



**PATIENT PRESENTING CLINICAL SIGNS**

Yume Chapell

History: acute onset anorexia, lethargy as well as diarrhea. No hx of vomiting. Prior hx of sterile nodular panniculitis - one new mass noted ventrum but not draining, erythematous or painful. Started on IVF yesterday + buprenorphine and cerenia.

**SPECIES**

Canine

Abnormal PE/Chem/CBC/UA Results: Weight loss noted, febrile ( 104.7). mildly painful cranial abdomen. Lateral/V/D thoracic/abdominal rads: NSF - lungs clear; adequate serosal detail on abdominal rads, otherwise NSF CHEM 15/lytes: Increased TP ( 8.5); increased GLOB ( 6.1); increased ALP ( 586), mild hypoglycemia ( 66) CBC: Microcytic, hypochromic non - regenerative anemia ( HCT = 31%); leukocytosis ( 21.15); neutrophilia ( 19.04); thrombocytopenia ( 129K) CPL: abnormal Saline autoagglutination: Negative AFAST: negative Accuplex4Dx: negative all 4 Sent out blood panel to antech to double check CBC findings: CHEM: ( from antech): Decreased ALB ( 2.5), increased ALP ( 478), increased GLOB ( 5.2), hypoglycemia ( 68), increased TP ( 7.7) CBC: Leukocytosis ( 19.0), neutrophilia ( 17,100); HCT low normal @ 36%; MCV/MCH flagged as WNL. Patient transferred to local ER for continued IVF, BG monitoring and analgesics; fever has resolved today but still no appetite. BG normalized overnight without tx.

**BREED**

Sheltie Cross

**SEX**

Spayed female

**AGE**

11 years

**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. A minor amount of suspended and dependent debris was noted. No evidence of inflammatory or neoplastic changes was noted. Ureteral papillae were normal.

**WEIGHT**

17.1 lbs

The **kidneys** were swollen with slight pyelectasia and mildly enhanced surrounding mesentery. The right kidney measured 5.19 cm. The left kidney measured 5.18 cm with slight pinpoint mineralization.

**INTERPRETED BY**

Eric Lindquist, DMV  
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**Adrenal Glands**

**IMAGING PERFORMED BY**

Jessica Biles

The left **adrenal gland** was enlarged, nodular and mildly irregular. The cranial pole of the left adrenal gland was 0.71 cm with a length of 2.25 cm. The right adrenal gland was normal in size and contour measuring 2.36 x 0.62 cm at the caudal pole and 0.44 cm at the cranial pole.

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**Spleen**

The **spleen** was enlarged and swollen with subtle, micronodular and granular appearance.

**REFERRING VET**

Dr. Bailes

**Liver**

The **liver** was swollen and slightly heterogenous with increased portal markings. The gallbladder and common bile duct were unremarkable.

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**Gastrointestinal**

**DATE**

9/9/22

Examination of the **gastrointestinal tract** revealed a stomach free of stasis, of normal wall thickness, acceptable curvilinear mural detail, and peristaltic activity. Spastic small intestine was present.



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**Pancreas**

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The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Some parenchymal remodeling, however, with mild deviation from curvilinear normalcy was observed. Pancreatic duct and capsular irregularities were present consistent with age related changes. If pain upon imaging (+ Murphy sign) was present or if the patient is focally painful in subxiphoid palpation then low-grade smoldering chronic pancreatitis should be suspected.

**ULTRASONOGRAPHIC FINDINGS**

Prominent left adrenal gland.

Age related renal changes with mild swelling and possible underlying nephritis.

Bladder debris.

Swollen spleen. Reactive versus round cell neoplasia.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Multiple JPEG and MP4 images were submitted.

I am concerned for emerging splenohepatic neoplasia in this patient versus reactive state. Spastic bowel is noted. This is consistent with enteritis. Coagulation panel and 25-gauge FNA of the spleen and liver is recommended.

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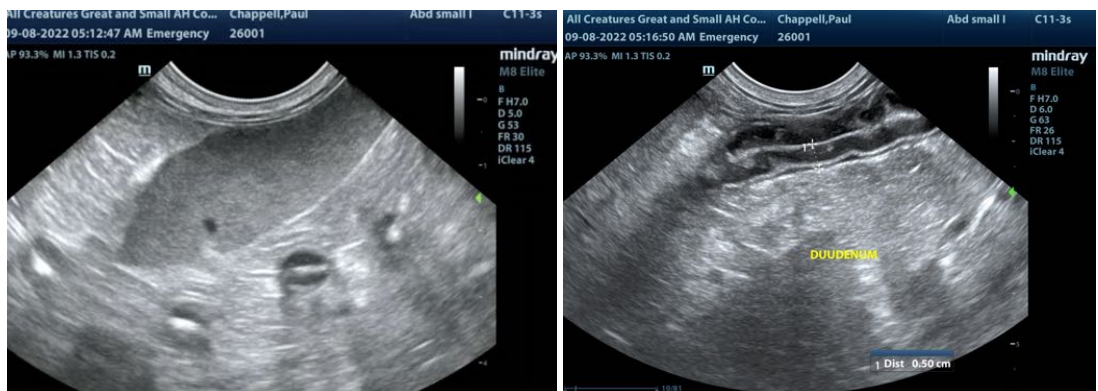
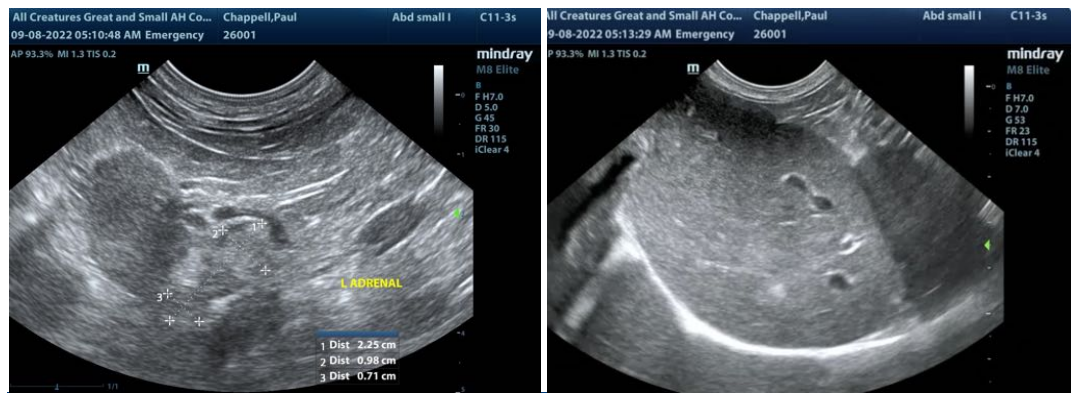
Dr. Bailes

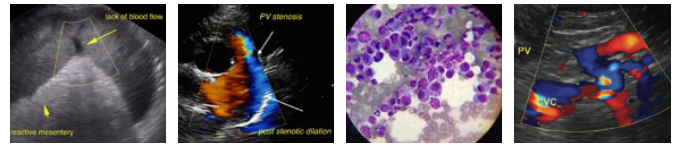
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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The following is an applicable excerpt from the *Curbside Guide to Diagnosis and Treatment of Sonographic Disease* offered by [SonoPath.com](http://sonopath.com) Lindquist, Fra Lobetti, and Modler.

**IMAGING PERFORMED BY**

Jessica Biles

An essential quick guide for every general practitioner and sonographer.

<https://sonopath.com/products/curbside-guide-editing-due-release-1201201>

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**Fever of Unknown Origin**

<http://www.sonopath.com/FUO>

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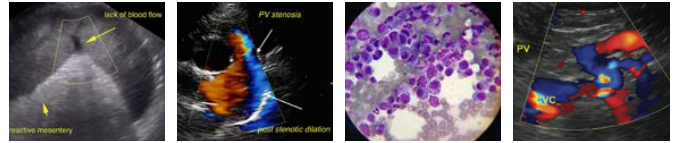
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Long axis of the mid-abdomen in a dog with an omental abscess after foreign body penetration from the gastrointestinal tract. The hypoechoic necrotic center of the lesion is surrounded by a thick echogenic capsule and hyperechoic mesenteric fat (arrow) indicating focal peritonitis. The linear echogenic needle (5 cm depth) is barely visible owing to the density of the purulent material contained within the abscess.

**Description:** The definition of a fever of unknown origin (FUO) has not been clearly defined for animals. Currently, it is either understood to be a fever that does not resolve within the period one would expect for a “self-limiting infection” being treated with appropriate antimicrobial therapy, or that for which an underlying diagnosis has not been determined despite considerable diagnostic effort. The common causes of FUO were summarized concisely in a presentation at the American College of Veterinary Internal Medicine 2004 Forum. The presenters synthesized information from three veterinary papers on the subject, which suggested the following:

Final Diagnosis	Bennett (dogs & cats)	Dunn and Dunn (dogs only)	Lunn (dogs & one cat)	Total
Infection	21	16	10	47
Immune	18	22	6	46
Bone marrow disease	4	22	2	28
Neoplasia (outside marrow)	0	10	2	12
Miscellaneous	2	12	2	16
No diagnosis	0	19	2	21



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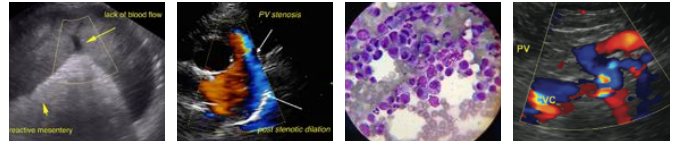
	Final Diagnosis	Bennett (dogs & cats)	Dunn and Dunn (dogs only)	Lunn (dogs & one cat)	Total
<b>TOTALS</b>		45	101	24	170

The types of infection diagnosed in this case series were varied, ranging from discospondylitis (8 cases), blastomycosis (6), and bacterial endocarditis (4), to leishmaniasis (1), prostatitis (1), and *Ehrlichia canis* infection (1); a multitude of other infectious causes also fell within the spectrum. Of the cases in which immune-mediated disease was found, 44% had immune-mediated polyarthritis. Bone marrow diseases included myeloproliferative disease, myelodysplasia (8), lymphocytic leukemia (8), myeloma (3), chronic granulocytic leukemia (3), lymphoblastic leukemia, and malignant histiocytosis. The types of neoplasia located outside the bone marrow included lymphoma (6), metastatic disease (2), and neoplasms of the lung, spleen, and stomach. Finally, miscellaneous diseases included hypertrophic osteodystrophy (6), meningitis (3), portosystemic shunt (3), lymphadenitis (2), panosteitis, and intervertebral disc disease. Overall, the most common causes across all cases were polyarthritis (44), lymphoid neoplasia (15), discospondylitis (8), myelodysplasia (8), hypertrophic osteodystrophy (6), and blastomycosis (6).

**Clinical Signs:** Animals usually present with either persistent or waxing and waning fevers ranging from 103°F to 106°F. Other clinical signs depend on the underlying cause of the fever. Careful and thorough physical examination is required to assess potential causes.

**Diagnostics:** FUI etiologies are partly related to geography, and thus locale or travel history should factor into a practitioner's diagnostic approach. A patient's lifestyle may also provide clues regarding exposure to certain etiologic agents. Therefore, conducting a thorough history can unveil important pieces of the diagnostic puzzle. Physical examination is especially important and should include an inspection of all accessible lymph nodes, palpation and movement of the joints, a fundic examination, a neurological evaluation, spinal and limb palpation and range of motion tests, and a rectal examination.

A minimum database should include a CBC reviewed by a clinical pathologist, as well as a biochemical profile and urinalysis. Retroviral testing should also be considered in cats. In areas where tick-borne disease is prevalent, in-house testing should be performed early. Advanced laboratory work can include: urine culture, blood culture, and infectious disease panels (PCR and/or serology). In dogs, one may screen for the following infectious agents: *Ehrlichia* spp., *Borrelia burgdorferi*, Rock Mountain Spotted Fever, *Bartonella* spp. (culture and PCR), and *Leptospira* spp. in cases of hepatic or renal involvement. In cats, one should evaluate for FeLV, FIV, feline infectious peritonitis (FIP) virus, toxoplasmosis, *Hemoplasma* spp. (*Mycoplasma*), and *Bartonella* spp. (culture and PCR). Testing for *Ehrlichia* spp., *Rickettsia* spp., and *Anaplasma phagocytophilum* can also be considered. A fungal assay is indicated if the patient lives in or has had exposure to a region with a higher incidence of fungal disease. Other infectious disease tests may be performed depending on the geographical location of the pet. Screening for *Brucella* should be done in breeding dogs. Immune-mediated disease screening can include a Coomb's



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test, a slide agglutination test (if the patient is anemic), and an antinuclear antibody (ANA) test. Immune disease is often a diagnosis of exclusion.

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Imaging should include thoracic radiographs, abdominal ultrasound, and/or abdominal radiographs. Ultrasound can be very useful for assessing evidence of cholangiohepatitis, pyelonephritis, chronic urinary tract infection, abscess formation, peritonitis, and neoplasia; it also permits an examination of the intra-abdominal lymph nodes. An echocardiogram can offer assessment for vegetative endocarditis, whereas spinal radiographs offer assessment for discospondylitis. In cases where all other testing has proven negative and the patient has not responded to broad-spectrum antibiotics and supportive care, arthrocentesis should be considered to evaluate for septic joint disease, immune-mediated polyarthritis, and infectious disease. Finally, one can consider assessing the cerebrospinal fluid for meningoencephalitis, GME, and meningitis/arteritis. A bone marrow exam should be performed if blood dyscrasias are noted on the CBC.

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**Treatment:** Treatment of the fever depends entirely on the underlying cause. Ideally, a thorough diagnostic plan will yield a diagnosis that will guide the appropriate therapeutic course. However, if an exhaustive approach has not produced a definitive diagnosis and there is no response to broad-spectrum antibiotics, trial therapy with immunosuppressive agents such as prednisolone can be considered to treat presumed immune-mediated diseases. Given the potential for negative sequelae should an underlying infection be present, one must be certain that the investigation is thorough and monitor the patient's response carefully.

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**Conclusion:** If a documented fever has not responded to antibiotics, antipyretics, or general nursing care, it is important to obtain a diagnosis to guide more specific treatment. A systematic physical examination and thorough history-taking will help inform further diagnostics in addition to what is revealed by the minimum database.

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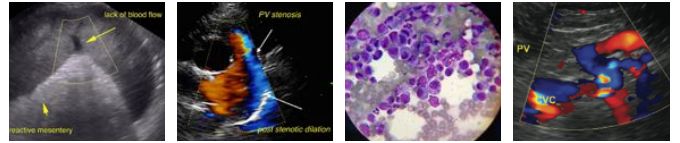
Long axis of the left pancreatic limb (between calipers) in a cat with pancreatitis after undergoing a renal transplant. Note the decrease in echogenicity and mild loss of regular echotexture of the swollen and irregularly contoured pancreas. Also note the mild dilation of the pancreatic duct (arrow). Focal peritonitis is evident by increased echogenicity and loss of the linear echotexture of the surrounding mesentery.

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Long axis of the right kidney in a dog with pyelonephritis. Note the increased echogenicity and irregular outline of the renal crest and diverticuli and the mild dilation of the renal pelvis (arrow).

Long axis of the right pancreatic limb in a dog with acute pancreatitis. The swollen hypoechoic pancreas is embedded in hyperechoic mesenteric fat (arrow). Note the regional differences in blood flow intensity within the parenchyma as demonstrated by Power Doppler interrogation compatible with multifocal disruption of vascularization as a sequela of the severe inflammation.

**References:**

Bennet D. Diagnosis of pyrexia of unknown origin. *In Practice* 1995;17(10):470-81.

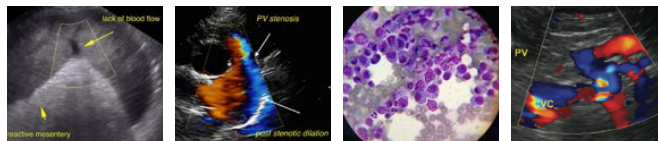
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Lunn KF. Fever of unknown origin: a systematic approach to diagnosis. *Compend Contin Educ Vet* 2001;23(11):976-92.



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Lunn KF. Fever of unknown origin: appropriate choice of diagnostic tests. Proceedings from the American College of Veterinary Internal Medicine, Minneapolis, MN, June 9-12, 2004.

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