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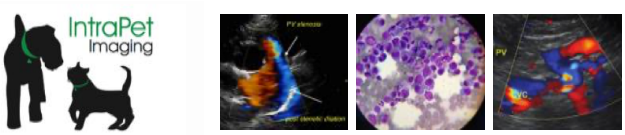

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**DATE**

8/19/21

**PATIENT**

Max Mooney

**SPECIES**

Canine

**BREED**

Hound mixed breed

**SEX**

Male, neutered

**AGE**

1/1/2009

**WEIGHT**

29 kg

**INTERPRETED BY**

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

**HOSPITAL NAME**

Timonium Animal Hospital

**REFERRING VET**

Dr. Montessi

**INVOICE**

11914

## PRESENTING CLINICAL SIGNS

History: Lethargy, anorexia; Hx of suspected OA, seasonal atopy.

Current Medications: Amoxicillin 500mg day 1 the ampicillin @ 20mg/kg IV q12 today. Maropitant @ 1mg/kg IV x 2 days. Carprofen @ 2.2mg/kg x 2 days. Gabapentin 300mg 8/18 evening.

Lab Results: Labs: PCV/TP elevated (likely dehydration)
hyperglobulinemia (inflammation vs relative to dehydration)
ALT 138 (<125). CBC: Leukocytosis (19.5k) with neutrophilia (16.5k) and monocytosis (1.5k)
4DX negative.
Radiographs: Abdominal imaging: potential splenomegaly
Date of Previous IntraPet Ultrasound: No previous IntraPet scans.
Sedation: Butorphanol administered prior to scan.
Stat Report: STAT report not requested by the veterinarian.

## 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 mostly anechoic urine. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The prostate is normal in size (1.15 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal size (6.78 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. Mild pyelectasia is present (0.28 cm in the transverse plane). There is no evidence of nephroliths, infarcts or hydroureter.

The right kidney is normal size (6.09 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. Trace pyelectasia is present. There is no evidence of nephroliths, infarcts or hydroureter.

### *Adrenal Glands*

The left adrenal gland is normal size (0.64 cm at cranial pole) (0.83 cm at caudal pole) (2.57 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 (0.78 cm at cranial pole) (0.72 cm at caudal pole) (2.80 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 subjectively prominent in size (2.47 cm in width at the level of the hilus) with normal curvilinear peripheral contours. The parenchyma is diffusely mottled bordering on “moth eaten” appearance. Splenic vasculature appears normal with no evidence of thrombosis.

### *Liver*
The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen and subtly heterogeneous in appearance. There is increase in portal markings. No focal lesions are observed. Hepatic vascular is 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 gastric lumen is mildly distended with ingesta and gas. The gastric wall is thickened (up to 1.04 cm) with retention of the 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 right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat. No focal lesions are observed. The pancreatic duct is not overtly dilated. Surrounding mesentery is mildly hyperechoic.

### *Free Abdomen*
There is no evidence of free fluid. At least 2 prominent to enlarged lymph nodes are observed in the right cranial quadrant, the larger node measuring 2.10 x 1.04 cm. Surrounding mesentery is hyperechoic.

## ULTRASONOGRAPHIC FINDINGS
**Primary Findings:**

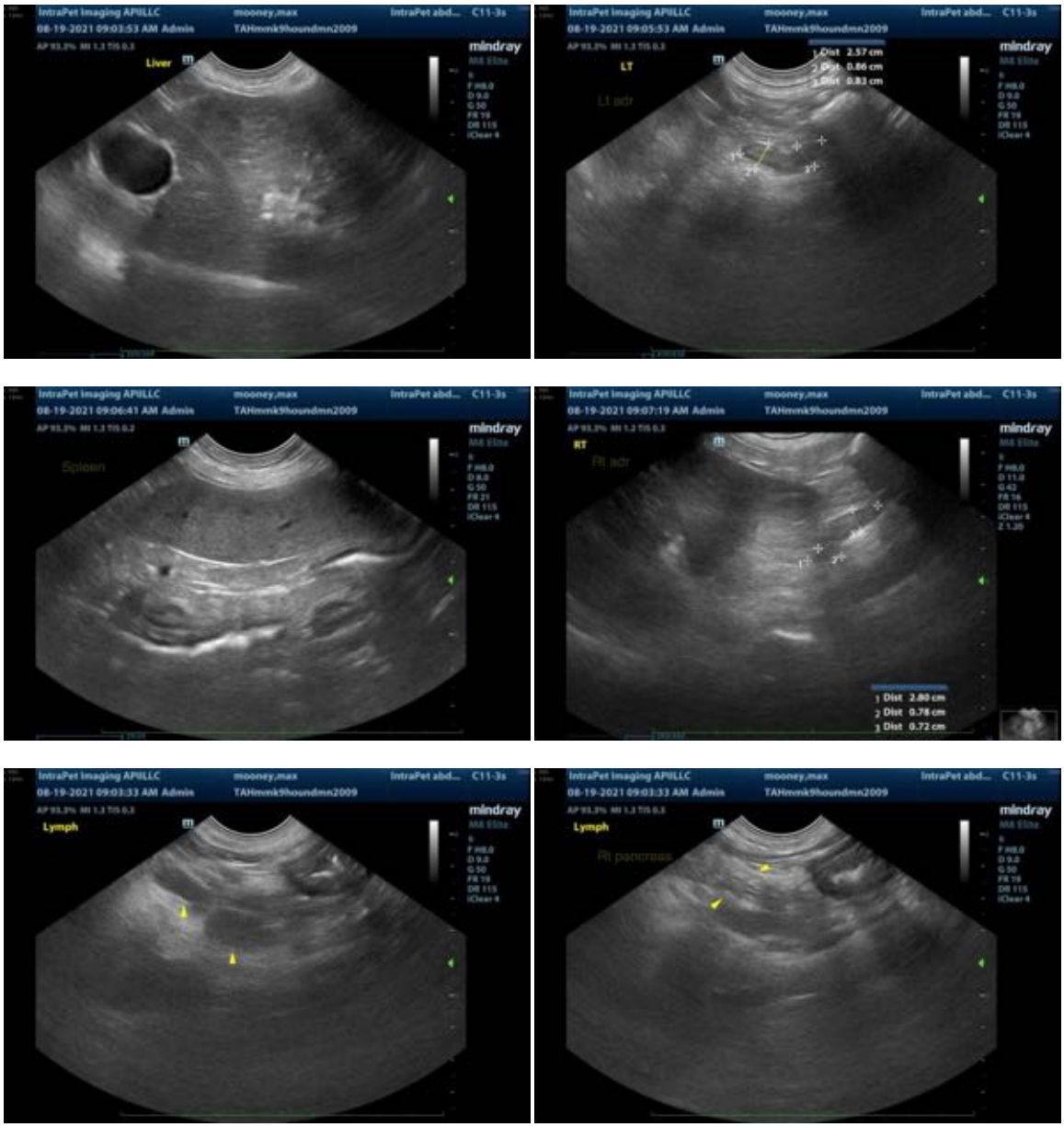
- The splenic parenchymal changes are concerning for infiltrative neoplasia (i.e., round cell tumor). However, a benign process (i.e., lymphoid hyperplasia or extramedullary hematopoiesis) cannot be excluded.
- The abdominal lymphadenopathy could be consistent with infiltrative neoplasia, lymphoid hyperplasia or reactive lymphadenitis.
- The pancreatic changes are suggestive of mild pancreatitis.
- The gastric wall changes are most consistent with inflammation/gastritis with a lower possibility of emerging neoplasia.
- Cranial peritonitis is present likely secondary to pancreatic, gastric and/or lymph node pathology.

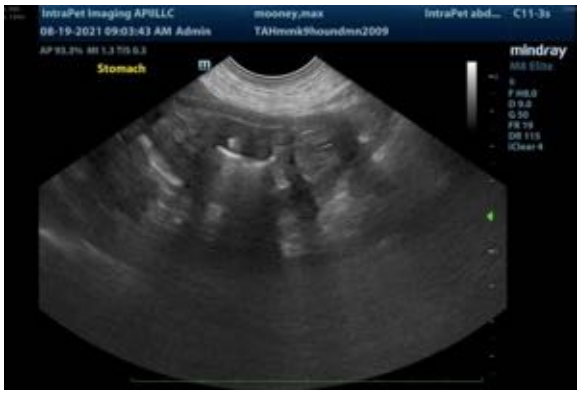
**Secondary Findings:**

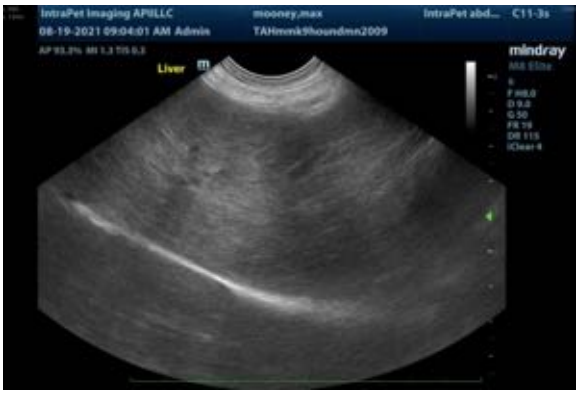
- Non-specific diffuse hepatopathy. Differentials include inflammatory, immune mediated disease, hepatotoxicosis (i.e., copper), infiltrative neoplasia (less likely), reactive hepatopathy +/- concurrent benign age-related changes.
- Bilateral age-related renal pathology.

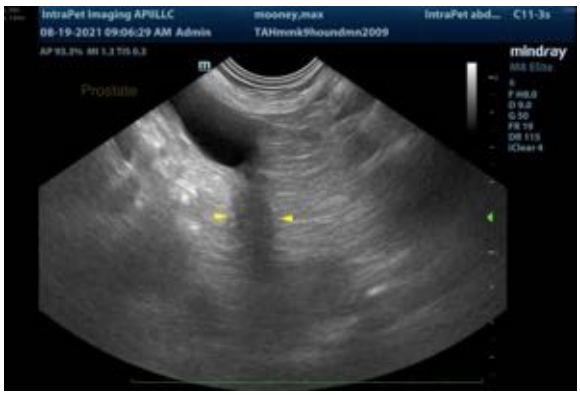
## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

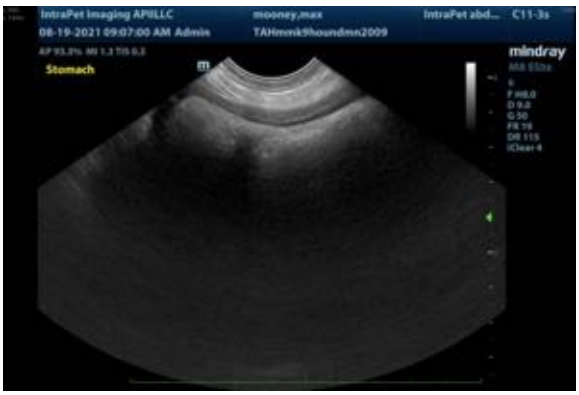
- Three-view thoracic radiographs are recommended to assess cardiopulmonary status.
- A fine needle aspirate of the spleen is also recommended (if clotting status is appropriate). A 25-gauge needle should be used.
- If the above diagnostics are inconclusive, an abdominal exploratory with gastrointestinal, abdominal lymph node +/- splenic biopsies may be necessary to get a definitive diagnosis.
- Also consider a malabsorption panel including serum cobalamin, folate, TLI and PLI.

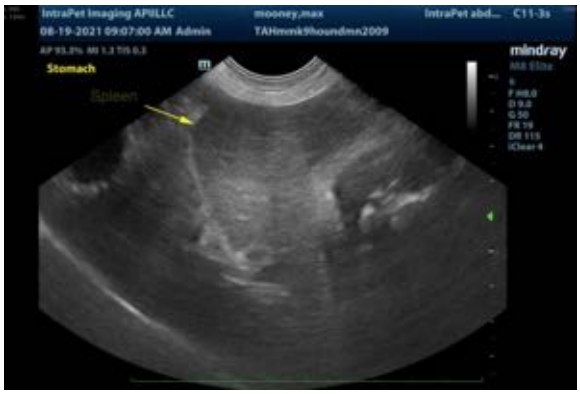





**The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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.

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