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Clinical Sonography & Telecytology
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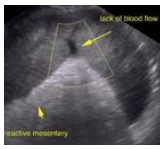

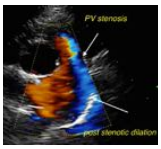

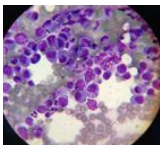
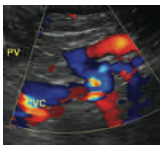

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1-800-838-4268 info@sonopath.com

PATIENT
Molly Ward

SPECIES
Canine

BREED
Mix

SEX
Spayed Female

AGE
9 years

WEIGHT
39 lbs

INTERPRETED BY
Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY
Shari Reffi, CVT

HOSPITAL NAME
Animal Hospital of Roxbury

REFERRING VET
Dr. Elia

INVOICE
30168

DATE
5/5/22

PRESENTING CLINICAL SIGNS

History: Inappetence. Current meds: Entyce, Famotidine.
Abnormal PE/Chem/CBC/UA Results: Urine prot/creat ratio 2.5, color-Dk. yell, Ph 6, Prot 3+, USG 1.024, cysto pending

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 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 right kidney measured 6.42 cm.

Adrenal Glands

The right adrenal gland is at the upper limits of normal and measured 1.93 x 0.8 cm at the cranial pole and 0.69 cm at the caudal pole. The left adrenal gland is normal in size and contour measuring 1.71 x 0.45 cm at the cranial pole and 0.61 cm at the caudal pole.

Spleen

The **spleen** was uniformly enlarged with relatively uniform parenchyma without evidence of masses. The capsule was mildly swollen. 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 **liver** images submitted revealed subjectively normal liver size, contour, and structure. Parenchymal echogenicity was naturally coarse and hypoechoic to the spleen. Vascular and biliary tracts were of normal volume with no evidence of congestion. The gallbladder presented acceptably thin walls with primarily anechoic content. The cystic and common bile ducts were normal. No pathological hepatic lymphadenopathy was evident. No overt structural evidence of inflammatory, infiltrative or regenerative pathology was evident.

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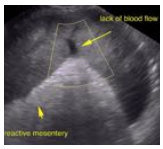
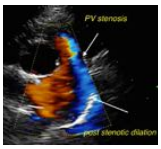
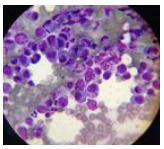
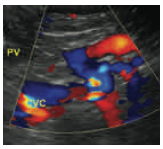

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Gastrointestinal

Examination of the **gastrointestinal tract** revealed a stomach and intestine free of stasis, of normal wall thickness, acceptable curvilinear mural detail, and peristaltic activity. Minor echogenic material was noted in the stomach and may represent the radiopaque material noted on radiographs, yet is non-obstructive. 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.

ULTRASONOGRAPHIC FINDINGS

Minor hypersplenism.

Upper limits of normal right adrenal.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the drop in urine specific gravity and proteinuria underlying emerging PDH may be an issue. The cause of inappetence is not evident in this patient. If weight loss is an issue FNA of the spleen is indicated. Otherwise, other cause of inappetence such as orthopedic/spinal pain, CNS or thoracic disease should all be considered.

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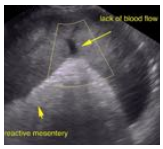
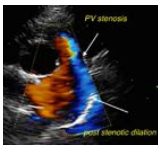
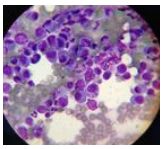
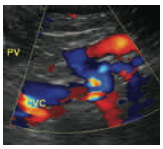

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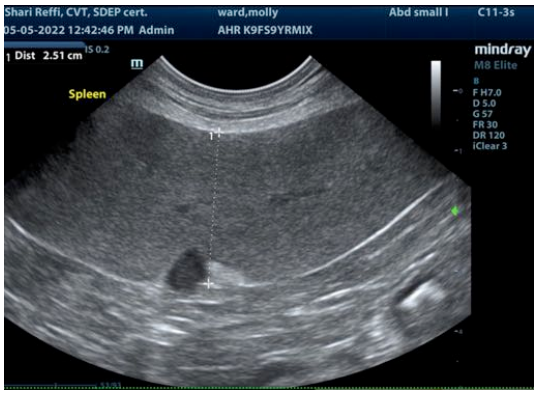

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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