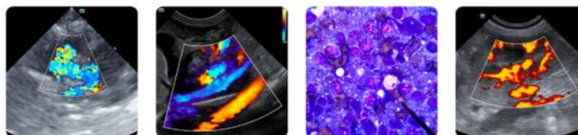

PATIENT

Auggie Mione

SPECIES

Canine

BREED

Catahoula Mix

SEX

Neutered Male

AGE

7 Years

WEIGHT

21 kg

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Dr. Meghan Myers

HOSPITAL NAME

Hershey Animal Emergency Center

REFERRING VET

Dr. Cara Sinopoli

INVOICE

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01/14/26

PRESENTING CLINICAL SIGNS

Reluctant to get out of bed and not walking well; very ginger steps on the front limbs today. Decreased appetite since yesterday. No vomiting. Blood in urine this morning. Owner concerned about possible ingestion of fabric/foam from a toy. Temp 105.1 Mucus membranes tacky, mildly prolonged skin tent Sinus arrhythmia Rectal: Yellow diarrhea on glove, thick paste in anal glands bilaterally, no masses palpable in anal glands Musculoskeletal: Reluctant to stand or ambulate on his own but can ambulate, grade 4/5 lameness forelimbs, walking very gingerly on forelimbs, painful on palpation and flexion of carpi (left>right) Depressed

Abnormal PE/Chem/CBC/UA Results: 4DX: Negative EPOC: pH 7.401, BE -8.4 L, TCO2 15.7 L, pCO2 26.4 L, Potassium 3.3 L, Calcium 1.74 H, Lactate 4.44 H, Creatinine 1.81 H CBC: WBC 3.78K L, Immature neutrophils 0.15K, Lymphocytes 0.29K L, Monocytes 0.10K L, Platelets 9K (<50 K on Invue, markedly decreased) Chem15: Creat 2.0, Phos 2.0 L, Globulin 4.9 H, ALP 250 H UA: USG 1.020, pH 8.0, protein 3+, blood 4+, WBC >50/hpf, RBC >50/hpf, large amount of rods on Sedivue Urine culture, pending Tick PCR, pending CONCLUSIONS: 1. The appearance of the gastrointestinal tract is consistent with a paralytic ileus. 2. Cystic calculi. 4. Normal carpal joints, no significant soft tissue swelling. 5. Linear mineralized material superimposed over the liver 6. Urethral calculi Resting cortisol: 22.6 H Lepto witness: Negative

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and visible pelvic urethra were of normal thickness. The ureters were not visible which is normal. There was normal wall layering with no masses, or abnormal thickening visualized. Multiple gravity dependent cystoliths were present in the urinary bladder.

The left kidney has a smooth capsule and with mild hazing of corticomedullary definition. Pinpoint areas of cortical mineralization. The left kidney measured 6.2 cm in length.

The right kidney has a smooth capsule and with hazing of corticomedullary definition to the point of inability to determine cortical/medullary ratio. Hyperechoic, shadowing foci present in renal parenchyma and calyces consistent with nephrocalcinosis. The right kidney measured 6.4 cm in length.

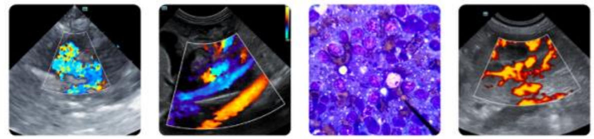
Adrenal Glands

Both adrenal glands were visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The left adrenal gland measured 1.98 cm in length and 0.42 cm at the cranial pole and 0.46 cm at the caudal pole. The right adrenal gland measured 2.1 cm in length and 0.55 cm at the cranial pole and 0.59 cm at the caudal pole.

Spleen

The spleen was prominent with a smooth homogeneous normal parenchyma with a smooth capsule. Normal splenic vasculature with no signs of congestion or thrombosis. No specific nodules or masses were visualized.

Liver



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The liver is subjectively mildly enlarged. The parenchyma is diffusely coarse with no specific masses visualized. There is scant free fluid between liver lobes. Biliary tracts contain mineral material consistent with biliary mineralization. I suspect biliary mineralization is the cause of reported mineral opacity superimposed over liver on radiographs.

Gallbladder wall is diffusely thickened and hypoechoic measuring up to 0.5 cm in thickness. Gallbladder is not significantly distended, and bile is largely anechoic. There is hyperechoic partially shadowing debris visible within the gallbladder lumen.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis: mucosa layer ratio. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was not visualized. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The area of the pancreas was isoechoic to surrounding tissue with no overt inflammation. Pancreatic tissue was not distinctly visualized which is common.

Lymph Nodes

There is scant free fluid visualized in every quadrant.

ULTRASONOGRAPHIC FINDINGS

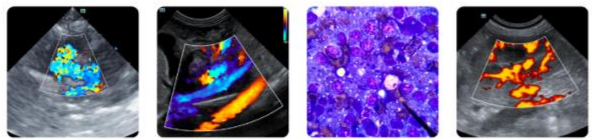
- Scant free fluid.
- Prominent spleen.
- Biliary mineralization.
- Thickened gallbladder wall- suspect secondary to chronic inflammation from gallbladder debris.
- Cystoliths.
- Aging renal changes with nephrocalcinosis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No definitive cause of reported thrombocytopenia and diffuse joint pain or fever is identified on abdominal ultrasound. Abdominocentesis should be considered to further define the cause of abdominal effusion. Given the severity of thrombocytopenia, hemorrhage is a risk with this procedure.

Ideally, joint taps, abdominocentesis, and splenic aspirate would be done, however, thrombocytopenia does limit the safety of these diagnostics. Tick-borne disease testing (ideally PCR) is recommended.

Other causes of autoimmune, severe inflammatory, and neoplastic disease-causing thrombocytopenia, fever, and systemic inflammation remain possibilities. Gallbladder wall thickening does not have the



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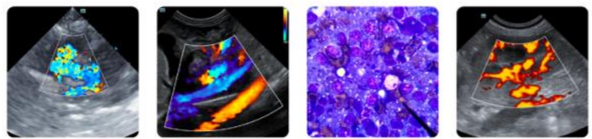
ultrasonographic appearance of a halo sign, and I suspect this is related to chronic inflammation from mineralized debris passing through and within the gallbladder. This is generally incidental and not a likely cause of current clinical signs. Acute anaphylaxis with severe systemic inflammation cannot be completely ruled out.



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Normal prostate

Left kidney

Spleen

Free fluid

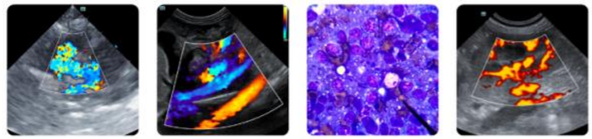
Mineralization in biliary tree

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.

Dr Brittany Sinclair, BVSc(hons), DACVECC

info@SonoPath.com



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