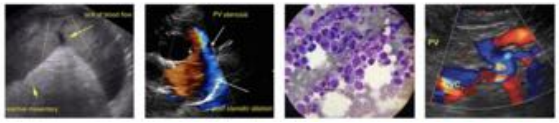


PATIENT

Ares Lips

SPECIES

Canine

BREED

Siberian Husky

SEX

Neutered Male

AGE

9.24.2015

WEIGHT

23.3 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

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

HOSPITAL NAME

Blue Pearl Mt Pleasant Emerg

REFERRING VET

Dr. Ann Marcario

INVOICE

11701

DATE

9.25.22

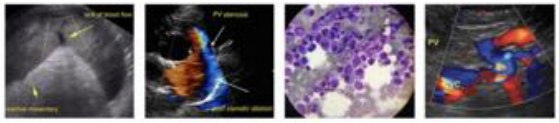
PRESENTING CLINICAL SIGNS

Clinical Exam Findings: He has diarrhea and no stool intermittently since last week. HE is getting hamburger and rice. Wednesday night switched to chicken and rice. Thursday/Friday. Friday he had 2 small solid stools. He postured like he was constipated owner con't chicken and rice. This AM he didn't want to eat. When owner got home from work today, he was stumbling and swaying. owner had to help him wlk. No medications 09-25-2022 3:36:30am Ann Marcario, DVM 09-24-2022 7:38:25pm Initial triage taken by Dawn Multiple bouts of diarrhea starting about 1.5 weeks ago Owner has been feeding chicken/rice then hamburger/rice then back to chicken/rice. He's had a decreased appetite. Ataxia and lethargy started today; he's also been panting. Noticed a right sided head tilt and nystagmus darting to the left when taking vitals. No current medications and no previous medical issues. Ares is UTD on vaccines and prevention. He takes Simparica Trio. On presentation patient is QAR EENT mmb pink <2 very MS/N Very slow nystagmus FF right, right head tilt, ambulating normally. CV/R no murmur/arrhythmia lungs clear abd palp benign UG nsf PLNS wnl integ nsf 7yo MN Husky with 1.5week Hx diarrhea right head tilt and FF right nystagmus Unsure how diarrhea and neuro are related if at all. neuro = vestibular idiopathic vs clot vs neoplasia. SWO and reviewed history. Ares is showing signs of vestibular syndrome Reviewed vestibular syndrome. I don't know how or if the diarrhea and vestibular signs are related. Recommend work up provided estimate 3 view AXr- decreased detail, questionable free gas ventrally. FAST scan- free fluid cloud serosang 3 view CXR sternal lymphadenopathy Chem 17 NSF CBC WNL Discussed results with owner. I found that Ares has fluid in his abdomen. IT is not blood. I am unsure why. It is likely related to the GI signs he has been exhibiting lately. I am not sure how it correlates with the neurologic signs. Tonight we need to send his radiographs to the radiologist and perform a cytology on the fluid from the abdomen. IF the fluid from the abdomen has bacteria in it, Ares will need to go to surgery to see why there is an infection in the abdomen. If there is no bacteria then he will need an ultrasound that I hope we can get for him tomorrow. I don't know if the ultrasonographer will be available. IF this is a medical problem he can transfer him to IM in SV on Monday. For now we can get him admitted and start to rehydrate him and give him injections to help him feel better. IF she approves estimate I won't call unless this is a surgical problem. She will hear from the daytime doctor one the ultrasound is performed. Owner approve estimate. ATh IVC BG 77 lactate 5.1 Phylyte 600ml over 1 hour then 80ml/hr IV Cerenia 1mg/kg IV SID famotidine 1mg/kg IV BID Buprenorphine 0.015mg/kg IV Q8H Cytology of abdominial fluid is 90% large lymphocytes, no bacteria seen, no neutrophils seen.

Abnormal lab-work values: 3 view AXr- decreased detail, questionable free gas ventrally. FAST scan- free fluid cloud serosang 3 view CXR sternal lymphadenopathy Chem 17 NSF CBC WNL

Current Medications: Cerenia 1mg/kg IV SID famotidine 1mg/kg IV BID Buprenorphine 0.015mg/kg IV Q8H

Radiographic Findings: Report of Imaging Findings: Thorax: The cardiac silhouette is within normal limits of size. Intracardiac and cardiothoracic ratios are normal, failing to demonstrate evidence of individual chamber enlargement or pericardial disease. The lungs are clear. There is no evidence of pulmonary nodules or masses, lobar consolidation, enlargement of the esophagus, or pleural effusion. The diaphragm is intact and the extra-thoracic skeletal structures are normal. There is a moderate enlargement of the sternal lymph nodes. Shoulders: There is no abnormality detected at the level of the scapula and humerus. The caudal aspect of the humeral head and the supraglenoid tubercle are smoothly outlined. No abnormality is seen at the level of the attachment of the bicipital, infraspinatus, and supraspinatus



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tendons. Abdomen: Loss of peritoneal serosal detail in the cranial abdomen. No evidence of peritoneal free gas. No mass effect. The visible vertebrae are normal in number, shape, and density. There is a normal alignment of the vertebral canal. No abnormalities are detected at the level of the intervertebral discs.

Assessment: Moderate enlargement of the sternal lymph nodes suggests an inflammatory or neoplastic process within the abdomen. - Moderate general loss of peritoneal serosal detail compatible with moderate peritoneal effusion (transudate, exudate, paraneoplastic) and/or mesenteric fat reaction. Ultrasound of the abdomen and aspiration of the peritoneal fluid is recommended for further evaluation.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** wall is 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. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The **prostate** is normal in size (0.28 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 (6.34 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 (6.69 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 (0.49 cm at cranial pole) (0.59 cm at caudal pole) (2.61 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.

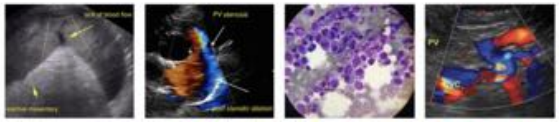
The **right adrenal gland** is normal size (0.84 cm at cranial pole) (0.64 cm at caudal pole); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The **spleen** is prominent to enlarged (3.30 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.

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.



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

Gastrointestinal

The **gastric lumen** is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The small intestinal lumen is not segmentally fluid-distended (mild). An approximately 6.00 to 7.00 cm jejunal mass is visualized. The wall in this region is severely thickened (up to 1.01 cm) and hypoechoic with loss of the normal layering pattern. A few additional small intestinal segments are thickened (up to 0.48 cm) with loss of the normal layering pattern. The colonic wall is normal. There is no evidence of an obstructive pattern.

Pancreas

The region of the **pancreas** is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional inflammation or effusion.

Free Abdomen

The mesentery throughout the abdomen is hyperechoic and irregular/nodular in appearance. A small amount of free fluid is present. Several enlarged, rounded hypoechoic **lymph nodes** are observed in the mid to caudal abdomen, the largest measuring 4.47 cm in diameter.

Other

A **brief echocardiogram** reveals no evidence of pericardial effusion or obvious right atrial/auricular mass.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The jejunal mass effect as well as the thickened small intestinal segments are more concerning for neoplasia (i.e., lymphoma, adenocarcinoma) with a lower possibility of a focal inflammatory process (i.e., pyogranulomatous).
- The diffuse abdominal lymphadenopathy is also concerning for infiltrative neoplasia (i.e., lymphoma). However, lymphadenitis (i.e., pyogranulomatous) cannot be completely excluded.
- Diffuse peritonitis is present, likely secondary to bowel and lymph node pathology.

Secondary Findings

- The splenic parenchymal changes are nonspecific and could be secondary to lymphoid hyperplasia, extramedullary hematopoiesis, splenitis, antigenic stimulation, or infiltrative neoplasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Three-view thoracic radiographs are recommended to assess for pulmonary metastases.

If the cytology on the abdominal fluid is inconclusive, consider fine-needle aspirates of the enlarged abdominal lymph nodes and bowel mass.

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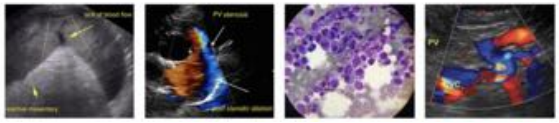

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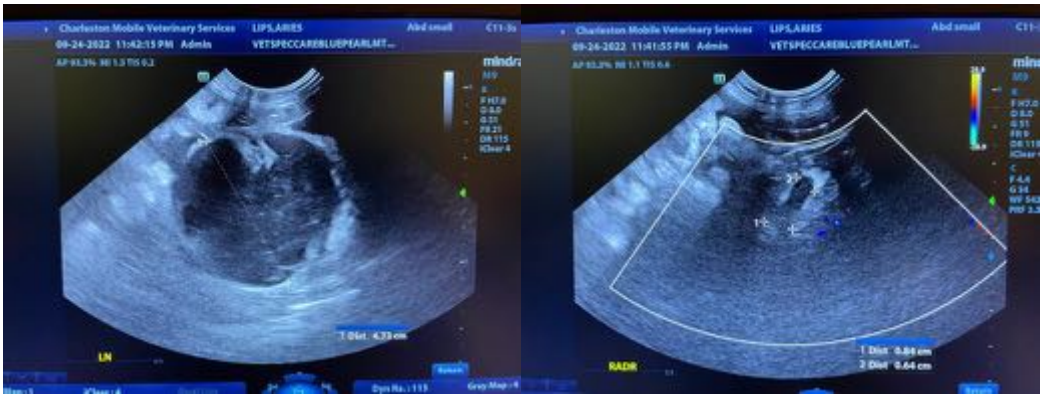

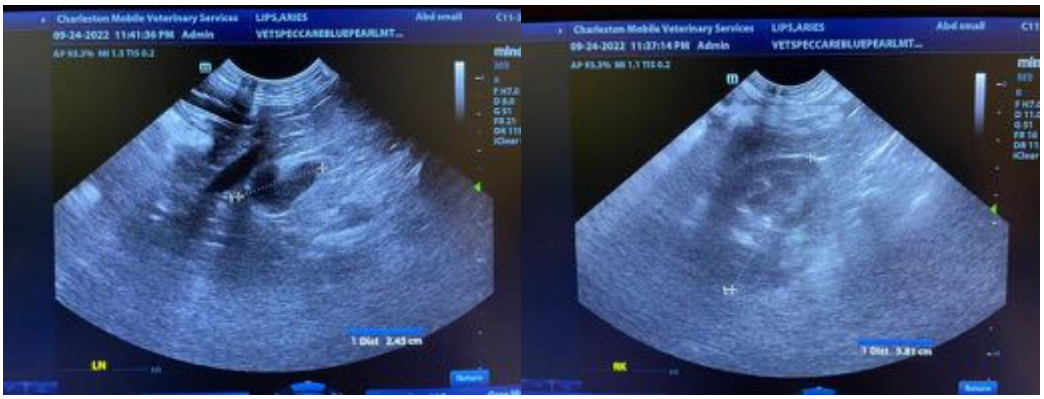

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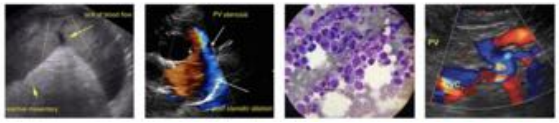

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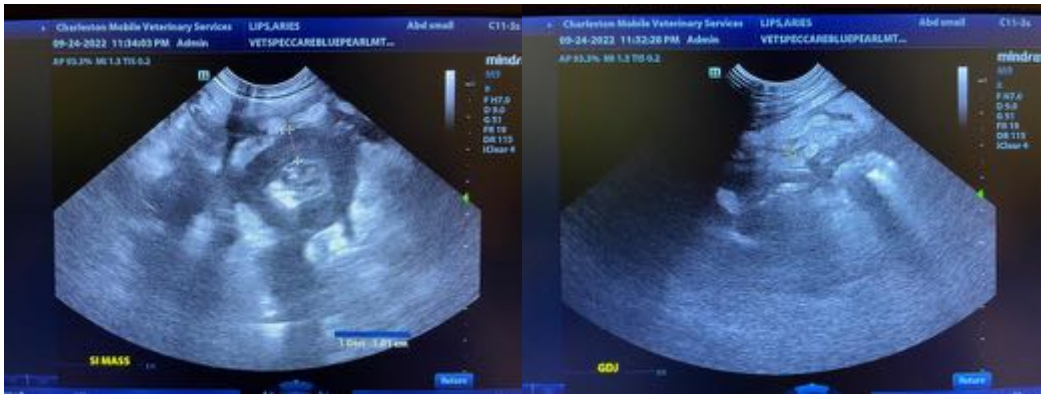

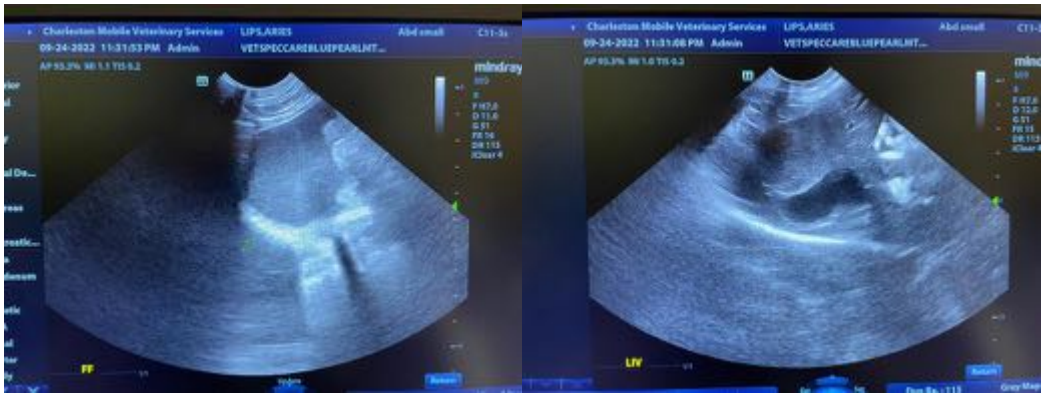

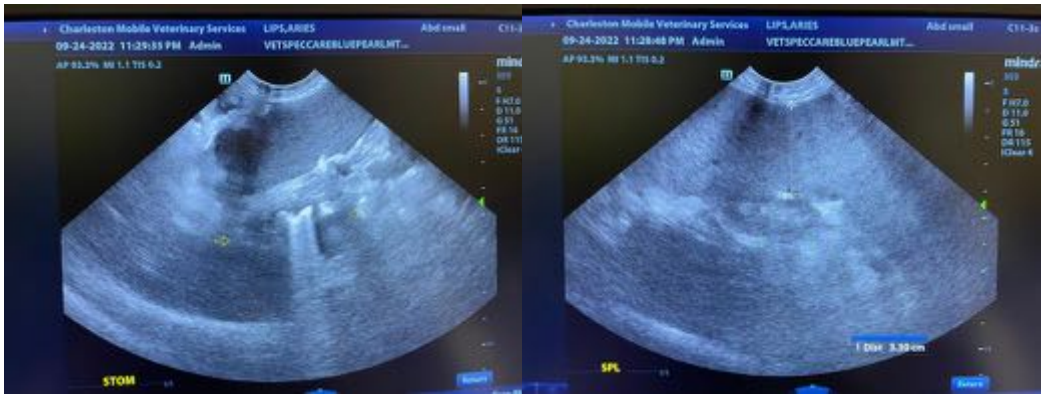

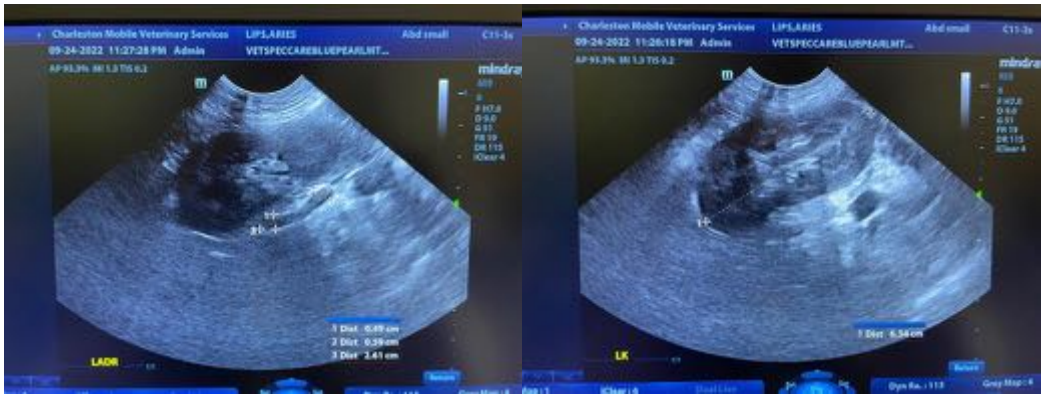

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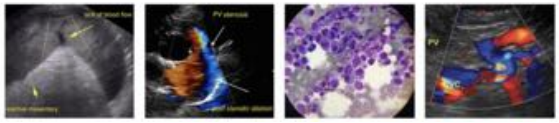

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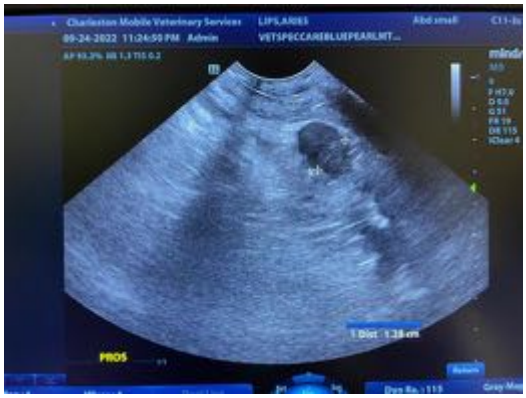

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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