

**PATIENT**Butch Velazquez
277494**SPECIES**

Canine

BREED

English Bulldog

SEX

Intact Male

AGE

3 years, 5 mos

WEIGHT

28.1 kg

INTERPRETED BYAndrea Nicastro, DVM,
Diplomate ACVIM
(Small Animal Internal
Medicine)**IMAGING PERFORMED BY**

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VET

WVRC Dr. Jochman

INVOICE

11460

DATE

8.19.22

PRESENTING CLINICAL SIGNS

History: Butch is a 3y 5m CM Bulldog (English) who presented to WVRC's Emergency Service on 8/18/2022 as a transfer for anemia of unknown origin. Butch was presented to his primary today for a 4 day history of anorexia and increased respiratory rate during rest. Additionally, over the past week Butch began with orange colored diarrhea that has since become formed but remains orange in color. Overall, Butch is weak and lethargic. Butch's PCV continued to decline overnight so he was given a blood transfusion.

Abnormal PE/Chem/CBC/UA Results: PCV/TS: 28%, 9.2 g/dL CBC: Hct 23 (L), WBC 26.2 (H), RBC 3.1 (L), Hgb 8 (L), seg neuts abs. 21.7 (H), mono abs. 2.6 (H), Plt 363 (N); noted made include saline agglutination "possible positive", 3+ "possible spherocytes", 2+ polychromatophils, few neutrophils with 1+ toxic change, rare small platelet clumps seen. Retic count: 160768 (H) Chem/lytes: Ca 8.9 (L), Na 136 (L), K 3.5 (L), Tp 7.5 (H), glob 4.4 (H), tbili 1.1 (H), chol 350 (H), hemolysis 1 noted PT: 7.5 (N) PTT: 12.3 (N) Flex4: Negative x 4 CXR 2 view: No obvious metastatic disease. Final radiologist report pending. Coomb's Test: PENDING. rDVM 8/18 WVRC 8/18 8/18- 10pm 8/18- 4am HCT 23% 23% PCV 28% 21 15 TP 9.2 9 8.6 TBil 0.1 high 1.1 PLT 363 RETIC 160768

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**Urinary System**

The **urinary bladder** is normal in thickness and the mucosal surface is smooth. The bladder lumen is distended with 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 **left kidney** is normal size (6.53 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. A 0.52 cm cortical cyst is present. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The **prostate** is enlarged (5.24 cm in width) with a slightly irregular shape. The parenchyma is hyperechoic relative to surrounding omental fat and heterogenous in appearance, with a few, ill-defined cystic areas within the parenchyma. The prostatic urethra is not overtly dilated.

The **right kidney** is normal size (7.34 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The **left adrenal gland** is normal size (0.67 cm at cranial pole) (0.70 cm at caudal pole); 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 (0.67 cm at cranial pole) (0.77 cm at caudal pole); 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 prominent in size (2.67 cm in width at the level of the hilus) with normal curvilinear peripheral contours. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

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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 **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 distended with fluid and 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 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

A portion of the **pancreas** is obscured by the gastric distention. In the visualized portions, no obvious abnormalities are seen.

Free Abdomen

Trace free fluid is observed. Trace ascites is also present. A 2.16 x 0.81 cm medial iliac **lymph node** is visualized. In addition, a few prominent mesenteric lymph nodes are seen, the largest measuring 2.06 cm in length.

Other

The testicles are subjectively normal in size, the left measuring (3.75 x 2.09) and the right (3.06 x 2.12 cm), with a normal size, shape and with homogenous parenchyma. No focal lesions are observed.

ULTRASONOGRAPHIC FINDINGS**Primary Findings**

- The mild splenomegaly, in conjunction with the patient's anemia, is likely secondary to extramedullary hematopoiesis. Other differentials include lymphoid hyperplasia, splenitis, antigenic stimulation, or less likely, infiltrative neoplasia.
- The trace ascites is likely secondary to increased vascular permeability (i.e., due to autoimmune disease). However, increased hydrostatic pressure and low oncotic pressure cannot be completely excluded. Correlation with the patient's clinical history is recommended.

Secondary Findings

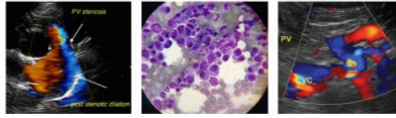
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- The prostate changes are consistent with benign prostatic hyperplasia with parenchyma cysts. Concurrent bacterial prostatitis is also possible but considered less likely in the absence of lower urinary tract signs.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- 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>

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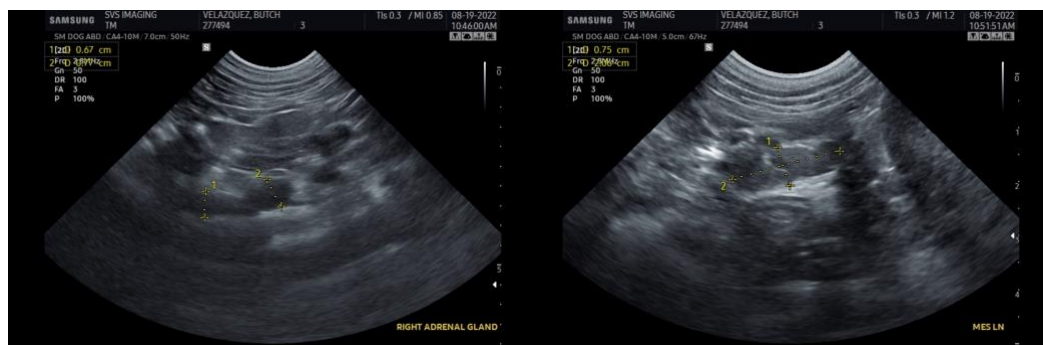
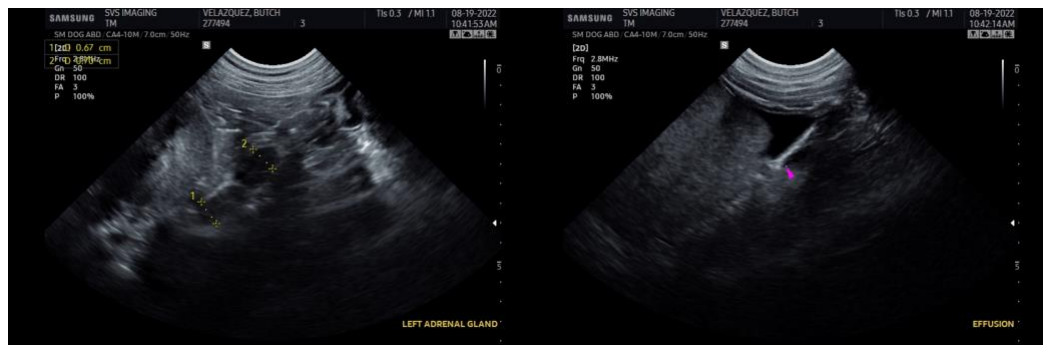
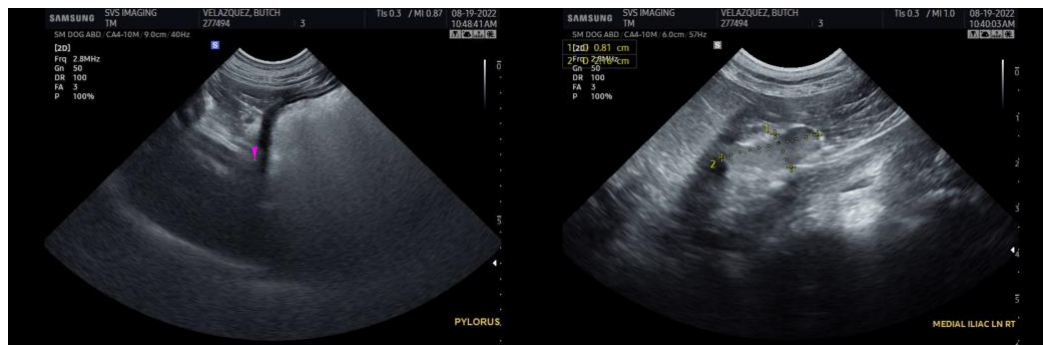
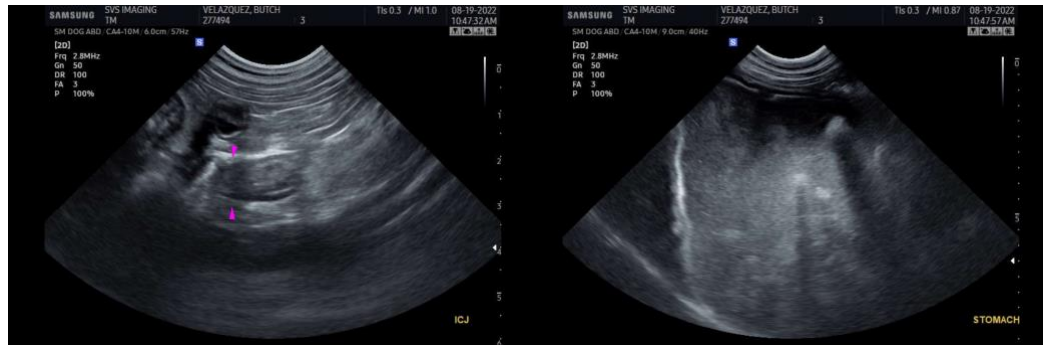
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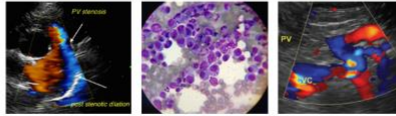
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- Consider initiation of treatment for immune-mediated hemolytic anemia, along with supportive care, while awaiting test results.



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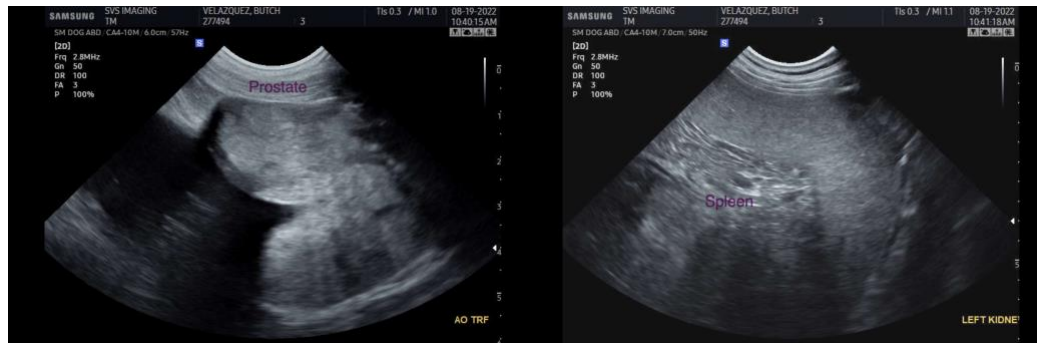
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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