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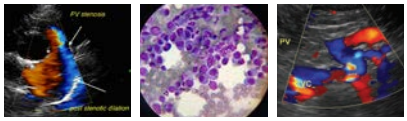

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DATE

10/21/21

PATIENT

Sarah Gillette

SPECIES

Canine

BREED

Rottweiler

SEX

Spayed Female

AGE

2014

WEIGHT

81.9 Pounds

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

HOSPITAL NAME

Animal Emergency Hospital

REFERRING VET

Dr. Thompson

INVOICE

26582

PRESENTING CLINICAL SIGNS

Referral, Seizures, & Vomiting.
History: Date: 10-21-2021 Notes: Sarah is a 7 y/o FS Rottweiler who presents for vomiting, chronic diarrhea, weakness, and seizure. Referral from Northwind, elevated LE/Kidney enzymes, low BG, enlarged liver, low PLT. Chronic diarrhea for the past 3 months, treated with steroids, formed feces the last day. Only eating boiled chicken and rice, history of weight loss. Strain vocalization today, found shaking. Vomiting dark brown to black material. Collapsed, could not stand, seizure like activity. Some historical weakness in hind limbs. No known toxin exposure. Previously vaccinated for lepto, no known water exposure. No change in urination, increased drinking since being on prednisone- 4dx negative. 10/5/21 Medications: - HW prevention - Prednisone 20 mg SID for 5 days then 10 mg SID until gone, recently finished - Proviable (prescribed multiple times) - Metronidazole 750 mg PO BID (prescribed multiple times).

Current Medications: Amp/Sulb (Unasyn) 1.5gm Injection (Per mL), Dextrose 50% Solution Injection (Per mL)
Lab Results: Blood work emailed
Radiographs: Enlarged liver on radiograph
Date of Previous IntraPet Ultrasound: No previous
Sedation: not needed
Stat Report: not requested

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (7.15 cm) with pyelectasia at 0.41 cm. Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (7.67 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.78 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.78 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is enlarged, swollen, and severely mottled. The splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

Liver
The liver is large in size, and normal in echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gallbladder lumen is minimally distended. The wall of the gall bladder appears hypoechoic and somewhat thickened, measuring 0.63 cm. Luminal contents are primarily anechoic. The cystic and common bile ducts are normal/not visible. Anechoic fluid is seen free in the abdomen around the gallbladder and liver.

Gastrointestinal
The stomach contains minimal luminal contents. It measures at a normal thickness of <0.7cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. The duodenum measured as normal (between 0.3-0.5cm in wall thickness) and the jejunum measured as normal (between 0.2-0.47cm.) Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas
The pancreas is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen
A small to moderate amount of free fluid is present. There is a severe mesenteric lymphadenopathy present with portal lymph nodes measuring 2.62 cm x 1.46 cm and 1.75 cm. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of increased echogenicity around the spleen and enlarged lymph nodes.

Other
A brief view of the heart was submitted. No significant pericardial effusion.

PRIMARY FINDINGS

- Large, irregular, mottled spleen – The diffuse splenic changes are non-specific and could be consistent with lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis. Additionally, the spleen is painful upon scanning and firm.

- Large, heterogeneous liver – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy.

- Moderate to severe mesenteric lymphadenopathy – The severe mesenteric lymphadenopathy is most concerning for a neoplastic process, although you can see significant lymphadenopathy in some cases of autoimmune/inflammatory disease, infectious disease(tick born disease-such as bartonella, fungal infections, etc. A fine needle aspirate with cytology is recommended for further evaluation.

- Free abdominal fluid – recommend fluid analysis and cytology.

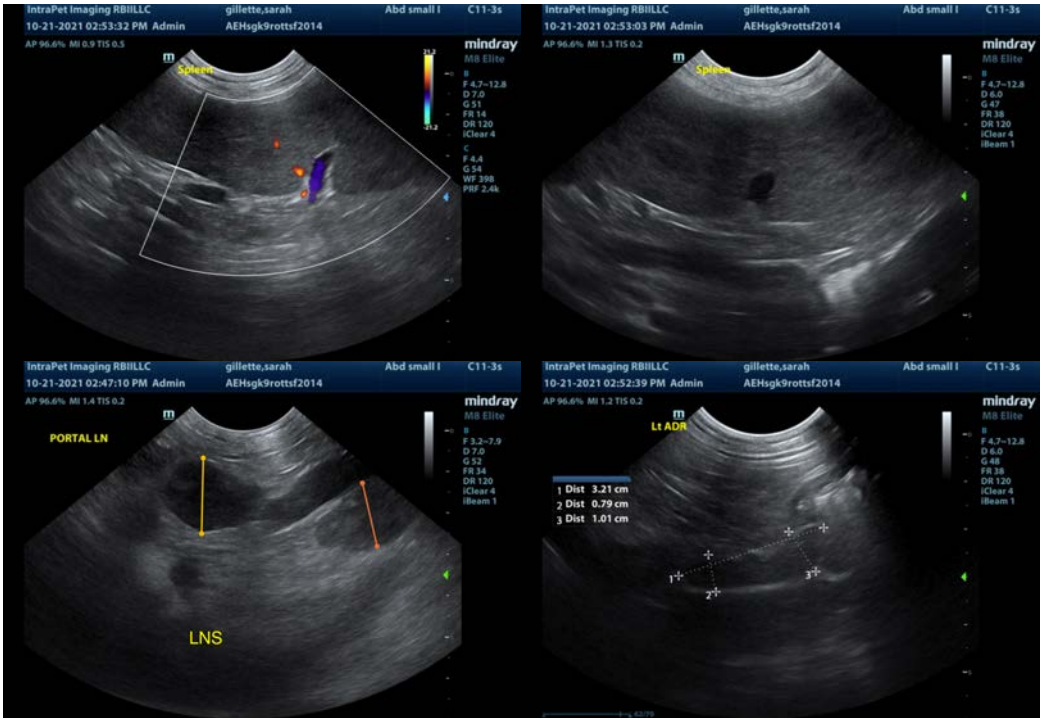
SECONDARY FINDINGS

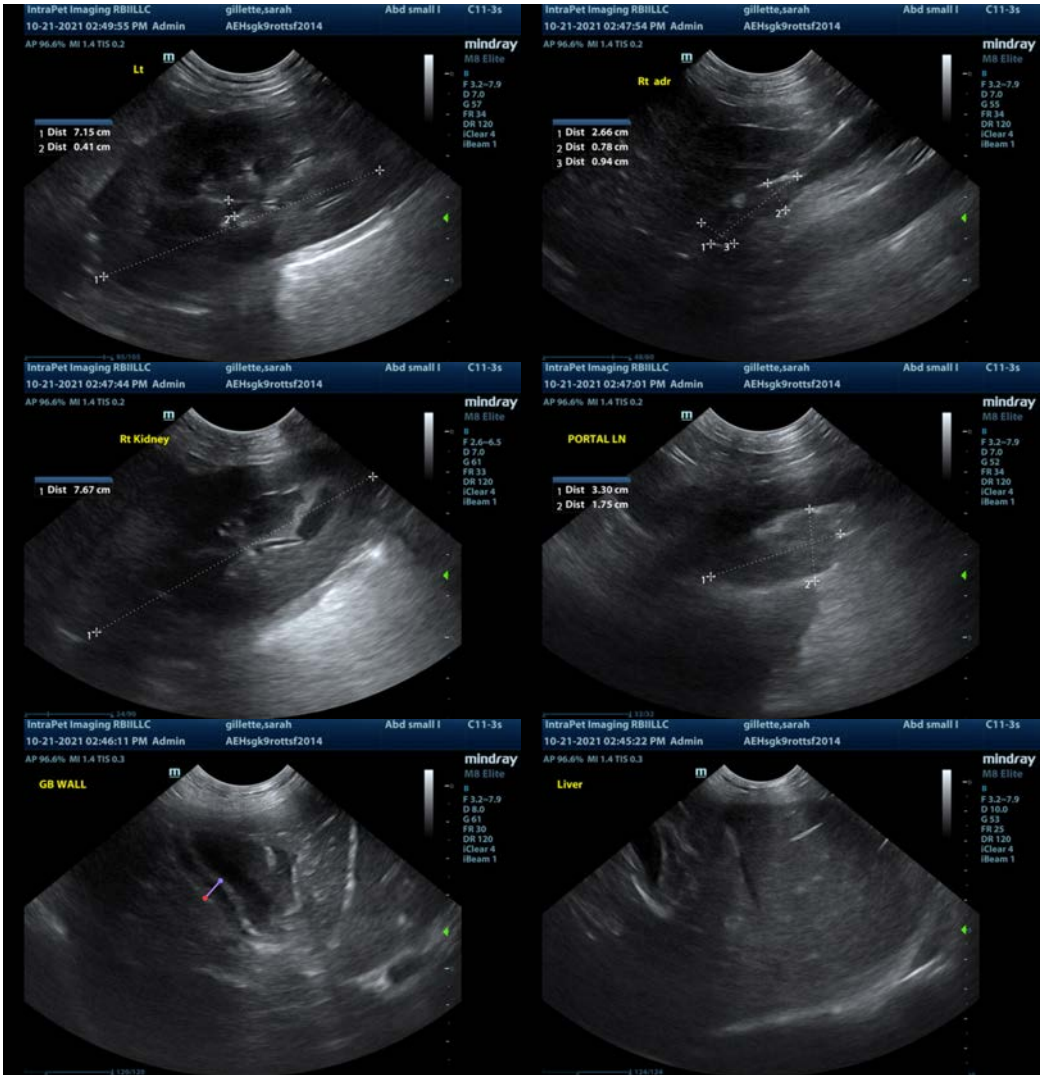
- Thickened gallbladder wall – The significance of this is unclear, although I suspect this is edema secondary to the free abdominal fluid.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The spleen is large, firm and mottled. Additionally, there are enlarged cranial abdominal lymph nodes. Consider a fine needle aspirate of the liver and spleen provided coagulation parameters are ok, and a fine needle aspirate of an enlarged abdominal lymph nodes.

Considering the hypoglycemia reported, recommend a liver function test, an ACTH stimulation test (if clinically appropriate), and if the blood sugar falls below 40, consider measuring insulin levels. Concern is high for an underlying neoplastic process, but other differentials such as tick borne disease, etc. can cause similar types of signs. Recommend tapering off of the Prednisone and anti-ulcer therpay, as the Prednisone may make obtaining a diagnosis more difficult. Recommend 3-view thoracic radiographs to evaluate for possible cardiac/intrathoracic disease.





The information and recommendations provided are based on the images presented by the referring veterinarian. 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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