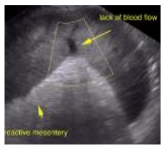
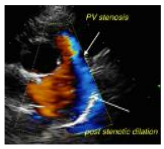
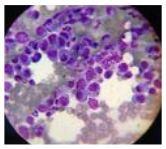
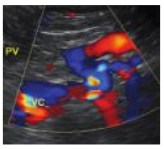




SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Snowey Brown

SPECIES

Canine

BREED

Rat Terrier

SEX

Spayed Female

AGE

10 Years

WEIGHT

41.4 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Adrianne Waffle

HOSPITAL NAME

Torch Lake VC

REFERRING VET

Adrianne Waffle

INVOICE

17026

DATE

8/24/22

PRESENTING CLINICAL SIGNS

History: There are 2 sets of images for this patient, second set shows bladder images. Hx of severe thrombocytopenia(see attached bloods) has been on pred, famotidine, sucralfate. Previous ecchymosis of abdomen, and jugular venipuncture site improving. attitude improving. However, inflammatory leukogram worsening. Has been treated with convenia. Mild jaundice noted today.

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 (3.79 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 small cortical cyst was noted in the left kidney.

Right kidney is normal is size (4.95 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

The area of both adrenal glands is examined without evident pathology.

Spleen

Spleen is subjectively large in size with subtly scalloped or undulating capsular contour. Parenchyma is normal in echogenicity with a mildly coarse/heterogenous echotexture. No focal nodules or masses are observed. Splenic vasculature appears normal.

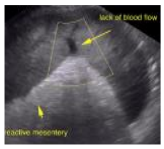
Liver

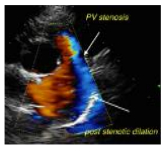
Liver is subjectively enlarged (swollen contour) without disruption of architecture. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen and falciform fat. No focal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

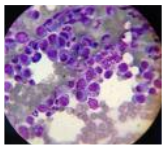
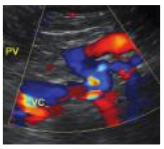
Gallbladder is mildly overdistended with a moderate amount of non-dependent, mildly aggregated/inspissated sludge. Hypo to anechoic cystic areas are noted between the gallbladder sludge and luminal wall. The wall is otherwise smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion. The area surrounding the neck of the gallbladder is hyperechoic/enhanced.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is moderately to markedly distended with echogenic nonshadowing luminal contents, gas and fluid consistent with normal ingesta. There is no evidence of foreign material or infiltrative disease, however, a partial gastric outflow obstruction cannot be definitively ruled out.





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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.

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. 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 a scant amount of anechoic free fluid noted in the images. There is no lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

- Emerging mucocele – 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. The non-dependent nature of this sludge combined with the cystic areas are suggestive, however, of possible emerging cystic mucosal hyperplasia or early gallbladder mucocele. The area around the gallbladder has changes to suggest a focal inflammatory response.

- 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.

- Scalloped spleen – can be associated with benign or malignant infiltrative disease. Common causes include a reactive spleen secondary to immune stimulus or early infiltrative round cell neoplasia such as lymphoma or mast cell tumor.

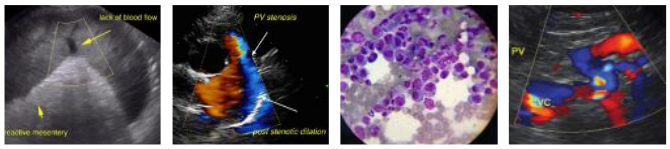
- The stomach is subjectively overdistended with fluid and what appears to be normal ingesta. This is likely a normal patient variant with normal ingesta versus partial ileus, secondary to a metabolic disease and focal inflammation, however, a partial delayed gastric outflow or even partial gastric outflow obstruction, while considered less likely, can't be definitively ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given this patients history of thrombocytopenia and medical management with prednisone, the progressive leukocytosis could be secondary to the prednisone administration, as steroid can cause a marked and persistent leukocytosis. Therefore, recommendations include tapering the steroids, if possible, and if the platelet count requires continued immunosuppression, a second immunosuppressant, such as modified cyclosporin or similar could be added to allow tapering of the prednisone.

If not already evaluated, however, a comprehensive infectious disease testing, especially tick-borne diseases, is recommended.

This patients newly reported jaundice could be secondary to a progression of the thrombocytopenia



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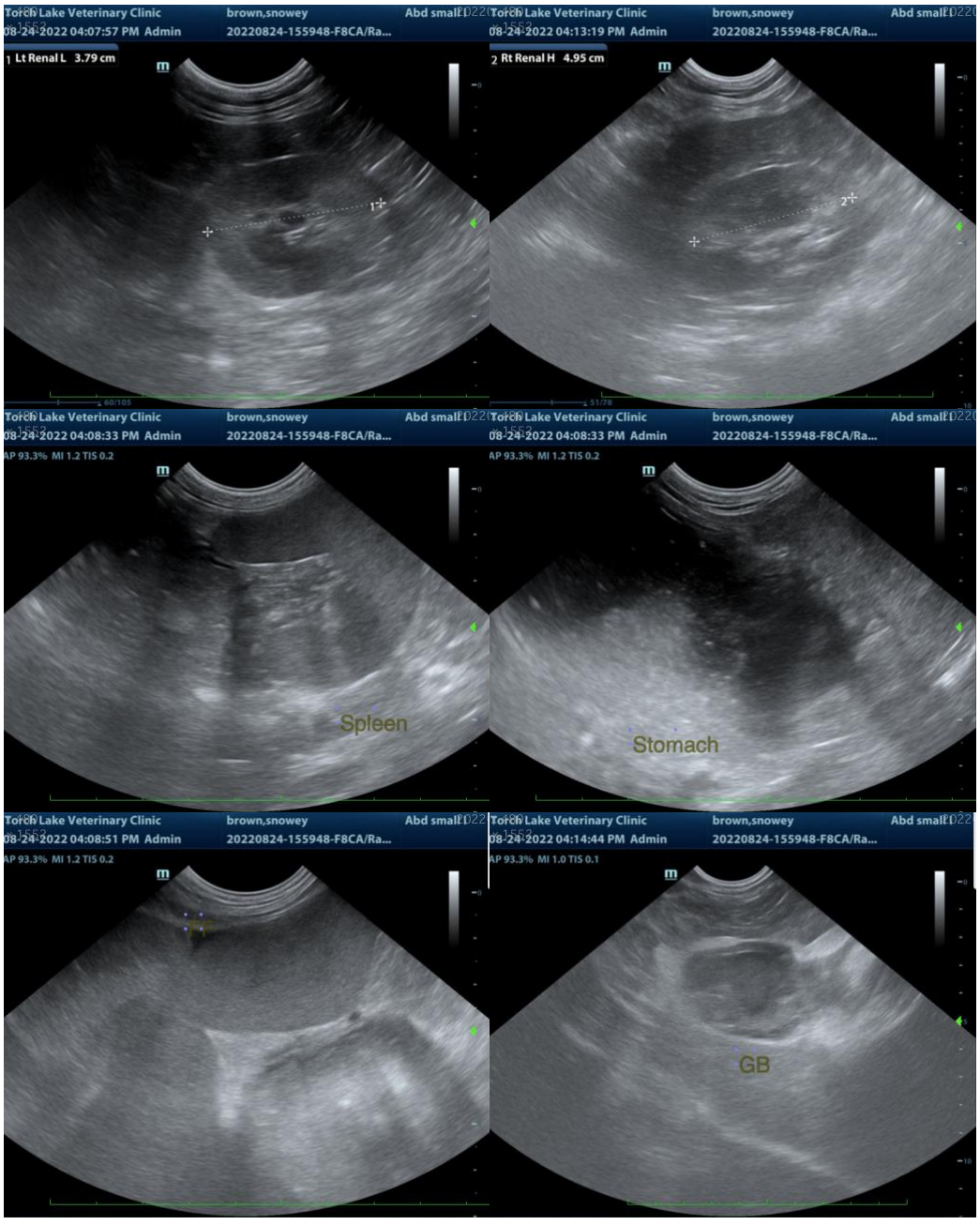
to Evan's syndrome and the jaundice is caused by hemolysis. However, given the appearance of the gallbladder, a post-hepatic cholestasis is also possible, in which case the gallbladder changes could also be partially contributing to an inflammatory leukogram. If clinical signs and/or laboratory changes exist to support this differential, such as cranial abdominal pain, nausea, inappetence, increased liver enzymes, etc., management of the gallbladder may be indicated in the form of a cholecystectomy. Given this patients thrombocytopenia, a cholecystectomy carries risk, therefore, medical management with broad spectrum antibiotics and ursodiol may be appropriate first, again, pending patients clinical and laboratory picture.



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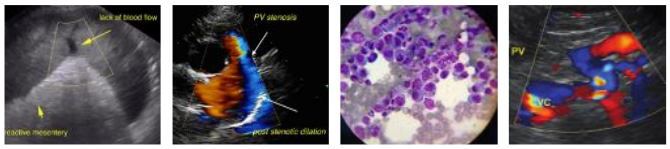

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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