

**PATIENT**

Doug Guest

SPECIES

Canine

BREED

Golden Retriever X

SEX

Neutered Male

AGE

9 Years 2 Months

WEIGHT

72.8 Pounds

INTERPRETED BYBeth Johnson, DVM
DACVIM**IMAGING PERFORMED BY**

Amy Mayhew, LVT

HOSPITAL NAME

SVS Imaging MI

REFERRING VET

Dr. Marie Haddock

INVOICE

43846

DATE

7/6/23

PRESENTING CLINICAL SIGNS

Hematochezia going on for one week. However, has also had a decreased appetite for at least three weeks. No vomiting observed. Hx of seizures well controlled on Zonisamide.

Abnormal PE/Chem/CBC/UA Results: Weight loss of 14 pounds since last year. Regenerative anemia with reticulocytosis; thrombocytopenia; mild neutrophilia, hypocholesterolemia, bilirubinuria, proteinuria, positive for lyme on 4dx (last done 6/22 and it was negative at that time); receives hg and topical frontline due to hx seizures; enlarged spleen on abdominal radiographs.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**Urinary System**

The urinary bladder is moderately 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.

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

The right kidney is normal in size (7.11 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.

The left kidney is normal in size (6.87 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

Adrenal glands are small (flattened contour). Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. The left adrenal gland measures 0.44 cm at the cranial pole and 0.48 cm at the caudal pole. The right adrenal gland measures 0.66 cm at the cranial pole and 0.60 cm at the caudal pole.

Spleen

The spleen is generally normal in size and shape with a smooth capsular contour. The parenchyma is diffusely somewhat nodular in appearance, characterized by primarily small, less than 1.0 cm in diameter, discrete hypoechoic, non-capsule disrupting nodules throughout the parenchyma. There are several larger more heterogeneous appearing nodules present as well, including a 2.5 cm x 3.5 cm heterogeneous, primarily hypoechoic mid body nodule, again non-capsule disrupting, as well as a 2.0 cm x 2.4 cm primarily hypoechoic nodule, again non-capsule disrupting, near the head of the spleen.

Liver

The 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 moderately distended with anechoic bile as well as 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.

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Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is 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 (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). 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 pancreatic parenchyma is appropriately isoechoic to surrounding tissue. Visible capsule is smooth and normal in contour. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is no evidence of free peritoneal effusion noted in these images.

Mild pancreaticoduodenal lymphadenopathy is present with a prominent hypoechoic rounded node measuring 0.60 cm in diameter imaged.

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.

There is no evidence of heart base or pericardial pathology noted in these images at this time. If cardiac function evaluation is desired a full echocardiogram is recommended.

PRIMARY FINDINGS

- Flat adrenal glands – This can be a normal patient variant and/or a sign of exogenous cortisol administration. If exogenous steroids are not being administered, hypoadrenocorticism (either relative or absolute) should be considered.
- The nodular appearance of the spleen could represent a benign change as is seen with micronodular hyperplasia, multifocal cysts or hematomas, extramedullary hematopoiesis, etc. However, infiltrative neoplasia can mimic benign lesions and cannot be ruled out without tissue sampling.
- Reactive medial iliac lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Mildly prominent pancreaticoduodenal lymph node – Both reactive lymphadenopathy as well as infiltrative neoplasia are differentials and cannot be differentiated without tissue sampling.

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SECONDARY FINDINGS

- 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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The first recommendation for this patient if not already evaluated is a manual platelet count to help determine whether the platelets are low enough to actually be resulting in the reported gastrointestinal hemorrhage, or if other causes of gastrointestinal hemorrhage should be investigated. Pending that result, further investigation of reasons for gastrointestinal hemorrhage could include:

A baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

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.

A fecal exam if not recently evaluated.

A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease.

Regardless of platelet count, in this patient specifically, given the appearance of the adrenal glands, a baseline cortisol is recommended. If the platelets are truly low, differentials include possible destruction secondary to infectious disease, paraneoplastic, or idiopathic autoimmune versus decreased production from bone marrow disease.

Given this patient's history, recommendations include comprehensive infectious disease testing, all while treating the lyme disease, which was reportedly recently diagnosed, as well as potentially a fine needle aspirate of the spleen depending on how low the platelet count is, with a fine needle aspirate only being advised if the platelet count is high enough to minimize or negate the risk of hemorrhage.

In the meantime, supportive/symptomatic medical management of the clinical signs is recommended in the form of antiemetics if clinically indicated, gastroprotectants including sucralfate, a probiotic such as Visbiome or Provable, potentially empirical deworming with a 5-day course of Panacur, as well as medical management of this patient's lyme disease.

Ultimately, if the cytopenias are believed to be a result of autoimmune destruction, immunosuppressants may ultimately be necessary. However, if possible, the remaining workup should be attempted prior.

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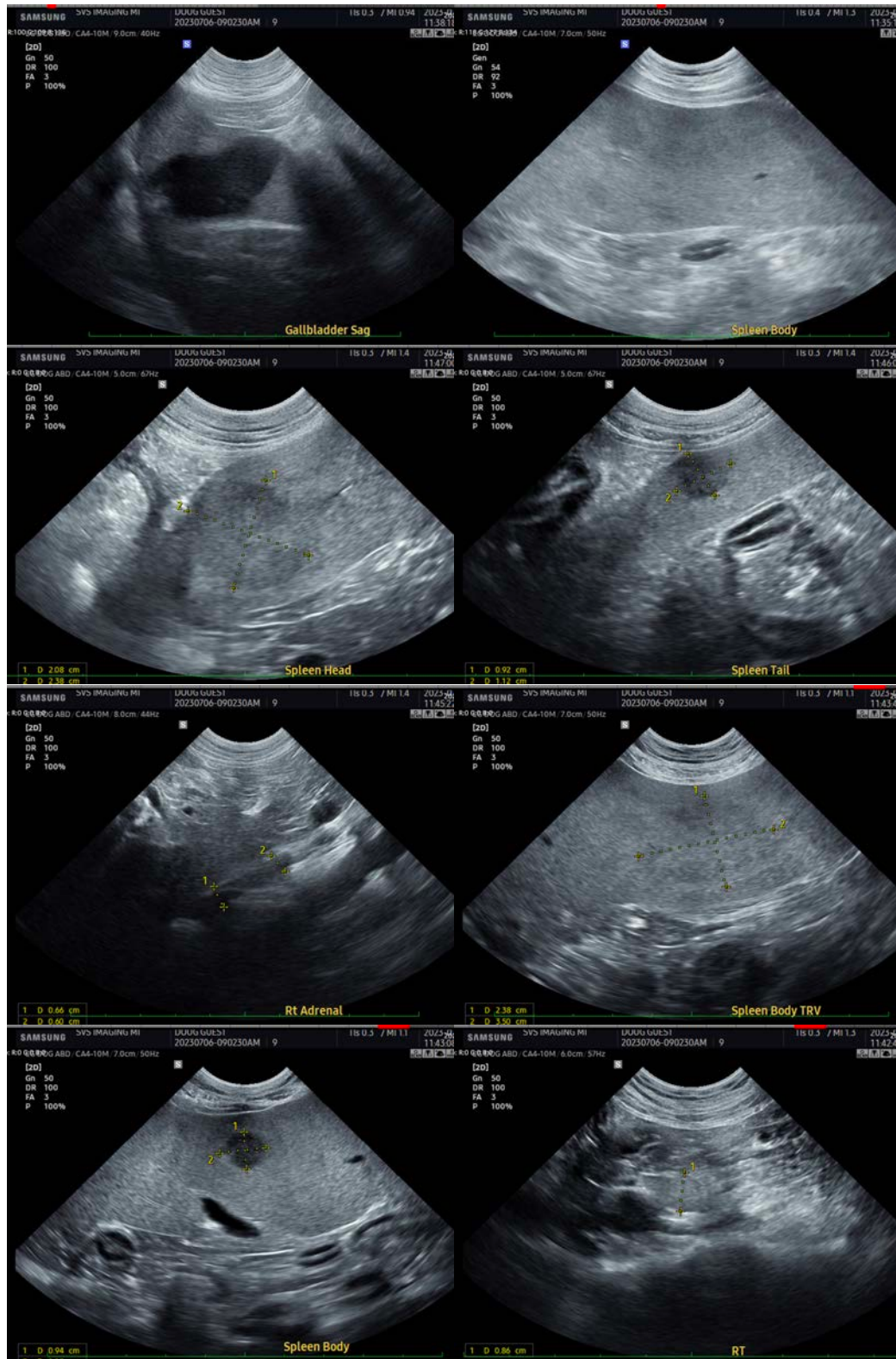
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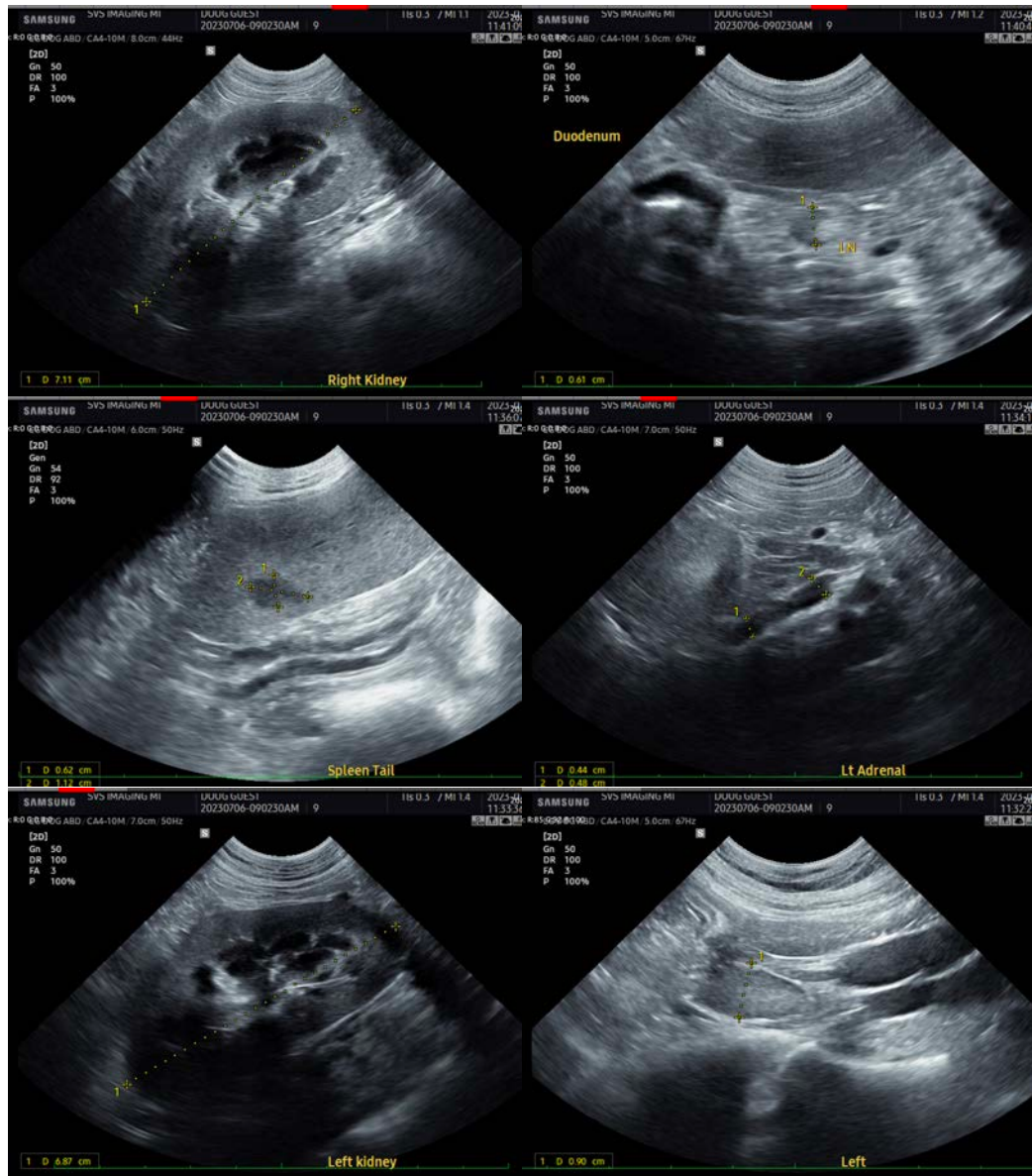
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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