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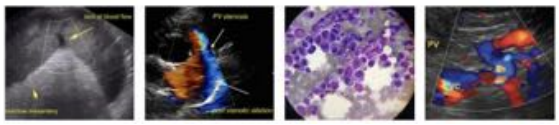


Charleston Mobile Veterinary Services
IMAGING PERFORMED BY
CharlestonMobile.Net 800.403.5408

PATIENT

Honey Tobey

SPECIES

Canine

BREED

Poodle

SEX

Female, spayed

AGE

10/14/10

WEIGHT

2 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

REFERRING VET

Dr. Marcario

INVOICE

13342

DATE

5/10/22

PRESENTING CLINICAL SIGNS

11.5 yo FS Poodle with lethargy, febrile, waxing and waning appetite. Honey was spayed in January of 2022 and has had some mucoid vulvar discharge recently. Cytology revealed neutrophils. No obvious bacteria.

HX nonacidotic ketotic DM- chronic
hepatomegaly
pancreatitis
increased LEs
anal sac mass

CBC- NSF
Chem gluc 384, BUN 28, ALKP 238, Chol 404, lip 2230
UA USG >1.050 quiet sediment Glucose 1000 ketone 15
AXR- stomach is distended with possible thickening of the stomach wall, possible splenic mass seen on VD.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended. The wall is normal in thickness with a smooth mucosal surface. A moderate amount of suspended echogenic debris is observed within the lumen. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2-3 cm, are normal. A 1.18 x 0.65 cm irregular hypoechoic to heterogeneous lesion is adjacent +/- adhered to the cystourethral junction dorsally.

The left kidney is normal size (4.92 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. A hyperechoic medullary band is observed at the corticomedullary junction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

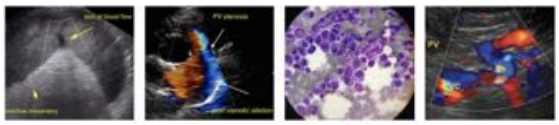
The right kidney is normal size (5.62 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. A hyperechoic medullary band is observed at the corticomedullary junction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is enlarged (0.61 cm at cranial pole) (0.88 cm at caudal pole) (1.79 cm in length) with a slightly irregular shape. 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 mildly enlarged (0.95 cm at cranial pole) (0.66 cm at caudal pole) (1.83 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



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The spleen is normal in size (0.92 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively enlarged with slightly swollen peripheral contours. The parenchyma is hyperechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion. The portal vein: caudal vena cava ratio is approximately 1:1. The gall bladder lumen is moderately distended. The wall is thin and smooth. A small amount of aggregated echogenic partially dependent debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is mildly 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 limbs and base of the pancreas are 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

Trace retroperitoneal fluid is observed. The abdominal lymph nodes are normal/not visible.

Other

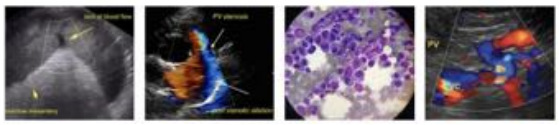
The uterine stump is fluid distended (up to 0.82 cm) with a thickened wall (0.32 cm). The proximal aspect (1.18 x 0.65) irregular hypoechoic to heterogeneous lesion/structure is observed and appears to be adjacent +/- adhered to the cysto urethral junction. The mesentery surrounding the uterine stump is hyperechoic/reactive.

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- Suspected stump pyometra with adjacent retroperitonitis. The lesion at the cranial aspect of the uterine stump, which is also adjacent +/- adhered to the caudodorsal urinary bladder wall, may represent an abscess, granuloma, or less likely, a tumor.
- The urinary bladder debris could be consistent with cells, crystals and/or exfoliated material.



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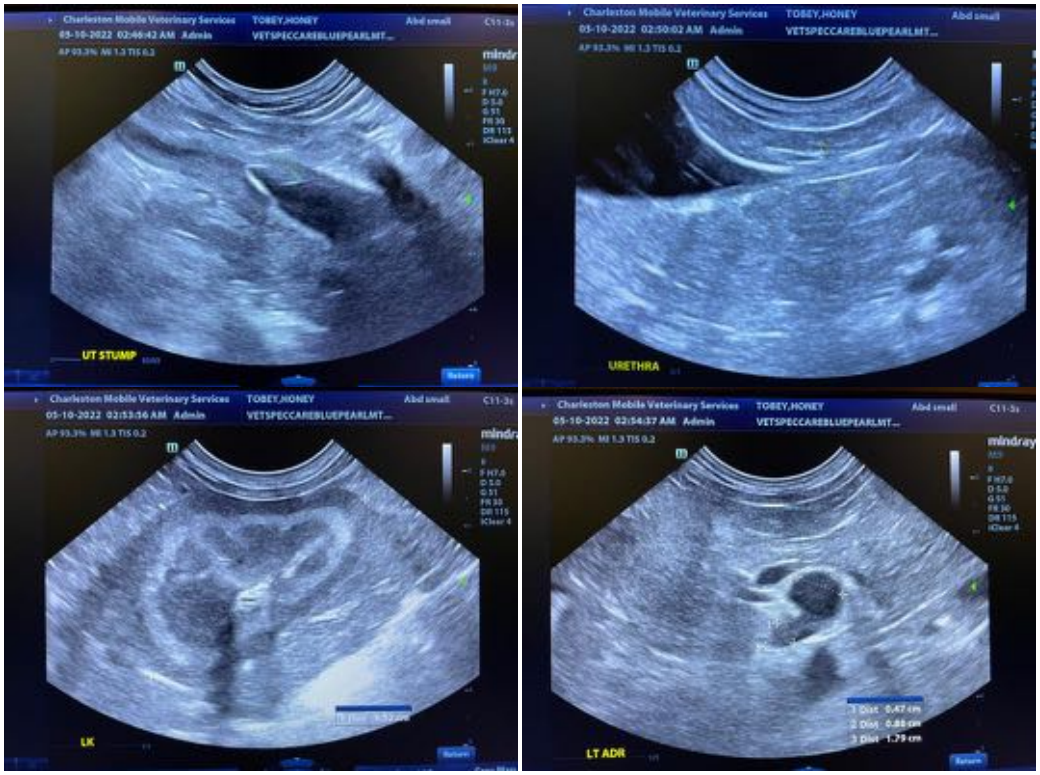
Secondary Findings:

- Mild bilateral adrenomegaly.
- Bilateral renal changes consistent with diabetic nephropathy.
- The hepatic parenchymal changes are non-specific and are at least in part likely secondary to diabetes mellitus. Concurrent regenerative nodular hyperplasia, inflammatory disease or other hepatopathy cannot be completely excluded. Infiltrative neoplasia is possible but 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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- An abdominal exploratory with evaluation +/- removal of the uterine stump and submission of all abnormal tissue for histopathology is recommended. A thorough search for an ovarian remnant is also recommended. Thoracic radiographs should be performed prior to anesthesia to assess cardiopulmonary status.
- A urinalysis +/- urine culture and sensitivity should also be considered, particularly if the patient has an active urine sediment.



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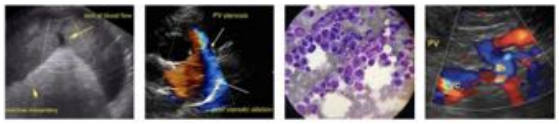

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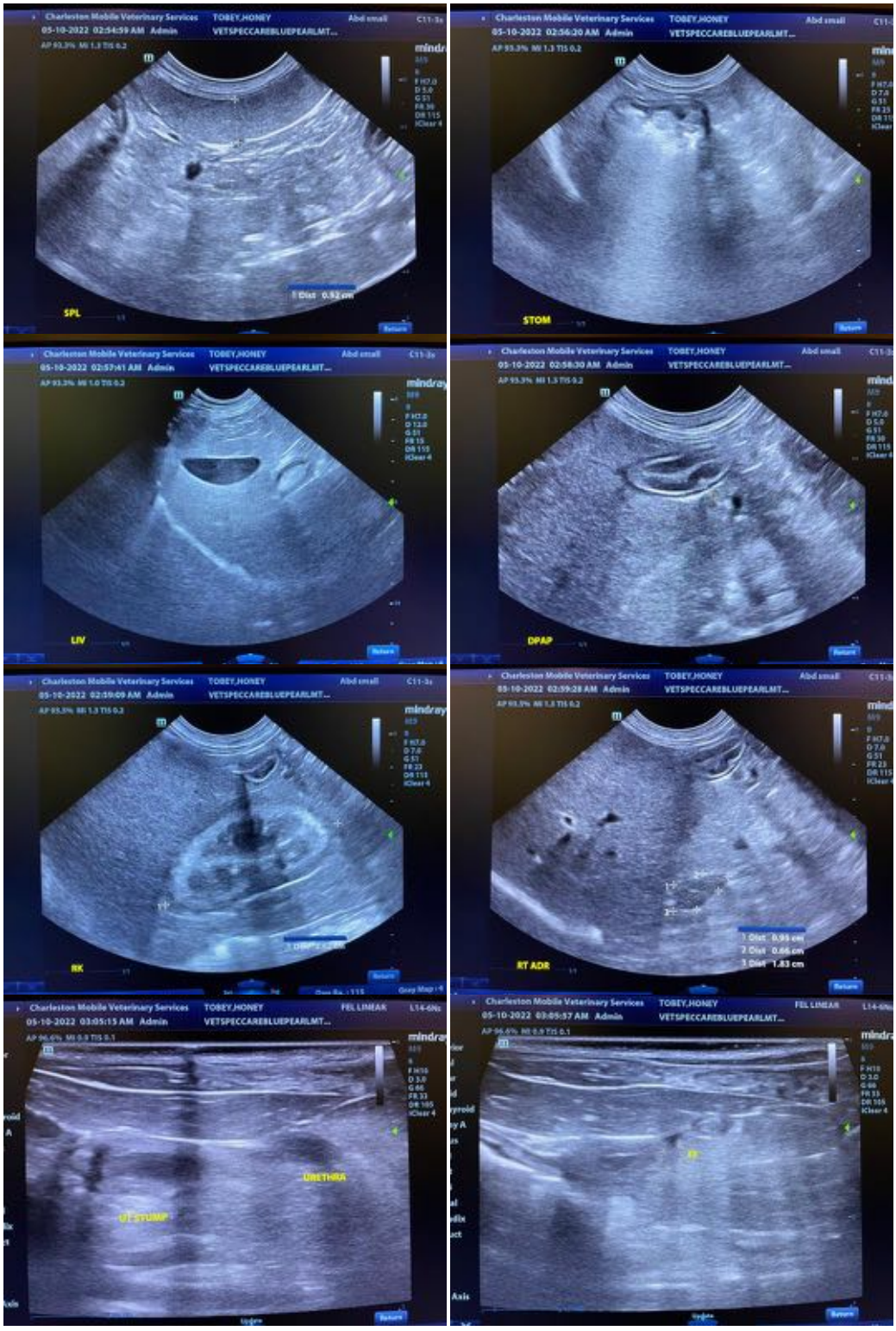

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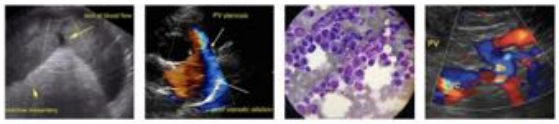

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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