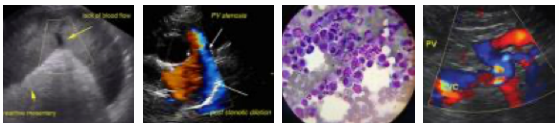


PATIENT
Bruno Phillips

SPECIES
Camome

BREED
Terrier Mix

SEX
Male, neutered

AGE
12 Yrs.

WEIGHT
19 lbs.

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

IMAGING PERFORMED BY
Jenna Walsh

HOSPITAL NAME
West Hills AH

REFERRING VET
Dr. Remcho

DATE
8/10/21

INVOICE
11854

PRESENTING CLINICAL SIGNS

History: Intermittent fever - most recent bout was this weekend (105.7) P was treated as an emergency with dexamethasone, antibiotics, and pain medications. P is afebrile today but depressed and dehydrated Current Medications Clavamox BID and SQ fluids currently
Abnormal PE/Chem/CBC/UA Results: cPL - Abnormal, WBC 20,780, Monocytes 2300, BUN 32, ALKP 403, Lipase 2255, USG 1.050. T4 normal, 4DX negative.

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 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 (0.91 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 (4.69 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. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (5.12 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. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

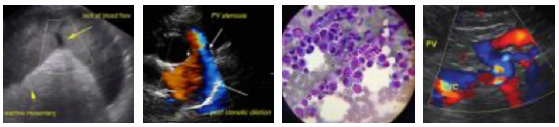
The left adrenal gland is normal size (0.61 cm at cranial pole) (0.56 cm at caudal pole) (2.00 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.66 cm at cranial pole) (0.55 cm at caudal pole) (2.76 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 normal in size (1.10 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A 0.82 x 0.71 cm heterogeneous nodule is observed at the cranial aspect. A few myelolipomas are also seen at the hilus. Splenic vasculature is normal.

Liver



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The liver is subjectively prominent in size with swollen curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen and exhibits mild heterogeneity. No distinct focal lesions are observed. Hepatic vasculature and biliary tracts are of normal volume with no evidence of congestion. The gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are mostly anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is 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 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 largely isoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Free Abdomen

There is no evidence of free fluid. The abdominal lymph nodes are normal/not visible.

Other

A brief visualization of the heart reveals no evidence of pericardial effusion.

ULTRASONOGRAPHIC FINDINGS

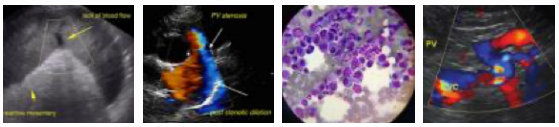
Primary Findings:

- An obvious cause for the patient's fever is not identified in this study. Considerations include underlying infectious, immune mediated, inflammatory or neoplastic disease.

Secondary Findings:

- The splenic nodule could be consistent with a benign process (i.e., myelolipoma, extramedullary hematopoiesis). Alternatively, a neoplastic process may be emerging.
- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory and infiltrative disease are considered less likely.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Bilateral age-related renal pathology.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS



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- Regarding the splenic nodule, a fine needle aspirate can be considered (if clotting status is appropriate). A 25-gauge needle should be used.
- Regarding the fever, consider the following workup for fever of unknown origin:

1. Urine culture and sensitivity.
2. Three-view thoracic radiographs.
3. 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/).
4. Echocardiogram (to assess for valvular endocarditis).
5. Thorough orthopedic and neurologic evaluation +/- arthrocentesis (to assess for immune mediated polyarthritis), +/- CSF tap (to assess for meningitis).

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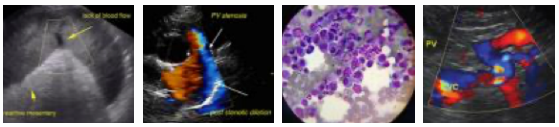

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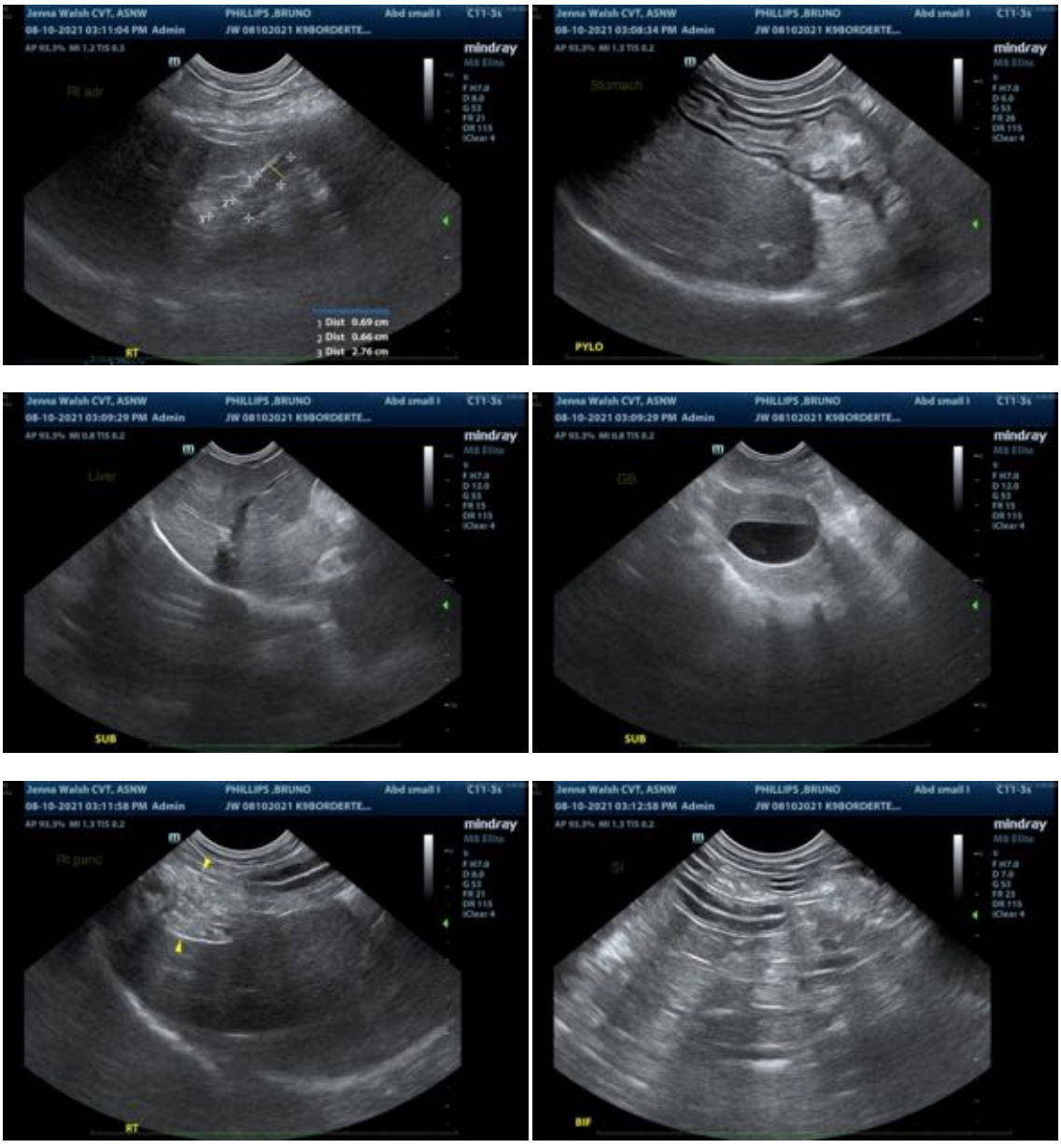

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

andrea.nicastro@sonopath.com

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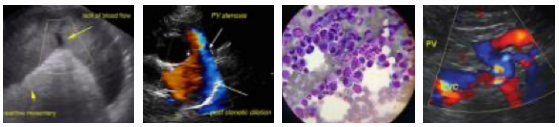

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