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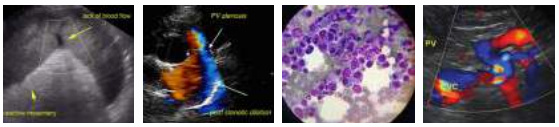

ANIMAL SOUNDS NW
MOBILE VETERINARY ULTRASOUND
IMAGING PERFORMED BY
AnimalSoundsNW.com 541-357-9423

PATIENT
Murphy Neubaum

SPECIES
Canine

BREED
Labradoodle

SEX
Female Spayed

AGE
12 years

WEIGHT
26 lbs.

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

IMAGING PERFORMED BY
Jenna Walsh

HOSPITAL NAME
West Hills Animal Hospital

REFERRING VET
Dr. Remcho

DATE
8/11/21

INVOICE
11617kk

PRESENTING CLINICAL SIGNS

History: P was recently seen for senior screen and preventative dentistry. P is 1 year post sarcoma removal from chest wall. Overall P has been well with only occ. bilious vomiting. Yesterday P presented with lethargy. Pale mm noted on exam and slight lumbar pain. Sedation protocol: 1 ml Fentanyl IV Seven radiographs of the thorax and abdomen were reviewed. The cardiac silhouette is within normal size limits and the pulmonary vasculature is unremarkable. The pulmonary parenchyma is within normal limits, with no evidence of pneumonia, soft tissue nodules or other abnormality. There is mild soft tissue swelling associated with the right caudal thoracic wall, with some evidence of deformity of the underlying ribs. There is a hempclip noted in this region also. Abdominal serosal detail appears mildly reduced. The liver and spleen are of normal size and shape. The kidneys appear symmetric and within normal size limits and the urinary bladder is mildly distended. There is mild fluid and gas filling of the G.I. tract.

Abnormal PE/Chem/CBC/UA Results: PCV 29.7% with 300,000 retics, WBC 32,000, PLT 55,00 and possible nRBC present. Other lab testing is wnl (One month prior, PVC previously was 42% - protein levels are unchanged over the month 6.1)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly distended. The wall is of appropriate thickness for the level of repletion. The mucosal surface is smooth. A small amount of echogenic debris is suspended within the lumen. No cystic calculi are observed. The region of the trigone is normal.

The left kidney is normal size (4.81 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 (5.19 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. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.69 cm at cranial pole) (0.49 cm at caudal pole) (1.57 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 (0.97 cm at cranial pole) (0.56 cm at caudal pole) (2.11 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 patient was previously splenectomized.

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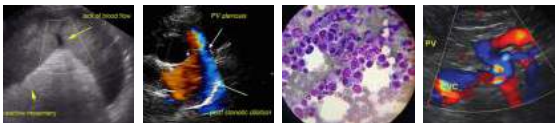

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Liver

The liver is subjectively normal in size with some rounding of the right lobes. The parenchyma is slightly mottled in appearance. No distinct focal lesions are observed. Hepatic vasculature and intrahepatic 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 anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric wall in the region of the fundus is normal in thickness with a normal layering pattern. Within the pyloric antral lumen, a small amount of fluid is present. The pyloric wall is thickened (up to 1.28 cm) and slightly irregular with a prominent muscularis layer. There appears to be 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 body/right limb of the pancreas is prominent to enlarged with irregular, peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat. No distinct focal lesions are observed. The pancreatic duct is not overtly dilated.

Free Abdomen

The mesentery in the cranial abdomen is hyperechoic. A small to moderate amount of echogenic free fluid is present. 1-2 prominent lymph nodes are suspected in the cranial abdomen.

ULTRASONOGRAPHIC FINDINGS

- The ascites may be a result of hemorrhage, increased vascular permeability, increased hydrostatic pressure, and other.
- The pancreatic changes are consistent with mild to moderate pancreatitis.
- The pyloric antral wall changes are most consistent with inflammation and/or hypertrophy with a lower possibility of emerging neoplasia.
- The hepatic parenchymal changes are most consistent with benign pathology. However, a more insidious process cannot be excluded.

Secondary Findings:

- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- Minor, age-related renal pathology.
- Urinary bladder debris.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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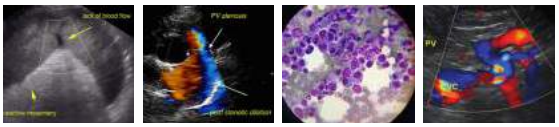

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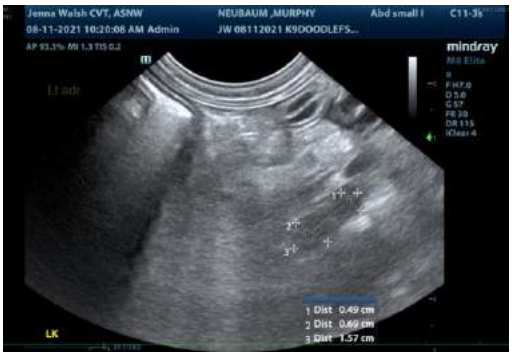
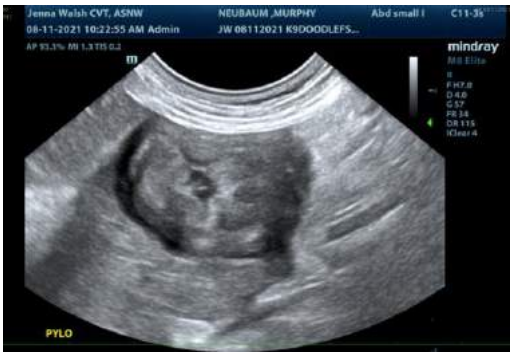
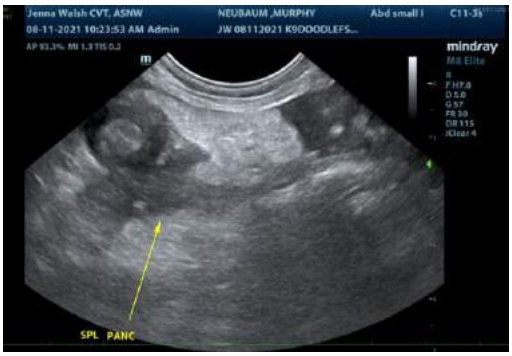
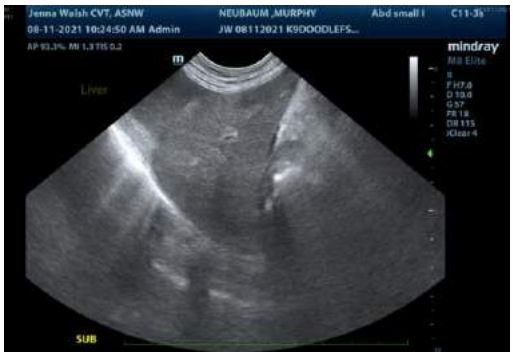
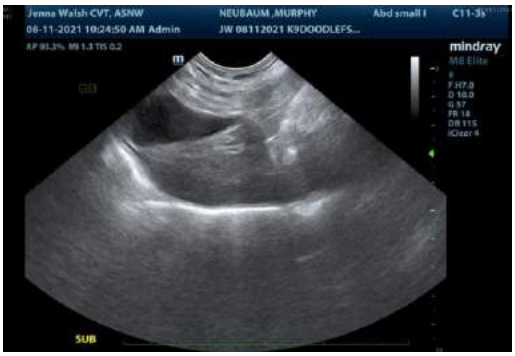
1. A fine needle aspirate of the abdominal fluid is recommended (if PT and PTT are normal). A 25-gauge needle should be used. If the fluid is consistent with hemorrhage and clotting times are normal, a small bleeding tumor may be present that was not visible sonographically. If the fluid is not consistent with hemorrhage, it should be submitted for cytologic evaluation.
2. If a hemoabdomen is not present, other diagnostic considerations include the following:
    a. Slide aggrupation to assess for autoagglutination.
    b. 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/)

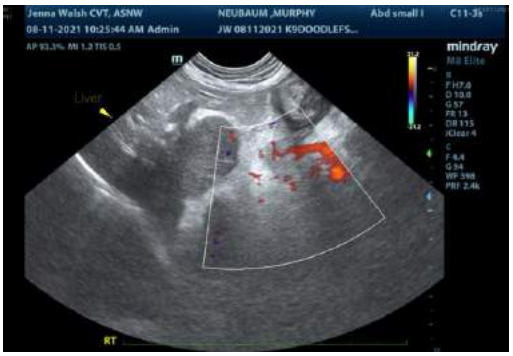












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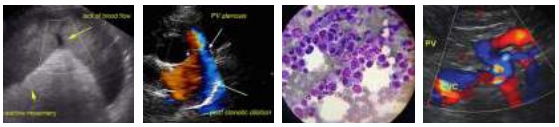

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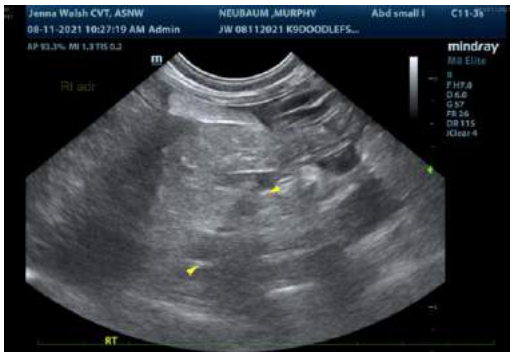

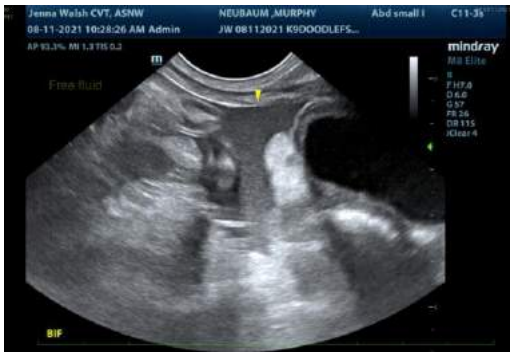

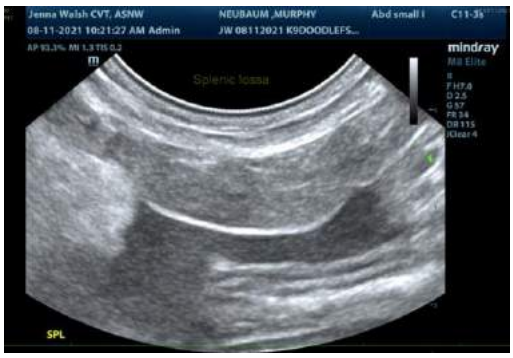

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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