with minimal deviation from the normal peripheral contours. The parenchyma is largely isoechoic relative to surrounding omental fat and subtly mottled in appearance. The pancreatic duct is not overtly dilated.

Free Abdomen

The peritoneal cavity is normal. There is no evidence of inflammation or effusion. A 1.37 x 1.02 cm lymph node is observed at the aortic trifurcation.

Other

The testicles are subjectively normal in size (left testicle: 2.74 x 2.13) (right testicle: 2.89 x 1.35) with a slightly irregular shape but are relatively symmetrical. The parenchyma in both testicles contains varying-sized hypoechoic nodules. symmetrical with homogenous parenchyma. No obvious pathology is observed.

A brief echocardiogram reveals no evidence of pericardial effusion or obvious right atrial/auricular mass. There is no obvious evidence of pleural effusion in the visible window.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

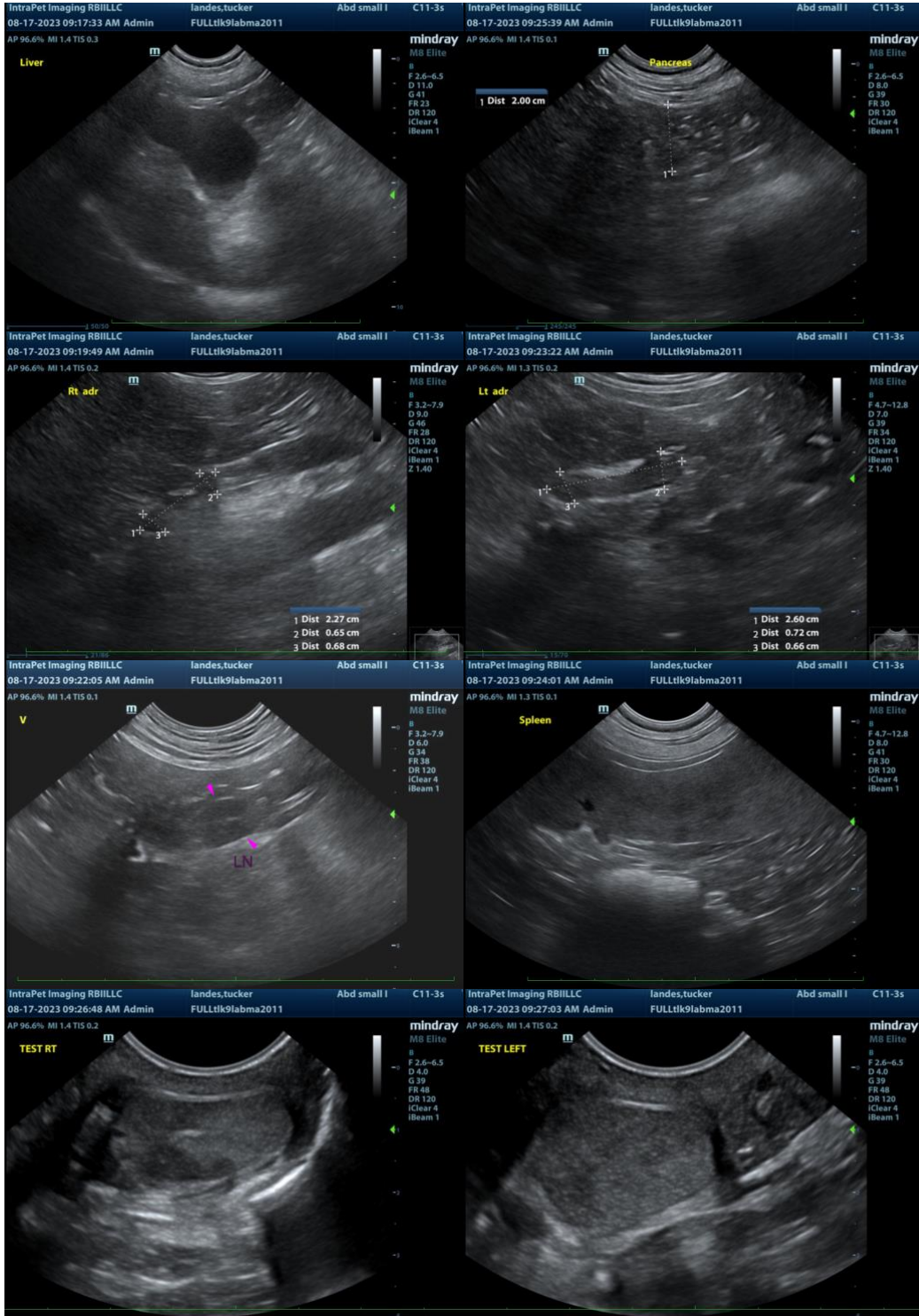
- The splenic parenchymal changes could be consistent with extramedullary hematopoiesis, lymphoid hyperplasia, emerging neoplasia (i.e., lymphoma), splenitis or antigenic stimulation.

Secondary Findings

- Mild bilateral chronic renal changes
- The hepatic parenchymal changes are nonspecific and are most consistent with age-related remodeling, with a lower possibility of inflammatory disease, regenerative nodular hyperplasia, emerging neoplasia, or other hepatopathy.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- If the patient was fasted for this study, the presence of ingesta within the gastric lumen could suggest delayed gastric emptying.
- The prominent medial iliac lymph node is likely reactive with a lower possibility of emerging neoplasia.
- 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.
- The testicular nodules may represent benign parenchymal remodeling. Alternatively, emerging tumors cannot be excluded.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for occult neoplasia in the chest.
- Clotting times (i.e., PT/PTT) are also recommended to assess for coagulopathy.
- 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/>.
- Consider sending a CBC to a diagnostic lab with a reticulocyte count and clinical pathology review.
- If the patient's clotting status can be stabilized, consider fine-needle aspiration of the spleen to assess for emerging lymphoma. A 25-gauge needle should be used.
- Also consider advanced imaging (i.e., ultrasound, CT, or MRI) of the swollen limb to assess for blood clots, fracture, etc.



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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