



PATIENT

Millie Apicella

SPECIES

Canine

BREED

Mixed

SEX

Spayed Female

AGE

12 Years

WEIGHT

23 kg

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Erin Wicks

HOSPITAL NAME

Shores VEC

REFERRING VET

Dr. Lupole

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DATE

3/28/23

PRESENTING CLINICAL SIGNS

History: Presented at our hospital for vomiting, anorexia. Seen at rdvm yesterday, concern for foreign body. Previous Health Concerns: CCL, arthritis, allergies (pollen) Current Medications: cbd pill; cytopoint; cerenia injection and sq fluids at rdvm today 12 pm Appetite/When did they eat last: decreased few days, did eat 2 meals yesterday, NE now

Abnormal PE/Chem/CBC/UA Results: Respiratory: mild increase BV sounds Abdominal: soft/ tender rads- primary vet- mid abdominal mass effect/ haze; no gas distension to SI or stomach Severe bilateral hip dysplasia BW- SVEC: Chem- ALT 124(H) ggt 16(H) EPOC- CI 105(L)

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 in size (6.92 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.

Right kidney is normal in size (7.41 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.

Adrenal Glands

Left adrenal gland is normal in size (3.62 cm long x 0.62 cm at cranial pole and 0.94 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.62 cm at caudal pole, cranial pole is unable to be well visualized in these images), 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. A (1.5 cm in diameter) hypo- to anechoic cystic non-capsule-disrupting nodule, as well as multifocal well-demarcated hyperechoic homogenous nodules are noted throughout the parenchyma. Splenic vasculature appears normal.

Liver

Liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

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 visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

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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.

**See Free Abdomen section.

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Pancreas

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.

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There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

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There is no evidence of peritoneal effusion. The medial iliac lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

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**In the mid abdomen, there is a focal bowel loop with an echogenic interface and distal progressively shadowing appearance, that, I believe, is normal colon, however, small bowel with a hairball or other similar fluid absorbing material cannot be ruled out. There is no obstructive pattern, plication, etc., to suggest that this is a small bowel obstruction.

ULTRASONOGRAPHIC FINDINGS

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- Hypersplenism with a hypo- to anechoic splenic nodule and hyperechoic splenic nodules – 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. The hypo to anechoic splenic nodule likely represents a benign lesion such as a cyst, hematoma, nodular hyperplasia, extramedullary hematopoiesis, etc., however while considered less likely, infiltrative neoplasia can mimic benign lesions, and cannot be ruled out. The hyperechoic splenic nodules are most consistent with benign myelolipomas. Other differentials such as fibrosis or calcification caused by old hematomas or infarcts, chronic inflammation, granulomatous disease or metastatic disease cannot be ruled out, but are considered less likely.

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- Reactive medial iliac lymph nodes- infiltrative neoplastic disease cannot be ruled out but is considered less likely.

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- While the appearance of the bowel described above is most consistent with/and believed to be normal colon, small bowel foreign material without a supporting obstructive pattern, etc., can't be definitively ruled out.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Further investigation for underlying metabolic causes of vomiting, decreased appetite, etc., possibly gastroenteritis, is recommended, beginning with a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory, for further evaluation of GI and pancreatic function. A baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH

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stimulation test is recommended to rule out hypoadrenocorticism. Additionally, a fine needle aspirate of the spleen could be considered if patients coagulation status is appropriate.

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In the meantime, supportive/symptomatic medical management with antiemetics, gastroprotectants, an appetite stimulant, and if tolerated, potentially a short-term transition to a bland easy-to-digest, or possibly low-fat diet is recommended. Additionally, empirical deworming with a 5-day course of Panacur is recommended. If clinical signs persist, recheck imaging, being sure to trace the bowel loop described above to either small bowel or colon, if possible, is recommended.

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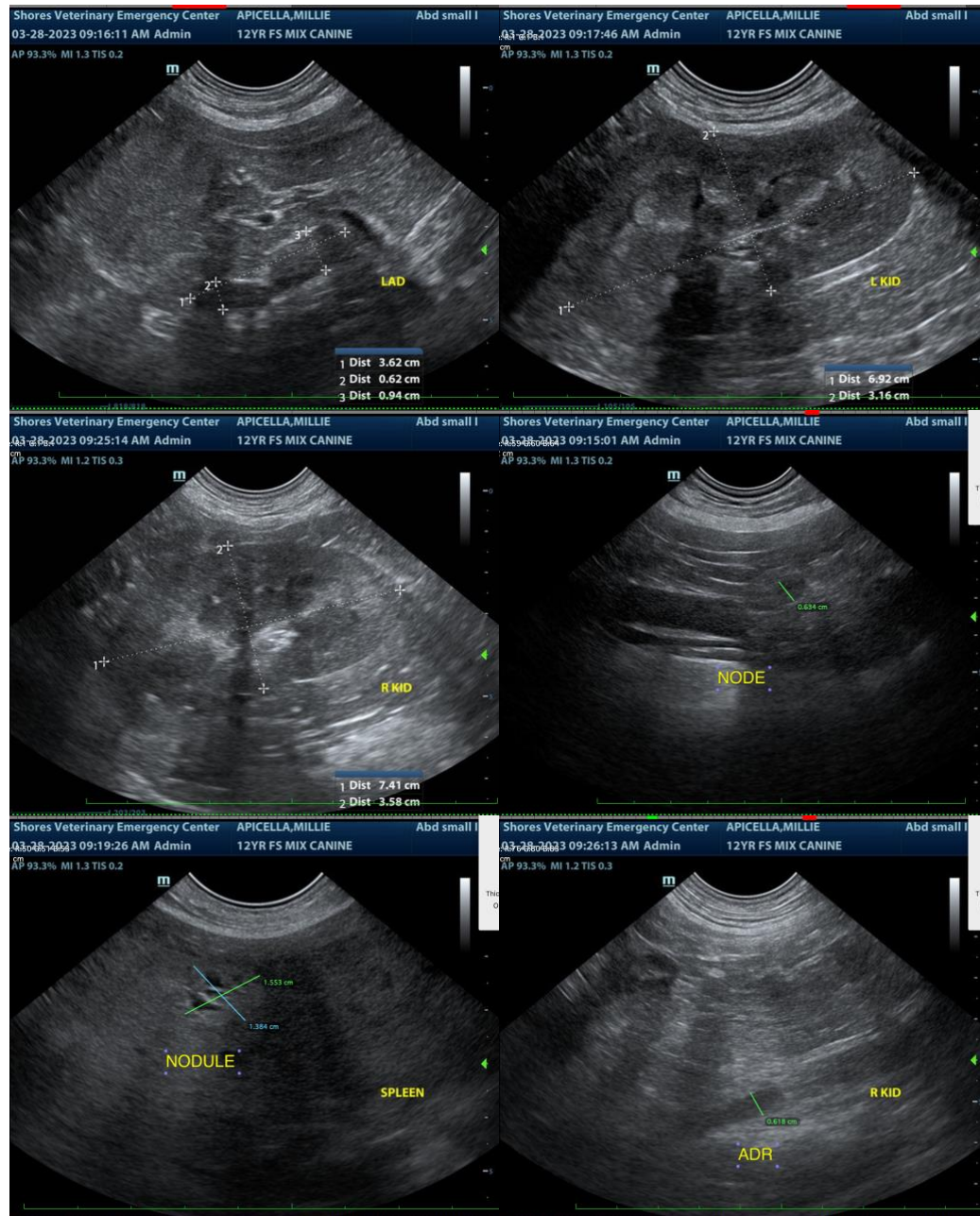
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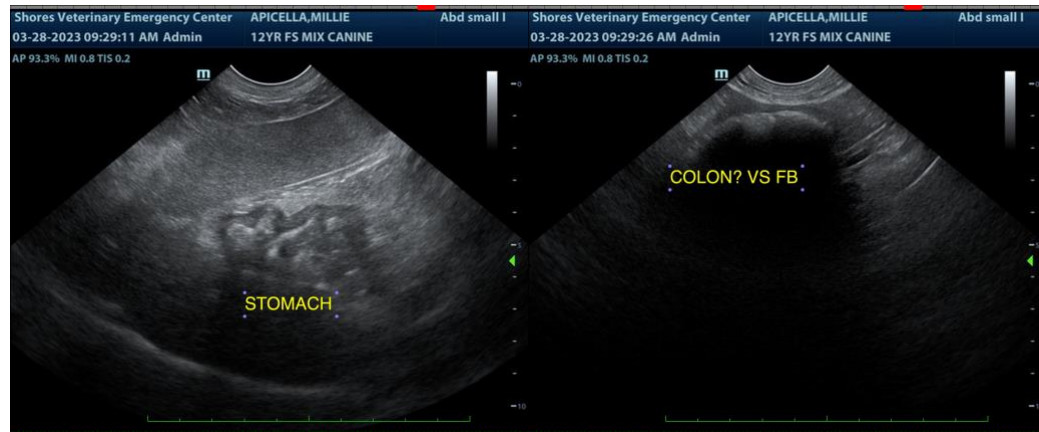
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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