



PATIENT

Jack Trussell

SPECIES

Canine

BREED

Schnauzer

SEX

Neutered male

AGE

15 ½ years

WEIGHT

16.7 lbs

INTERPRETED BY

Eric Lindquist, DMV
DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Harold Mike Beard

HOSPITAL NAME

West Prince AH

REFERRING VET

Dr. Stone

INVOICE

30354

DATE

5/13/22

PRESENTING CLINICAL SIGNS

History: Hx of urinating in house (not normal). Next, had vomiting and diarrhea, was weak. Chronic weight loss. Mildly dehydrated.
Abnormal PE/Chem/CBC/UA Results: Thin dog, periodontal dz, bradycardia (88). CPL normal. SDMA normal. UA normal. Chemistry WNL. CBC mild anemia (HCT 38).

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** and trigone 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 largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some age-related loss of curvilinear patterns regarding the capsule and C/M junction. The cortices presented largely uniform texture with some increased echogenicity expected for this age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. The left kidney measured 5.0 cm.

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.

Spleen

The **spleen** was uniformly enlarged with relatively uniform parenchyma without evidence of masses. The capsule was mildly swollen. Occasional, isoechoic nodule was noted in the spleen. This is most consistent with hypersplenism and reactive hyperplasia deriving from splenic white or red pulp. However, early infiltrative disease, such as lymphoma or mast cell neoplasia can, at times, present in this manner. True hypersplenism from an internal medicine standpoint causes sequestering of thrombocytes resulting in thrombocytopenia and anemia. Clinical manifestation of this phenomenon should be considered. US-guided FNA would be best in order to ensure only reactive hyperplasia is present. If clinical signs fit with potential neoplasia or mast cell disease, then Benadryl injection (1 mg/pound IM) 15 minutes prior to FNA would be recommended.

Liver

The **gallbladder** revealed somewhat mobile bile; however, dilation was excessive. Dependent sand and debris accumulation was noted in the cystic duct. This is consistent with emerging gallbladder mucocele likely contributing to the clinical signs. However, some bile is mobile. Full mucocele status is not present. The remainder of the liver was unremarkable.



PATIENT *Gastrointestinal*

Jack Trussell A minor amount of non-shadowing, non-obstructive ingesta was noted in the **stomach**. Transit of chyme into the small intestine was normal. Curvilinear patterns were maintained throughout the GI tract. The distal small intestine was unremarkable. No evidence of pathology. The distal small intestine was unremarkable.

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Pancreas

The **pancreas** is heterogenous with mixed echogenic changes noted in the right limb. The region measured 3.0 x 4.0 cm. Trace amounts of free fluid were noted around the pancreas.

ULTRASONOGRAPHIC FINDINGS

Emerging gallbladder mucocele.

Hypersplenism.

Non-shadowing ingesta in the stomach.

Pancreatitis.

Free fluid.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

I recommend splenic FNA in this patient. Treatment for pancreatitis is recommended along with a gallbladder motility study. Emerging round cell neoplasia cannot be completely ruled out. Ursodiol therapy over 6-8 weeks is warranted with a recheck of the gallbladder and/or gallbladder motility study. Testing for UTI is warranted given the urinary issues; however, structurally the bladder was unremarkable. However, distal urethral pathology cannot be completely ruled out as the urethra is not visualized.

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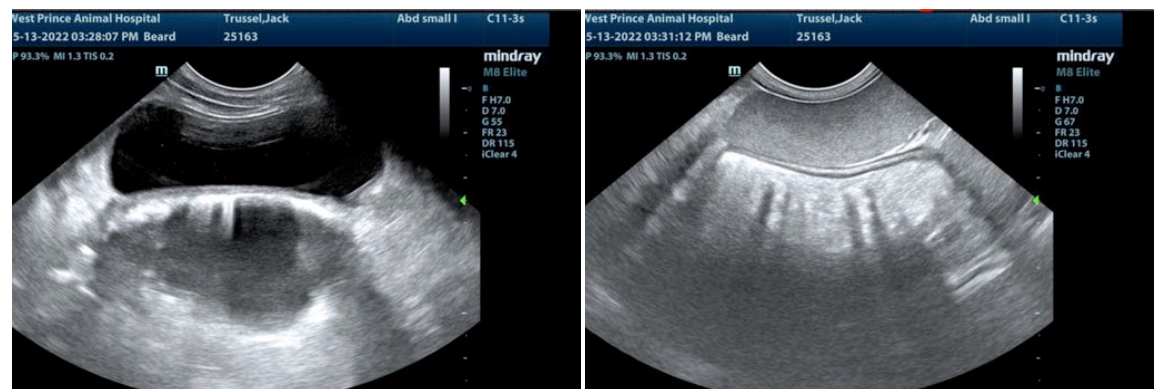
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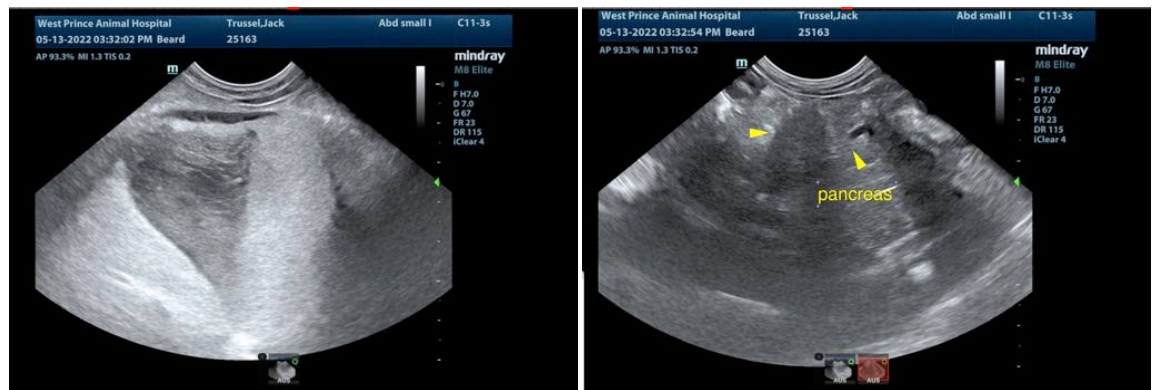
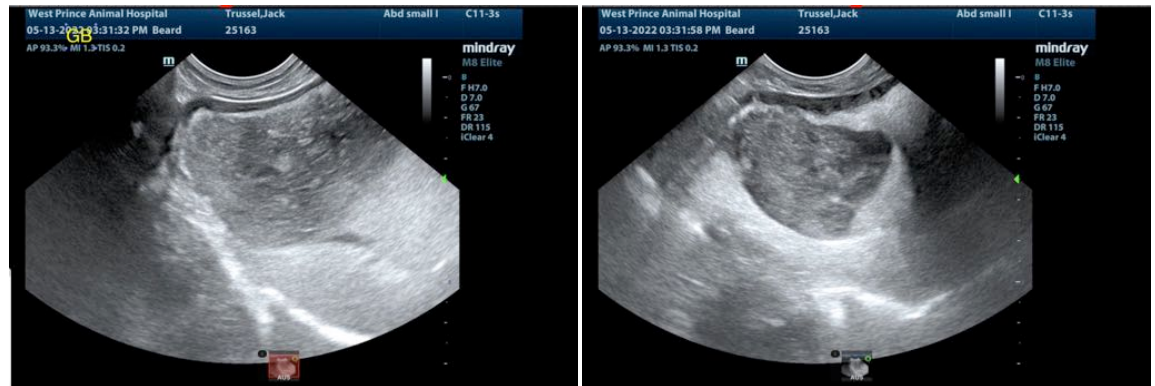
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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