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Clinical Sonography & Telecytology
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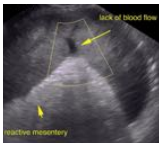
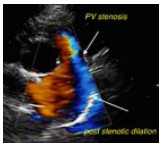
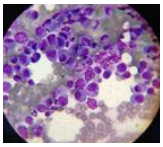
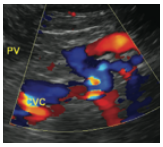





SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Kermit McKenna

SPECIES
Canine

BREED
Pug

SEX
Neutered male

AGE
11 years

WEIGHT
26 lbs

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Dr. Scott

HOSPITAL NAME
HoHoKus VH

REFERRING VET
Dr. Eisenberg

INVOICE
31766

DATE
7/19/22

PRESENTING CLINICAL SIGNS

History: Melena, decreased app and lethargy- pet did eat this morning before ultrasound Diabetic but not ketotic
Abnormal PE/Chem/CBC/UA Results: July 2nd: CBC HCT 44%, Neut 17Km WBC 21K GLu 179, ALP 1028 Yesterday: CBC: HCT 20K, MCV 81, MCH 20.6, MCHC 25, Retic 315, WBC 35.8, Neut 31K Band 71, Moderate anisocytosis, Slight spherocytes, neutrophils slightly toxic, Rouleaux present but saline agglutination negative

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with occasional echogenic non-shadowing debris, most consistent with exfoliated cells, mucous and/or small blood clots. Several, discrete, hyperechoic non-shadowing densities are noted. Cystoliths cannot be ruled out. Other differentials are mucous plugs, blood clots, etc. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Prostate (neutered) is normal in size, echotexture and echogenicity for a neutered male.

Left kidney is normal is size (5.1 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. A hyperechoic band parallel to the corticomedullary border is present. There is no evidence of pyelectasia, mineral or infarcts observed.

Right kidney is normal is size (5.0 cm),shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. A hyperechoic band parallel to the corticomedullary border is present. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

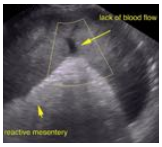
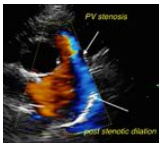
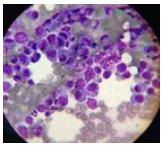
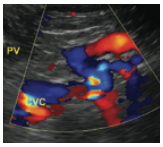
The adrenal glands are unable to be well visualized.

Spleen

Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). Multifocal well-demarcated hyperechoic homogenous nodules are noted. 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.

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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

The entire greater curvature of the stomach is mildly thick and measured 1.5 cm thick, hypoechoic in appearance with early emerging loss of layering. The stomach is mildly distended with mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

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 (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

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

Free Abdomen

There is no evidence of peritoneal effusion or apparent lymphadenopathy noted in these images. Tissue surrounding the stomach is mildly enhanced/hyperechoic in appearance.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

Mildly thick gastric wall with early emerging loss of layering suspected.

Secondary Findings

Medullary rim sign - 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.

Urinary bladder debris.

Hyperechoic splenic nodules – 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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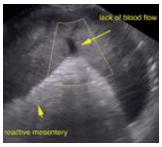
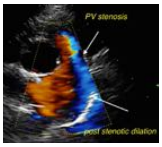
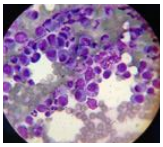
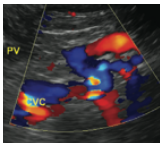

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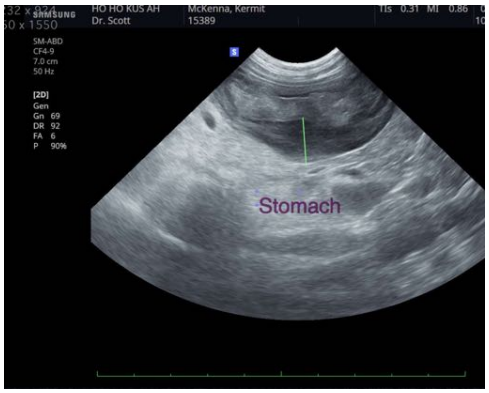
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

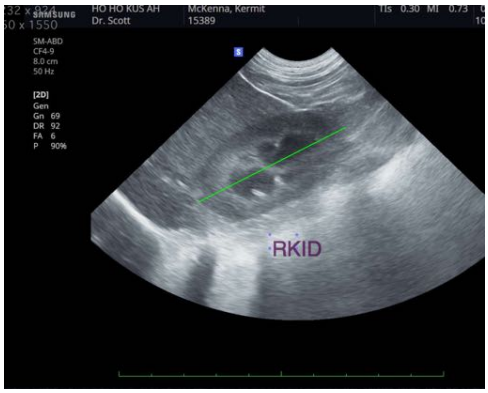
Given the reported melena combined with the reported spherocytosis in this patient include a GI bleed as well as potentially hemolysis could be contributing to the patient's anemia.

1. If the hemorrhage (melena) is believed to be severe enough to be causing this patients new anemia, and a conservative approach is elected then medical management of a GI bleed with antacids such as b.i.d. Omeprazole, Sucralfate, broad spectrum antibiotics and symptomatic support of gastrointestinal signs with close monitoring of both the melena as well as the red blood cell count for either progression or improvement could be considered along with empirical deworming with a 5 day course of Panacur. However, if a more aggressive approach is elected either a FNA of the stomach wall could be considered if the patient's coagulation status is appropriate or gastroscopy could be considered for further evaluation of the gastric mucosa as well as biopsies of the stomach.

2. If hemorrhage alone was contributing to this patient's anemia then a decrease in total solids would be expected. Therefore, if the hemorrhage is mild then the gastric changes could be secondary incidental and/or reactive/inflammatory and if hemolysis is determined to be a larger contributing factor to the anemia then further work-up of the hemolysis with infectious disease testing followed potentially by immunosuppressive therapy may be warranted. If this approach is elected, a recheck ultrasound (fasted if possible) of the stomach is recommended in 1-2 weeks.

3. 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.





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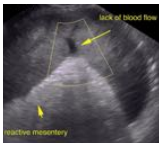
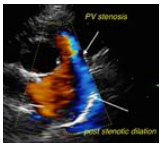
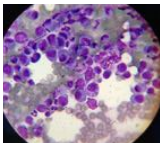
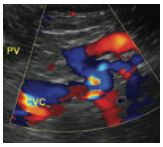

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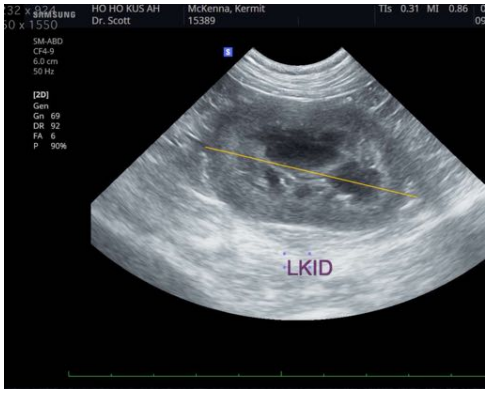

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM DACVIM

Beth.Johnson@SonoPath.com