IMAGING PERFORMED BY

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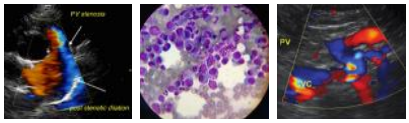

SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
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DATE

1/23/23

PATIENT

Bailey Leicht

SPECIES

Canine

BREED

Mixed

SEX

Spayed Female

AGE

6/1/2005

WEIGHT

49 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Animal Emergency Hospital

REFERRING VET

Dr. Kalwa

INVOICE

20756

PRESENTING CLINICAL SIGNS

History: Has been on Deramaxx for arthritis as well as Welactin and Dasuquin
Slowing, more trouble walking Went to rDVM; diagnosed with UTI; referred for continued care. At that time with RDVM-- rest of labwork wnl except mild non regen anemia and have a single lateral thorax. Tonight 1/23 noted her very winded after walking AFAST and can see FF in abdomen- Tapped and got light pink tinged/serosanguinous fluid
No obvious pericardial fluid, Lungs harsh, MM muddy after the walk-- panting heavily, pulse are synchronous. Worried about Right side heart vs cancer. RDVM rads =- only lateral chest , heart is plump, hepatosplenomegaly visible on 1/2 image of the abdomen, no obvious mass or loss of detail. Started lasix and pimobendan, off IVF, and chest fims-- cardiomegaly and faint edema pattern.

Current Medications: Lasix, Gabapentin, Cerenia, Clavamox, Buprenorphine.
Lab Results: See attached.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Rachel Brilhart, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Left kidney is normal is size (5.88 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia or infarcts observed. Nonobstructive mineralization is noted.

Right kidney is normal is size (6.0 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia or infarcts observed. Nonobstructive mineralization is noted.

Adrenal Glands

Left adrenal gland is normal in size (2.56 cm long x 0.78 cm at cranial pole and 0.84 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (2.51 cm long x 0.92 cm at cranial pole and 0.8 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is generally normal in size and shape with a smooth capsular contour. Parenchyma is diffusely nodular in appearance characterized by small discrete hypoechoic nodules. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged (swollen contour). Mild parenchymal remodeling with diffusely mildly coarse architecture and increased portal markings is present. Several cystic lesions are present, the largest of which measures 1.5 cm. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is moderately distended with anechoic bile as well as very mild suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The stomach is mildly distended and contains an echogenic interface with distal progressively shadowing material consistent with hairball density (or similar fluid absorbing material) noted.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The observed pancreas appears appropriately isoechoic to surrounding omental fat. The capsule is mildly irregular in shape. Parenchyma is mildly heterogenous and coarse. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

Both a small amount of anechoic free abdominal fluid and pleural effusion are noted in these images.

The mesenteric lymph nodes are enlarged with swollen irregular capsular contour and loss of normal length to width ratio (rounded in shape). Nodes are hypoechoic with loss of normal parenchymal detail.

The cranial abdomen is diffusely filled with hyperechoic enhanced mesenteric fat.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Hypoechoic hepatomegaly-This appearance is consistent with an acute hepatopathy or acute cholangiohepatitis. Infiltrative neoplasia (round cell neoplasia) should also be considered.

- Aggressive mesenteric lymph nodes – most consistent with infiltrative round cell or metastatic neoplasia. A benign aggressive inflammatory response cannot be ruled out without tissue sampling +/- culture.

- Splenic micronodular hyperplasia – This nodular change is often associated with benign aging nodular hyperplasia. Infiltrative neoplasia, however, including both early hemangiosarcoma as well as round cell neoplasia cannot be ruled out.

- Bicavitary effusion can certainly occur with congestive heart failure, and congestive heart failure should be definitively ruled out. However, given the enhanced mesenteric fat, lymphadenopathy, etc., a paraneoplastic effusion/inflammatory effusion is considered equally likely.

Secondary Findings

- Nonobstructive nephrolithiasis bilaterally
- Pancreatic age-related remodeling – Mild irregularities are consistent with benign age-related change. Low-grade smoldering chronic pancreatitis cannot be ruled out and should be suspected in the face of appropriate clinical signs.
- Very mild gallbladder debris - Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.
- A soft gastric foreign body, such as hair or soft material is suspected, however, normal ingesta/gas cannot be definitively ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

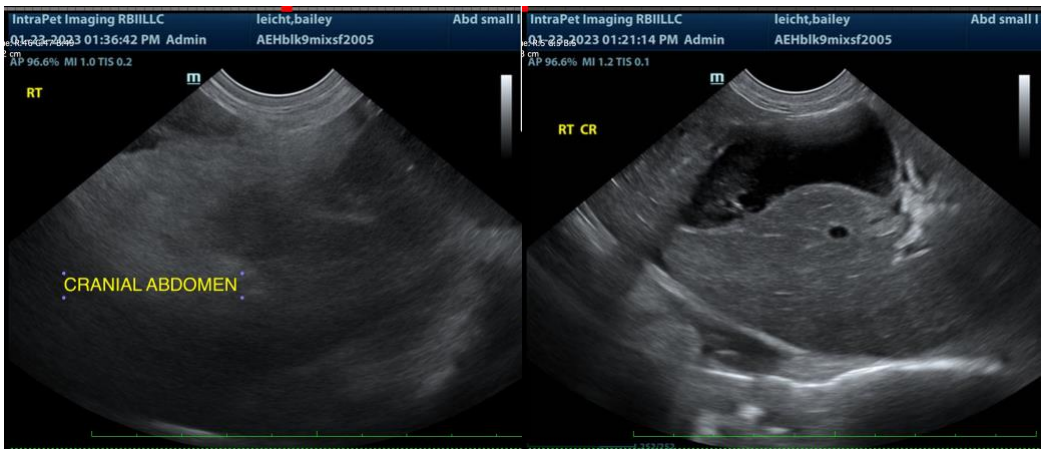
If not recently evaluated, three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

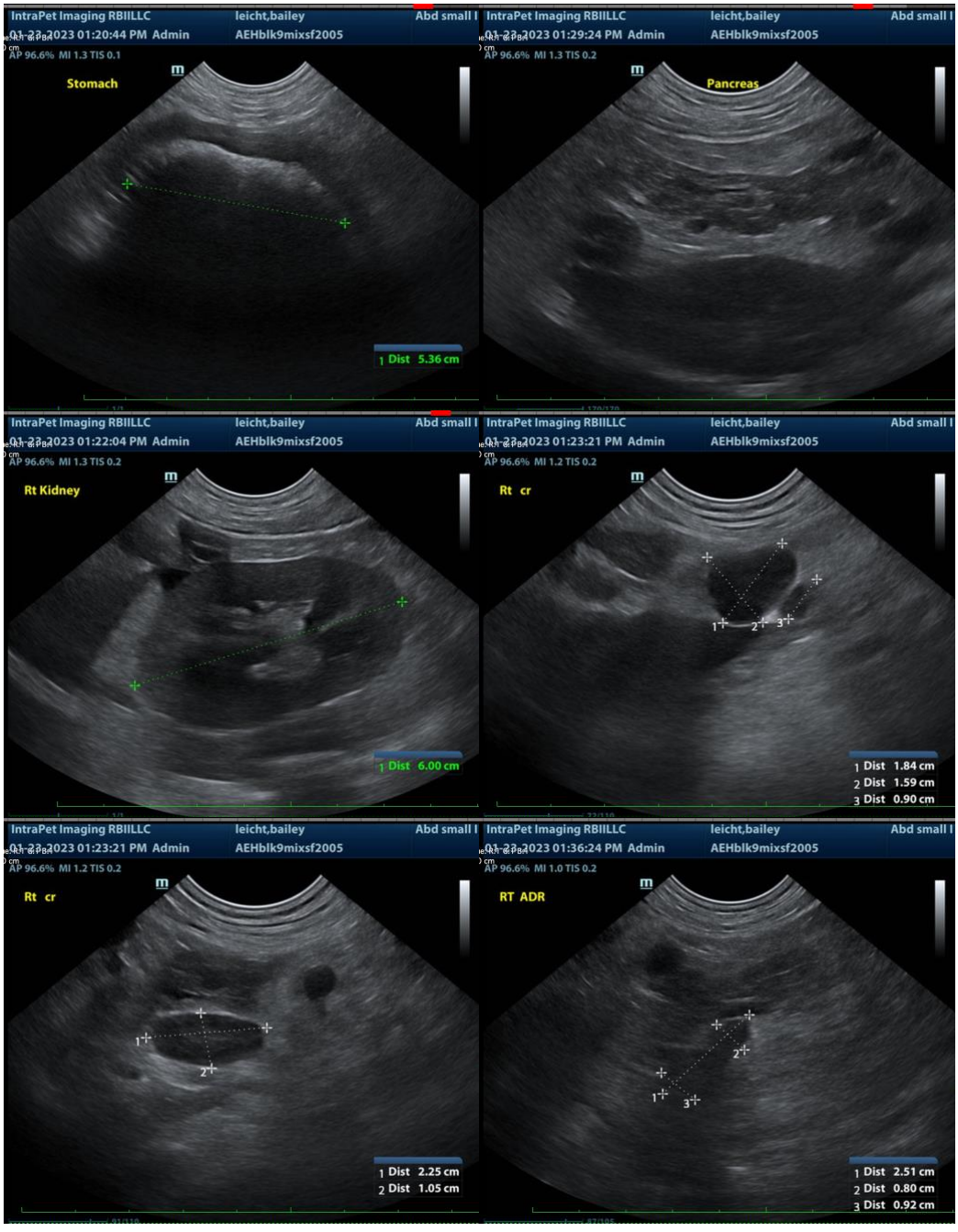
A full echocardiogram is recommended.

In the meantime, or prior to pursuing an echocardiogram, a fine needle aspirate of the enlarged lymph nodes +/- spleen and liver could be considered if patients coagulation status is appropriate.

Additionally, if the small fluid amount present can be safely sampled, fluid cytologic analysis could also be evaluated to look for evidence of paraneoplastic change.

Given this patients primary presenting complaint of respiratory signs, the suspect possible gastric foreign body is considered an incidental finding and should be interpreted in combination with clinical signs and/or rechecked to help more definitively identify foreign material vs normal ingesta.

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Stomach
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Abd small I
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Pancreas
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Rt Kidney
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leicht,bailey
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IntraPet Imaging RBIILLC
leicht,bailey
Abd small I
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IntraPet Imaging RBIILLC
leicht,bailey
Abd small I
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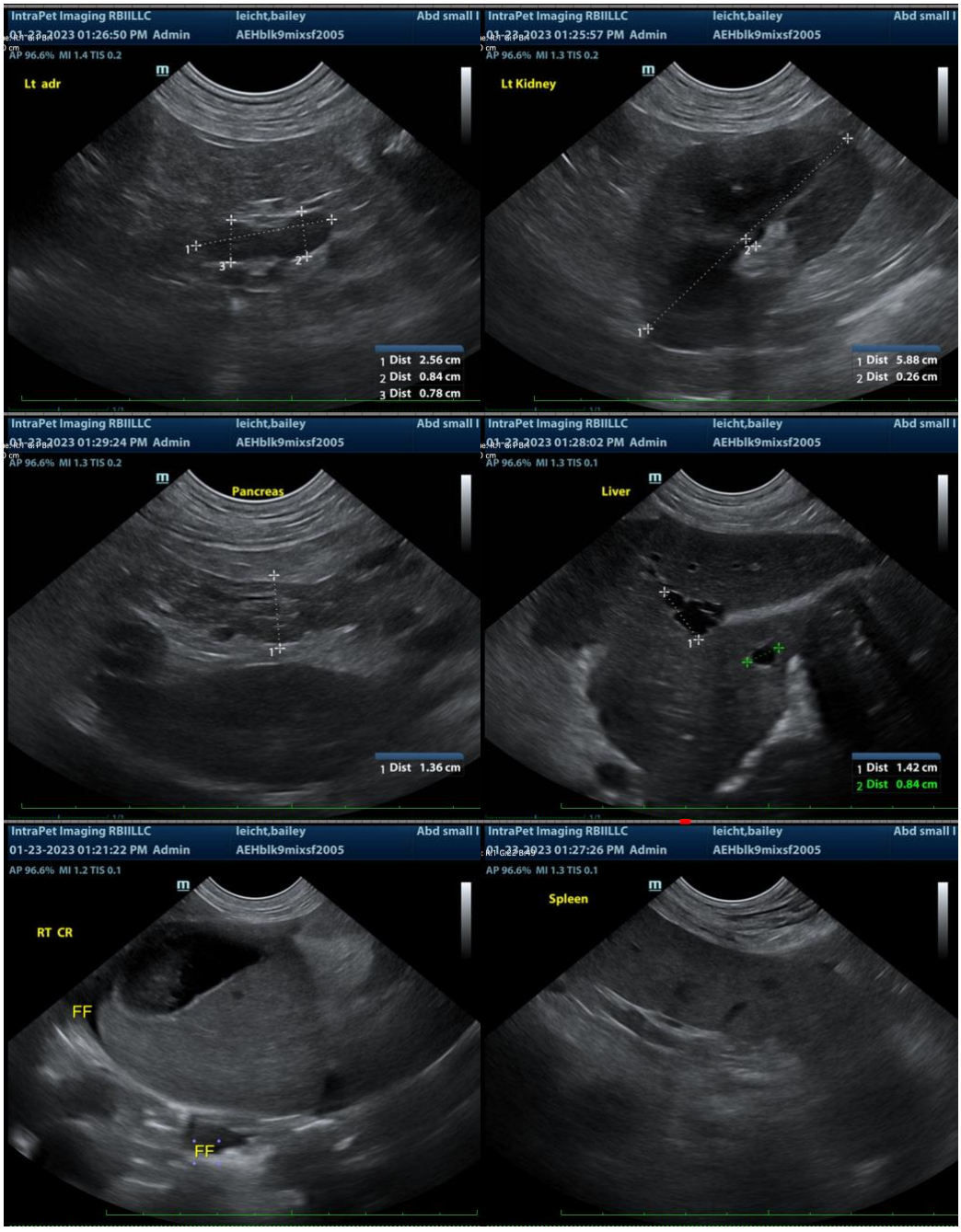
RT ADR
1 Dist 2.51 cm
2 Dist 0.80 cm
3 Dist 0.92 cm



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.

Beth Johnson, DVM DACVIM
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