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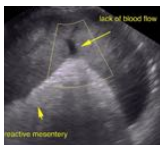

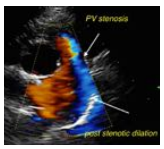

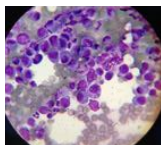
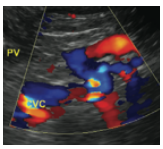

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1-800-838-4268 info@sonopath.com

PATIENT

Spyce Dunker

SPECIES

Canine

BREED

Labrador Retriever

SEX

Intact female

AGE

4 years

WEIGHT

82 lbs

INTERPRETED BY

Eric Lindquist, DMV
DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Krell

HOSPITAL NAME

Paws and Prairie Animal Clinic

REFERRING VET

Dr. Krell

INVOICE

42072

DATE

1/12/23

PRESENTING CLINICAL SIGNS

History: Post-partum 3 weeks, 5 days. - normal parturition. Acute onset of hyporexia, vomiting occasionally (when around puppies), hiding and more lethargic starting Monday night. No history of toxin or drug exposure, no changes in diet or dietary indiscretion. Found elevated renal values, trending toward mild anemia, hematuria, pyuria and some bacteruria on UA on 1/11/23. Found 1+ free fluid and hyperechoic mesentery. Patient treated with SQ fluids, enrofloxacin, clavamox, Cerenia and Famotidine. Pending Lepto PCR, UPC, and Urine Culture & UA (from cysto) prior to abx yesterday. 1/12/23 - AM noted improvement overnight, ate and drank well, vomited when with the puppies. Took medication this AM okay. Patient stayed for the day at the clinic for evaluation and fluids. Discussion with IDEXX consultant advised to continue plan change to omeprazole and add sucralfate. Concerns for GI bleed and/or pyelonephritis. PM - O reported vomiting a lot tonight - was given butorphanol for the AUS at 2 pm. O noted shaking and more lethargy yet at 6 pm.
Abnormal PE/Chem/CBC/UA Results: PE: QAR/BAR, MM pink, CRT <2s, slight dehydration, mild bloody discharge from vulva. Temp 99.3F today 1/11/23 Chem: SDMA - 17, BUN 122, Creat 2.5, Phos 8.7, TP 5.0, Alb 2.2. CBC: low retics, all RBC on low end of normal. WBC 17.82K, Mono 2.49K, Eos 1.63K, Plt 77K (manual confirmed 170K with clumping). 4Dx: negative UA: FREE CATCH - Proteinuria 500, Bld 250, SG 1.037, pH 7, pyruia 3/hpf, hematuria >50/hpf, some casts, suspect occasional cocci, unclassified crystals. UA (cysto), UPC, Urine culture, and Lepto PCR pending 1/12/23 Chem: SDMA 20, Creat 1.9, BUN 90, TP 4.6, Alb 2.0. Urine SG: 1.033 CBC: RBC 5.1, HCT 34.4, HGB 12.2, WBC 19.5, Neut 12.8, Mono 2.14

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The ureters were not visible which is normal. No uroliths or sediment were visualized and anechoic urine was present. No evidence of inflammatory or neoplastic changes was noted. Ureteral papillae were normal.

The **kidneys** revealed normal size and structure, corticomedullary definition and ratio for this age. The cortices presented largely uniform texture with normal echogenic relationship to liver and spleen. Medullary structure differed distinctly from the cortex and no evidence of pelvic dilation was present. The capsules were acceptably uniform without significant irregularities. The left kidney measured 6.56 cm. The right kidney measured 7.0 cm.

The uterus appeared mildly thickened, yet empty. There was no overt evidence of rupture noted. The uterus measured 2.0 cm in width.

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 right adrenal gland measured 3.15 x 0.45 cm at the cranial pole and 0.55 cm at the caudal pole. The left adrenal gland measured 2.23 x 0.27 cm at the cranial pole and 0.53 cm at the caudal pole.

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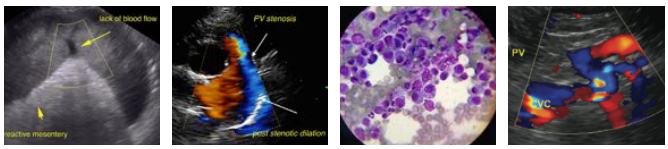

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Spleen

The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes was noted.

Liver

The **liver** images submitted revealed subjectively normal liver size, contour, and structure. Parenchymal echogenicity was naturally coarse and hypoechoic to the spleen. The vena cava was dilated in this patient and measured 1.8 cm. This is consistent with passive congestion liver pattern. Vascular and biliary tracts were of normal volume with no evidence of congestion. The gallbladder was edematous.

Gastrointestinal

Examination of the **gastrointestinal tract** revealed a stomach and intestine free of stasis, of normal wall thickness, acceptable curvilinear mural detail, and peristaltic activity. Small and large intestine demonstrated normal luminal chyme and stool consistency respectively. No obstructive or overt infiltrative disease was noted. No associated abnormal lymphatic activity was noted.

Pancreas

The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour were acceptably normal and parenchyma respected normal curvilinear patterns. No overt evidence of active inflammatory or neoplastic disease was noted.

Free Abdomen

Ascites was noted in the abdomen.

ULTRASONOGRAPHIC FINDINGS

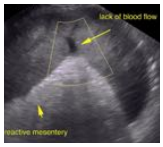
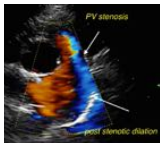
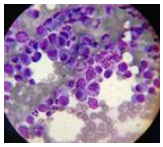
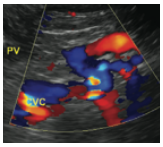
Ascites.

Thickened, post partum uterus.

Passive congestion liver pattern.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

I recommend abdominocentesis in this patient to ensure that the free fluid is simple transudate followed by thoracic work-up with echocardiogram and chest radiographs to assess for causes of passive congestion. The remainder of the organs appeared normal. If by chance the free fluid demonstrates sepsis then exploratory surgery is indicated.

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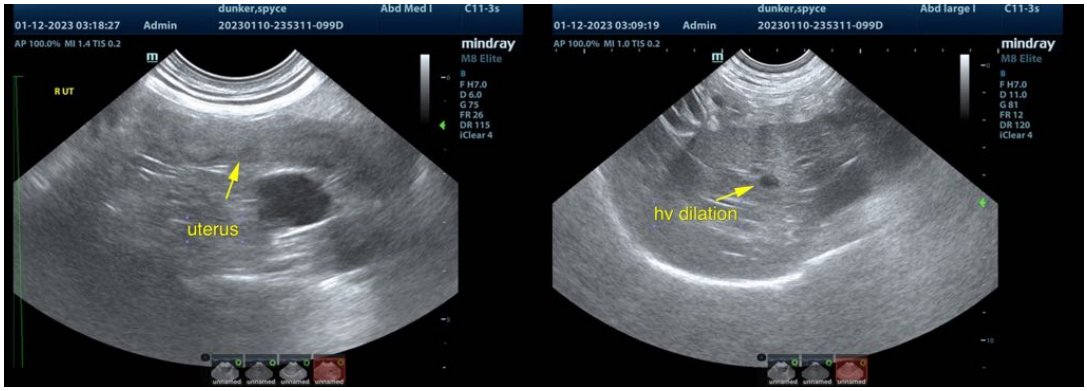
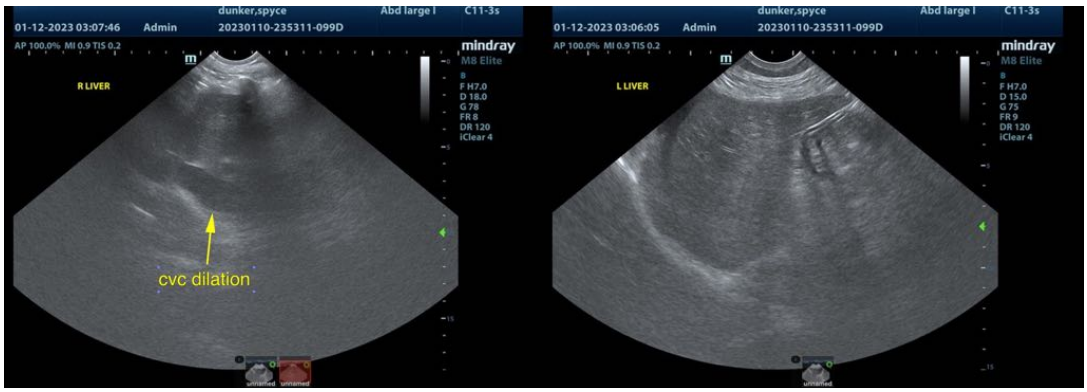
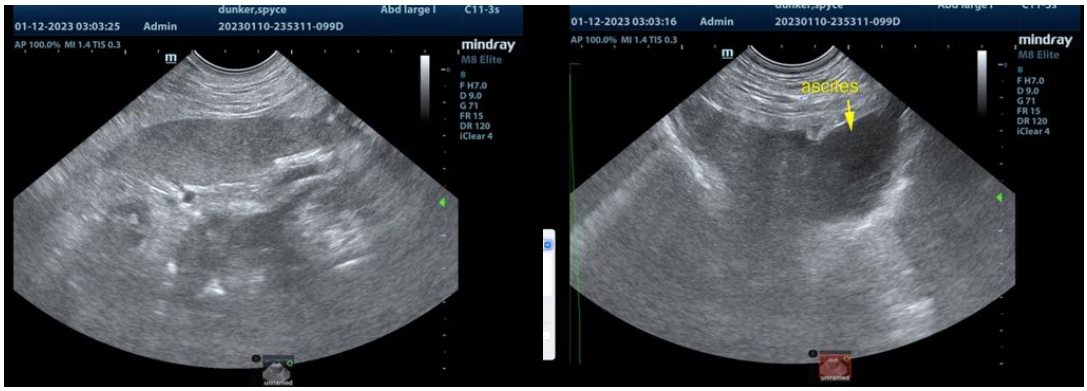
However, the dilated hepatic veins and vena cava would suggest passive congestion and a thoracic source of the ascites.







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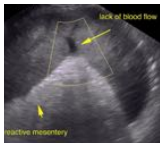
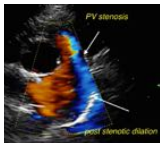
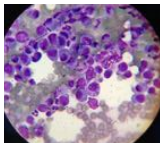
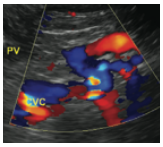

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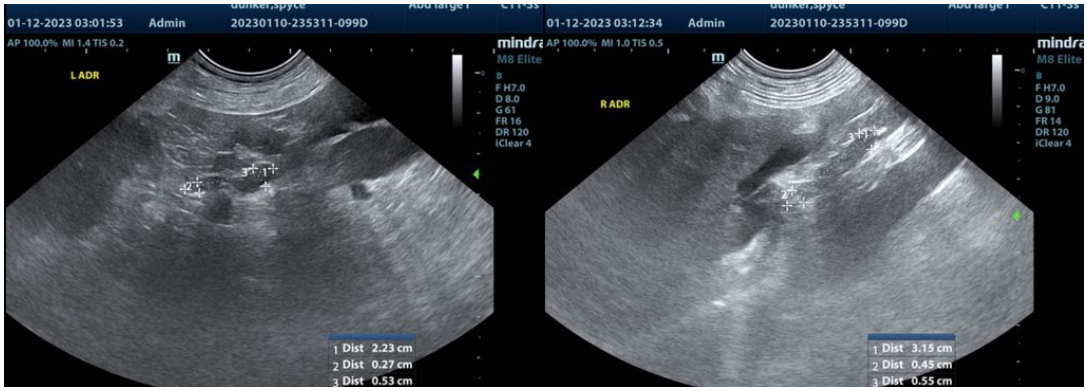

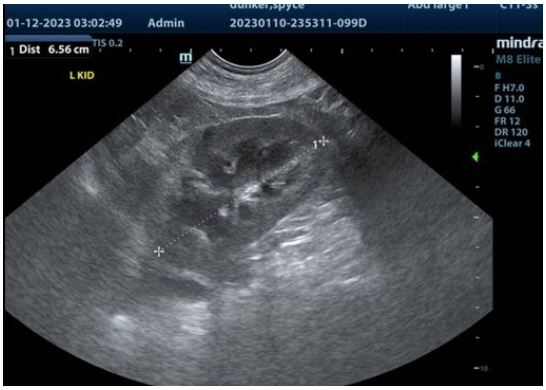

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Eric Lindquist, DMV, DABVP, Cert. IVUSS, CEO of SonoPath.com
info@SonoPath.com