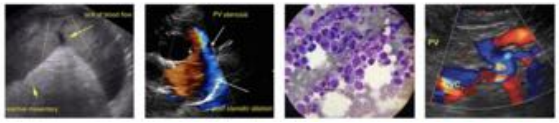

PATIENT

Rex Fox

SPECIES

Canine

BREED

Rottweiler

SEX

Neutered Male

AGE

8 years

WEIGHT

89.8 lbs/40.8 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

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INVOICE

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DATE

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PRESENTING CLINICAL SIGNS

Clinical Exam Findings: BAR and friendly ocular: cornea appears wnl, lens clear, scleral vessels wnl, no chemosis, epiphora, ocular discharge or blepharospasm noted Aural: ears are clean and free of debris AU, tympanic membranes intact AU integument: hair coat appears healthy with no alopecia, ectoparasites or masses noted Musculoskeletal: muscle wasting in temporalis and along dorsum. Pitting edema in the right front limb around digits and metacarpal bones but carpus and radius/ulna are much improved, there is mild swelling around the elbow still present. on palpation of long bones or digits, no swelling noted cardiovascular: heart sounds auscultate wnl, no murmurs or arrhythmias noted, pss respiratory: lungs auscultate wnl, no crackles, wheezes, stertor or stridor noted abdomen: abdomen is soft on palpation with no pain, masses or organomegaly noted, pt is potbellied in appearance. urogenital: bladder soft on palpation, external genitalia appears wnl neurologic: mentation appropriate, cranial nerves appear wnl, CPs wnl x4 lymphatics: lymph nodes palpate wnl oral: mm pink and moist, grade 1-2 pd with moderate tartar accumulation

Abnormal lab-work values: 9.28.2022: TT4 - 0.7 (1-4) Ca - 8.1 (8.4-11.8) TP - 4.1 (5.5-7.5) ALB - 0.4 (0.7-1.5) AST - 67 (16-55)

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. The region of the trigone and the visible portion of the proximal urethra are normal.

The cranial portion of the **prostate** is visualized and is subjectively normal in size with a normal shape and homogenous parenchyma. The prostatic urethra is not overtly dilated.

The **left kidney** is normal size (7.95 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. A 2.18 cm cortical cyst is observed at the medial aspect. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The **right kidney** is normal size (8.19 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.

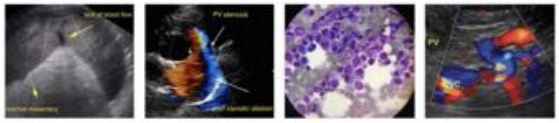
Adrenal Glands

The **left adrenal gland** is normal size (0.74 cm at cranial pole) (0.78 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 (0.92 cm at cranial pole) (0.82 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 subjectively prominent in size with slightly swollen peripheral margins and a curled contour. The parenchyma is slightly mottled in appearance. No distinct focal lesions are observed. Splenic vasculature is normal with no evidence of thrombosis.



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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 not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract appears patent. Within the lumen of several bowel segments, soft, shadowing material is visualized. The wall in these regions appears thickened (up to 0.57 cm) with apparent retention of the normal layering pattern. A few bowel segments in the cranial aspect are moderately distended with fluid and chyme and are hypomotile. Several bowel segments also appear empty. In the right caudal abdomen, a segment of bowel appears plicated. The colonic wall is normal. The colonic lumen contains shadowing fecal material.

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. A small amount of free fluid is observed. 2.18 cm left medial iliac **lymph node** is visualized.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Small intestinal obstructive pattern with suspected foreign material in several segments. The presence of fecal material within the colonic lumen suggests some intestinal transit.
- Diffuse peritonitis, likely secondary to bowel pathology.
- 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).

Secondary Findings

- The prominent medial iliac lymph node is likely reactive.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the clinical history and sonographic changes, an abdominal exploratory is recommended to assess for foreign material. If not found, gastrointestinal biopsies should be obtained.

Also consider a malabsorption panel including serum cobalamin and folate, TLI and PLI.

A fine-needle aspirate of the spleen can also be considered if clotting status is appropriate.

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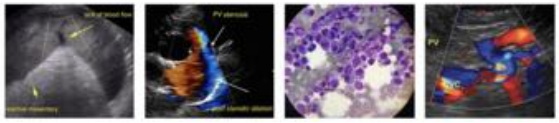

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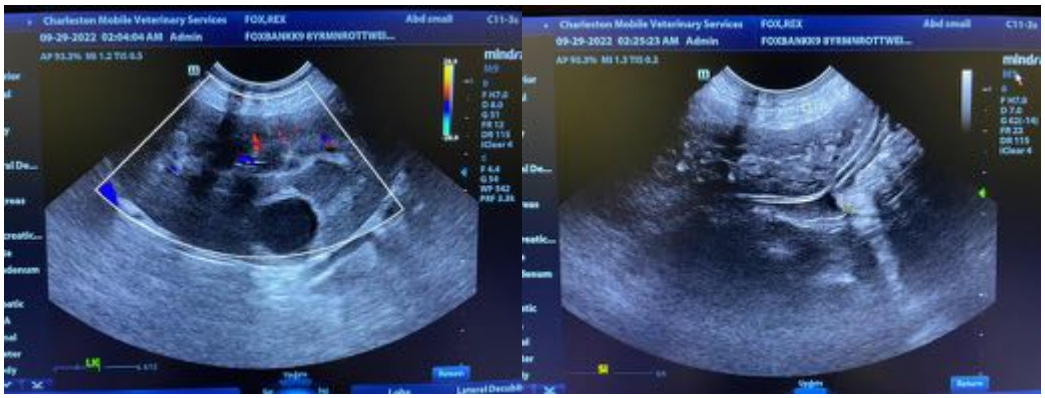

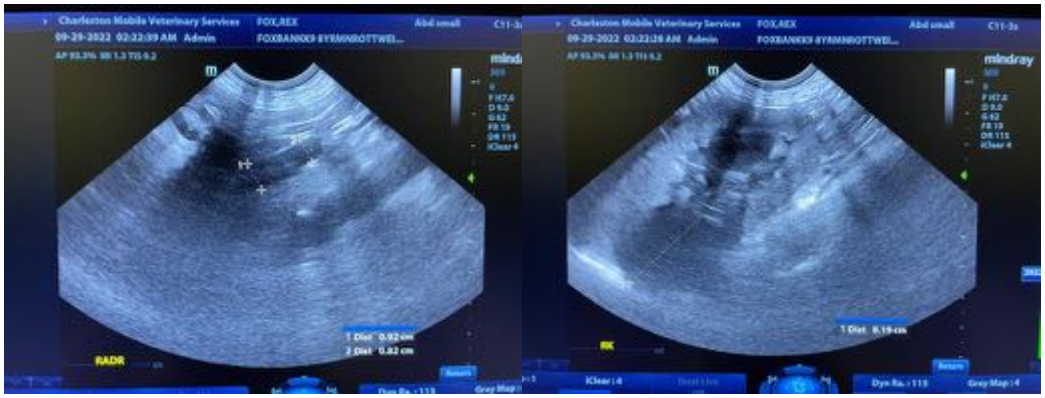

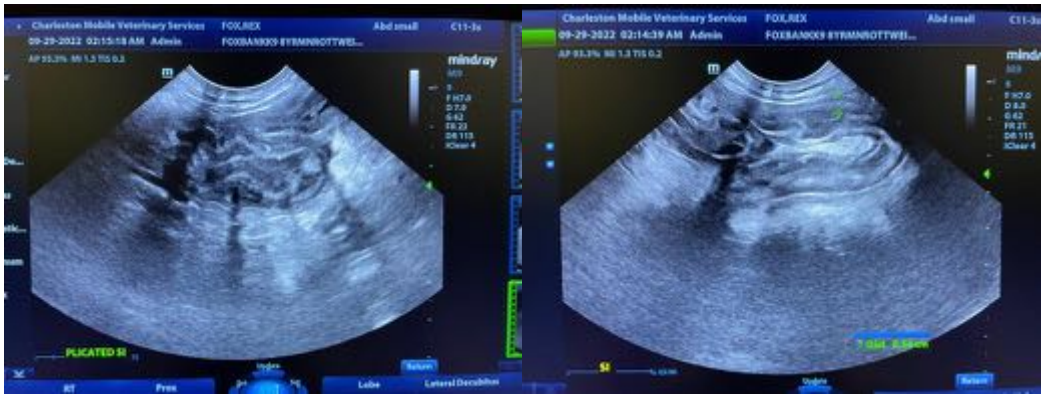

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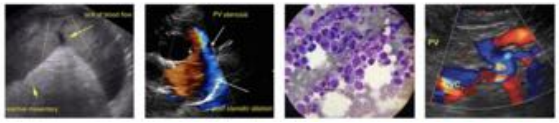

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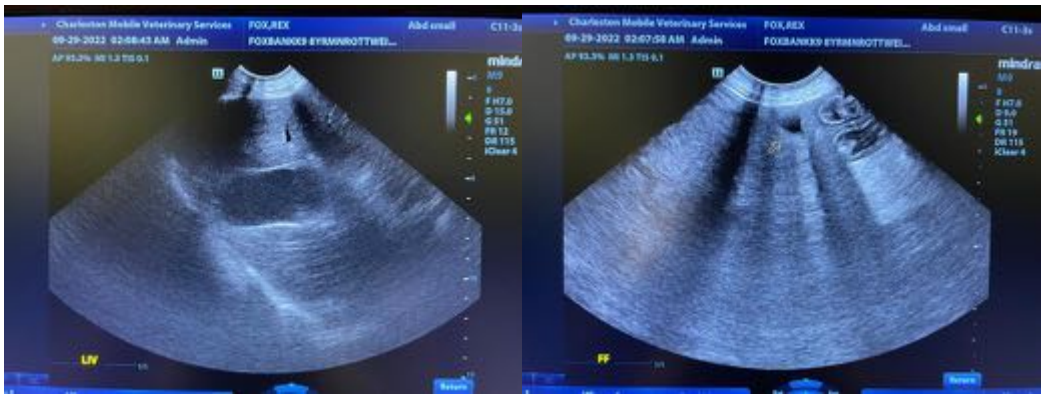

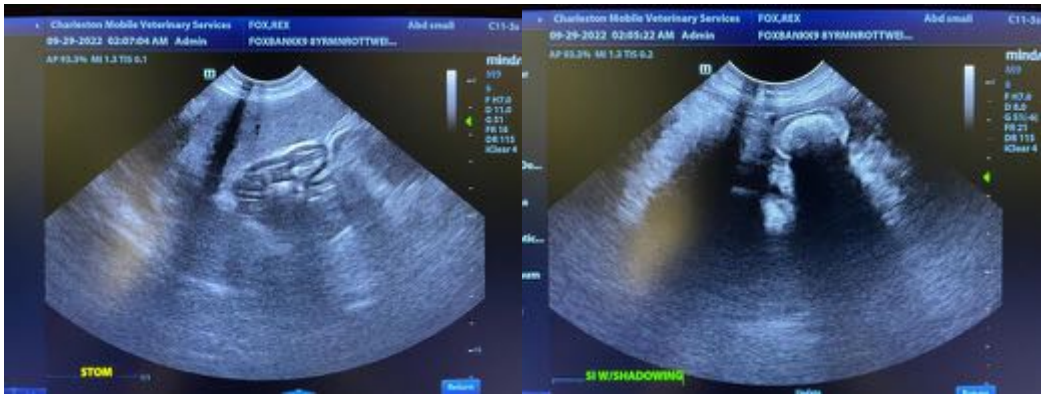

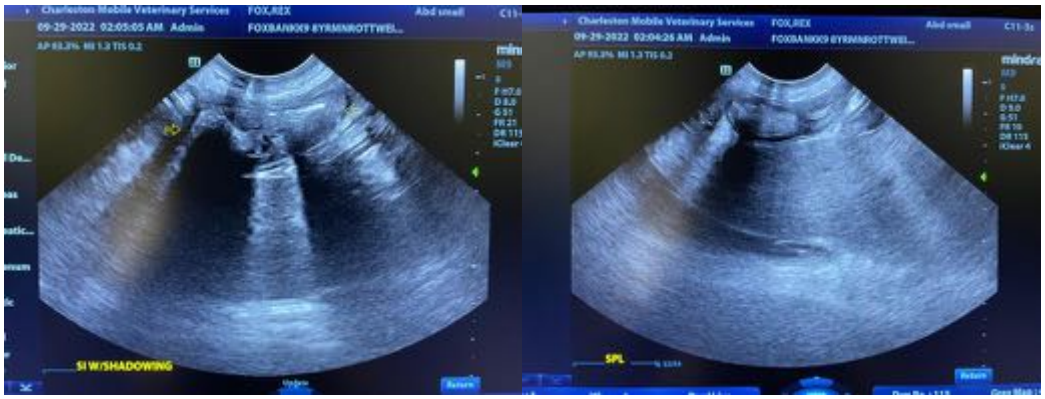

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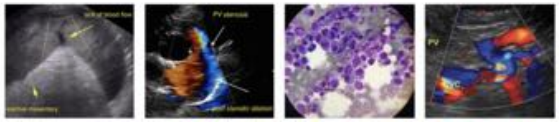

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com