



PATIENT

Chilly Boyinski

SPECIES

Canine

BREED

Pekingese

SEX

Spayed Female

AGE

7 Years

WEIGHT

10 kg

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Erin Wicks

HOSPITAL NAME

Shores VEC

REFERRING VET

Dr. Law

INVOICE

17803

DATE

10/18/22

PRESENTING CLINICAL SIGNS

History: Presented at our hospital for transfer from rdvm. Lethargy, anorexia. Pcv today 29%. Seen at rdvm on 10/13 blood work hct 36%, borderline Anaplasma positive. Previous Health Concerns: collapsing trachea, luxating patellas Current Medications: apoquel, since 10/13 metronidazole, entyce, proviable (difficulty medicating, no meds given in a few days) Appetite/When did they eat last: not eating for 5-7 days; 3 days ago ate small amount of pasta

Abnormal PE/Chem/CBC/UA Results: Cbc: wbc 28.85 H, neu 18.08 H, lym 8.45 H, bas 0.45 H, bas 1.6% H, rbc 3.68 L, hgb 9.8 L, hct 28.8% L, mcv 78.2 H Liver: glucose 138 H, ALP 309 H Epoc: pO2 89.3 H, O2SAT 97.4% H, pCO2 26.7 L, lactate 3.97 H, hct 27% L Flex 4 : positive anaplasma Rdvm rads: enlarged liver and spleen

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 (4.66 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, mineral or infarcts observed. A hyperechoic band parallel to the corticomedullary border is present.

Right kidney is normal is size (4.64 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, mineral or infarcts observed. A hyperechoic band parallel to the corticomedullary border is present.

Adrenal Glands

Left adrenal gland is normal in size (2.2 cm long x 0.56 cm at cranial pole and 0.45 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal. Hyperechoic nodules were noted in the cranial and caudal pole of the left adrenal gland.

Right adrenal gland is normal in size (0.42 cm at cranial pole and 0.46 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large in size with a mildly swollen but smooth capsule. Parenchyma is normal and homogenous in echogenicity and echotexture. No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged (swollen contour) without disruption of architecture. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen and falciform fat. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.



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Gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

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The Fundic mucosal hypertrophy with hyperechoic mucosa and some mucosal remodeling is noted. There is no loss of mural detail. Layering is normal. There is mild luminal fluid accumulation. No evidence of masses/nodules or foreign material present.

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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.

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

Pancreas

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The observed pancreas appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

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There is no appreciable free fluid and no specific lymphadenopathy noted in these images, however, medial to the spleen, in the area of the pancreas, there is a 1.2 cm x 0.7 cm hypoechoic structure that appears to be a possible splenic lymph node.

ULTRASONOGRAPHIC FINDINGS

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- Hyperechoic hepatomegaly – This appearance is non-specific and most consistent with a benign steroid (endocrine) or vacuolar hepatopathy or reactive or idiopathic hepatopathy. Inflammatory and/or infiltrative disease (such as round cell neoplasia) are also possible, but considered less likely.

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- Hypersplenism – can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.

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- Lymphadenopathy medial to the spleen, both reactive lymphadenopathy, as well as infiltrative neoplasia are differentials and cannot be differentiated without tissue sampling.

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- Gastritis – Consistent with irritation secondary to dietary indiscretion or intolerance, infection (bacterial, viral, other), parasitic or protozoal disease, toxin, other metabolic disease such as pancreatitis, other. Microulceration cannot be ruled out.

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- Medullary rim sign bilaterally - This finding is of unknown clinical significance and can be a normal variant, often idiopathic. Medullary rim sign can be present with renal disease including FIP, lymphoma, hypercalcemic nephropathy, Leptospirosis, tubular disease, other and should be interpreted in combination with other more specific indications of kidney disease such as isosthenuria, proteinuria, azotemia, etc. This is a common incidental finding in patients with diabetes mellitus.

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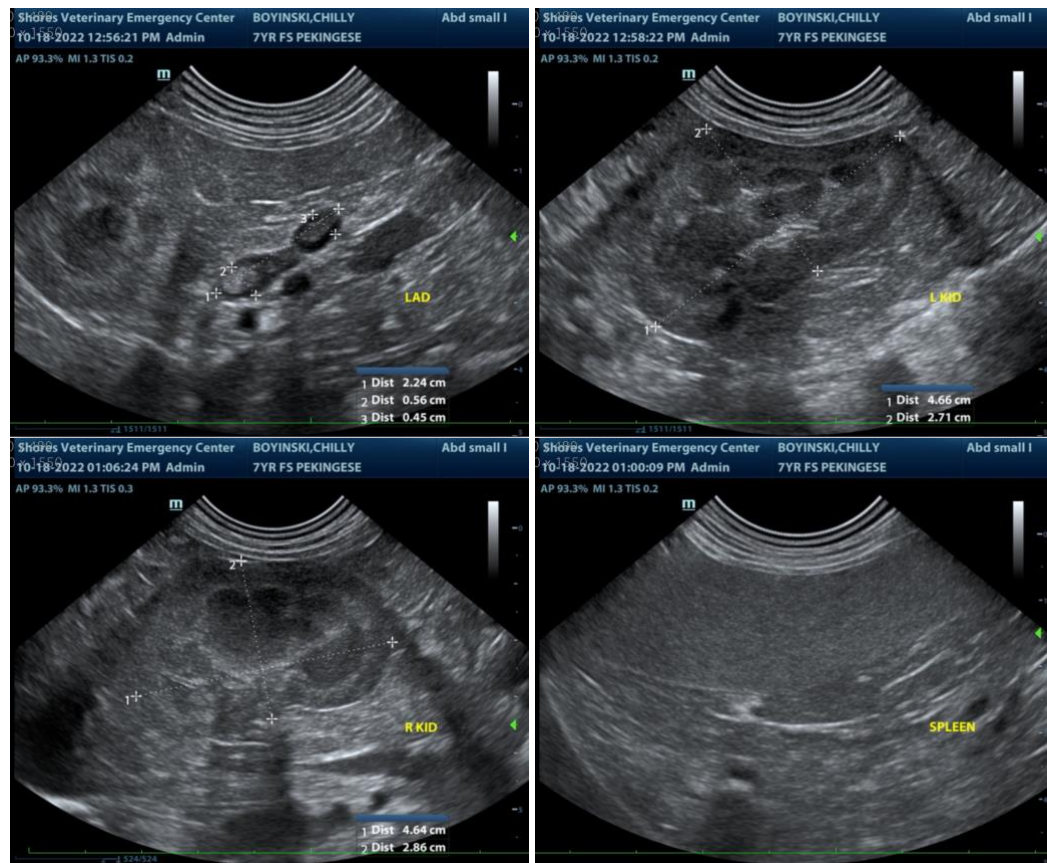
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Recommendations for this patient include a fine needle aspirate of the spleen +/- the liver, and if possible to safely reach the enlarged node medial to the spleen (if patients coagulation status is appropriate). Additionally, given the prolonged anorexia, a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function and a baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

In the meantime, therapeutic recommendations include addressing the anaplasma, as well as any other infectious disease that may be coinfections, as well as suspected mild gastritis with antiemetics, gastroprotectants, including twice per day antacid therapy and an appetite stimulant. However, given the difficulty medicating this patient while inappetent, it may be warranted to place a short-term feeding tube long enough to begin managing the anaplasma in addition to the suspected secondary anemia, as well as the gastrointestinal signs, etc. while awaiting for pending cytology results. Empirical deworming with a 5-day course of Panacur is also recommended.





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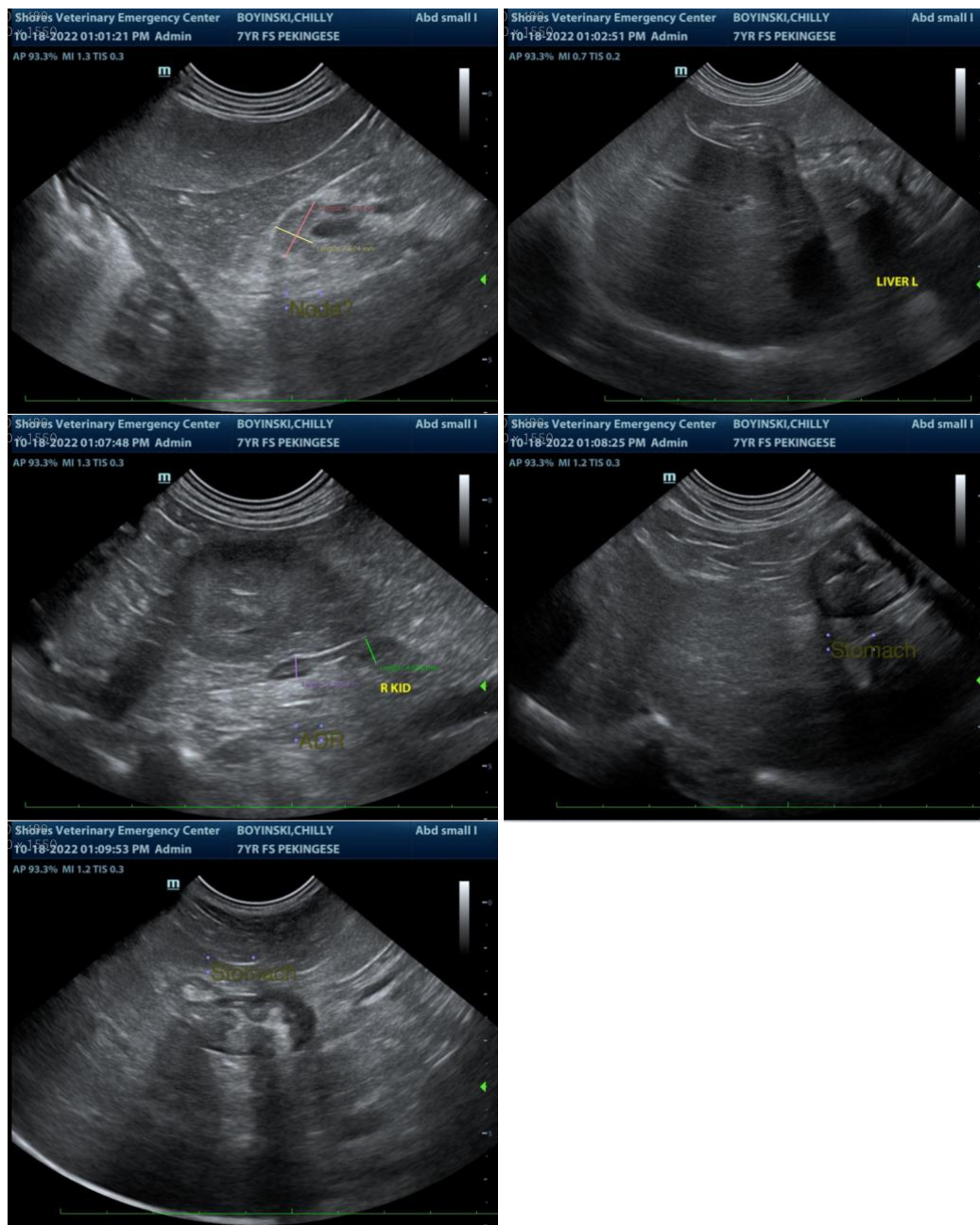
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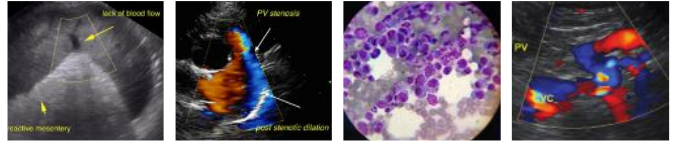


The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM DACVIM

Beth.Johnson@SonoPath.com



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