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Clinical Sonography & Telecytology
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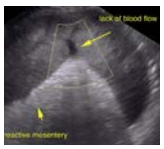
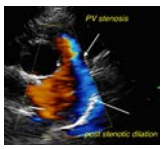
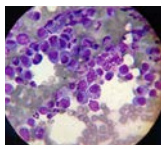
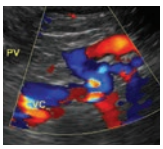

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1-800-838-4268 info@sonopath.com

PATIENT
Tazzie Baker

SPECIES
Canine

BREED
Labrador X

SEX
Intact Male

AGE
12 Years

WEIGHT
31.2 Pounds

INTERPRETED BY
Eric Lindquist, DMV
DABVP, Cert. IVUSS

IMAGING PERFORMED BY
Dr. Kristin Peterson

HOSPITAL NAME
Wilvet Salem

REFERRING VET
Dr. Kristin Peterson

INVOICE
40442

DATE
8/15/22

PRESENTING CLINICAL SIGNS

Patient was given his nexgard (has had it many times before) on Tuesday, when Tazzie started having runny stool recurrently & decreased appetite. Owner thought flea meds just upset his stomach, but symptoms persisted. Patient became very lethargic in the evening on 8/14, so o took to different ER vet: tx-rads, cbc/chem, sq fluids and cerenia. This morning patient did not want to eat or drink. Salem ER sent home Clavamox but owner has not started because patient did not want to eat. No vomiting.
Abnormal PE/Chem/CBC/UA Results: CBC - Neutrophils 13.62k/ul (H), lymphocytes 0.89k/ul (L), mpv 14.9fl (H) Chem - Lipase 1914u/l (H) rest nsf

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** was overdistended. The prostate was significantly enlarged, measuring up to 8.0 cm at the widest point. Micronodular and cystic changes noted with edema lines, most consistent with BPH and prostatitis. The largest cyst measured up to 1.0 cm.

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 his age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. The right kidney measured 7.0 cm.

Reactive iliac lymph nodes noted up to 1.0 cm.

Adrenal Glands

The **adrenal glands** were not visualized. No evidence of neoplasia.

Spleen

The **spleen** was uniformly enlarged with relatively uniform parenchyma without evidence of masses. It was folded upon itself caudally. 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 but not suspected. 25g 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.

Gastrointestinal

The **stomach** revealed a moderate amount of fluid accumulation, consistent with gastric ileus. Transit of chyme into the small intestine appeared to be present.

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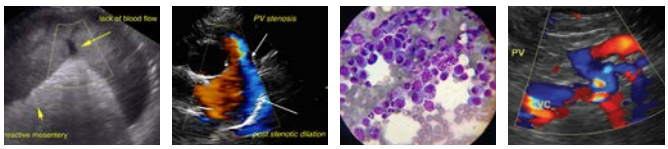

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Pancreas

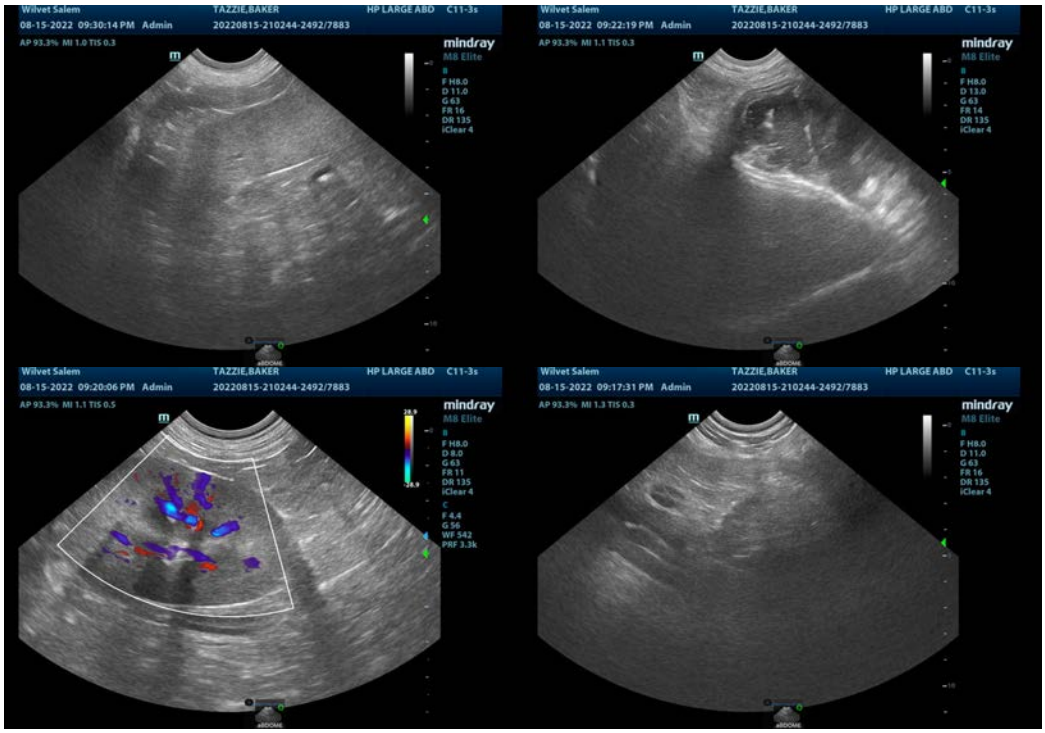
The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour were acceptably normal and parenchyma respected normal curvilinear patterns. No overt evidence of active inflammatory or neoplastic disease was noted.

ULTRASONOGRAPHIC FINDINGS

- BPH/prostatitis pattern
- Probable low-grade gastric irritation

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Neutering recommended with urinary workup, urine culture and sensitivity if any inflammatory sediment is present, which is suspected. IV fluid support and GI protectants indicated.



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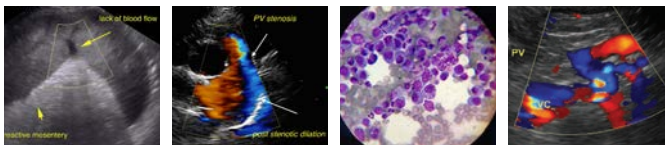

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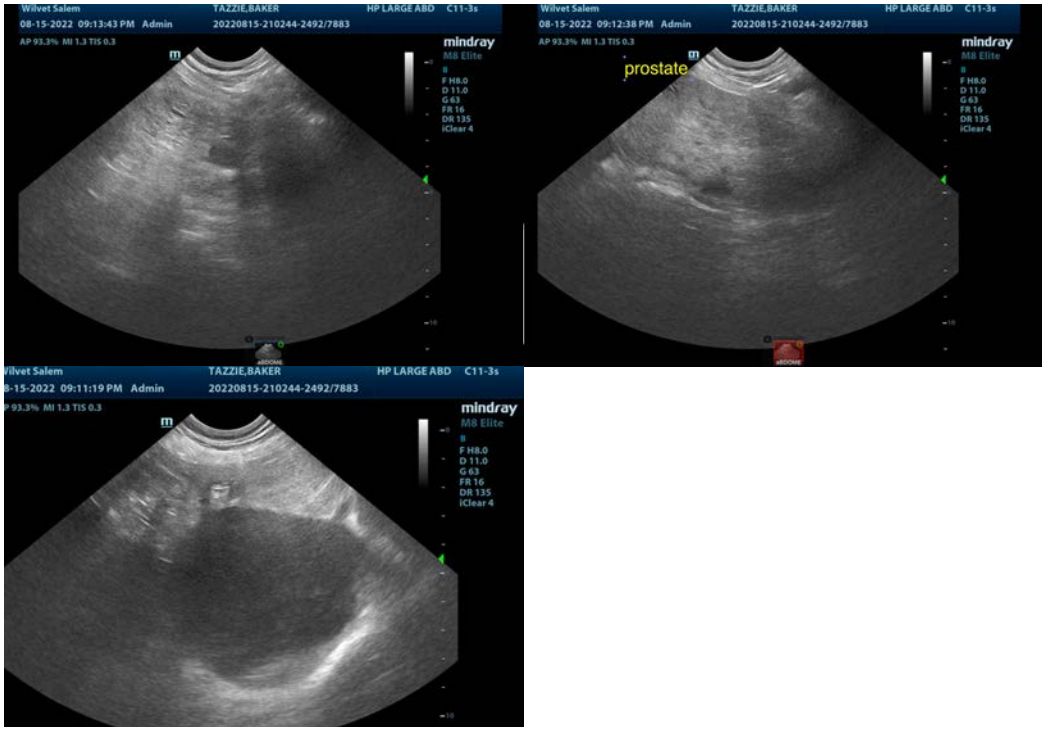

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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