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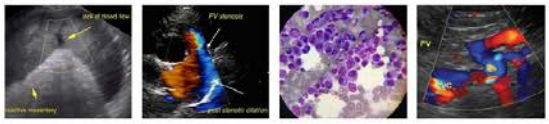


IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Cotton Kernytsky

SPECIES

Canine

BREED

ACD

SEX

Neutered Male

AGE

7 Years 4 Months

WEIGHT

47 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

Grass Valley VH

REFERRING VET

Dr. Kristi Cortright

INVOICE

45955

DATE

3/15/23

PRESENTING CLINICAL SIGNS

Heavy sedation for exams and diagnostics needed- Poor appetite for past 4-5 weeks. Vomit 1-2x- Aspirated right submandibular LN as was enlarged- presented for not eating. Started a couple weeks ago, P seemed to be picky. Original diet was ry kibble, O started adding canned food, rice, and chicken to encourage P to eat. Last 3-4 days not eating much at all, O feed a small amount of chicken nuggets last PM, P vomited shorty after. No food in vomitus, but a stinky brown liquid. Energy seems about the same. No know exposure to any toxins, O doesn't typically chew or eat nonfood items (occasionally sticks from the yard). Recent wt. loss.

Abnormal PE/Chem/CBC/UA Results: FAST scan of mediastinal thorax revealed enlarged right lymph node hypoechoic 0.99cm x 2.57cm- ALP 250, ALT 180, mild neutropenia and lymoh/macro are low-normal. RADS_ unremarkable abdomen.

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 prostate is normal in size (0.72 cm) and shape for this neutered male dog. The parenchyma is homogenous and the external margins are smooth. The prostatic urethra appears normal with no evidence of irregularity, invasion, mass effect or calculi.

The left kidney has a normal shape and size (6.08 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal 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 (5.85 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

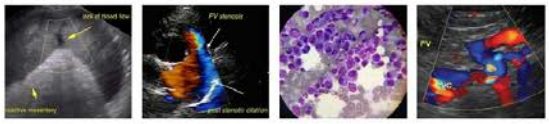
Adrenal Glands

The left adrenal gland is normal in size measuring 0.60 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 0.75 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 subjectively normal in size, echotexture is homogenous, and the splenic capsule is smooth with no irregularities. Echogenic material is visualized within the splenic vessels, most consistent with a thrombus. Color flow within the spleen appears adequate, and there may be some residual blood flow that is still getting by the partial occlusion. No associated inflammation or parenchymal defects



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observed consistent with an infarcted spleen. There is a very small hypoechoic nodule visualized measuring 0.39 cm.

Liver

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

The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and primarily anechoic. The cystic and common bile ducts are normal/not visible.

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. Duodenum wall measures 0.50 cm. Jejunum wall measures 0.48 cm. 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

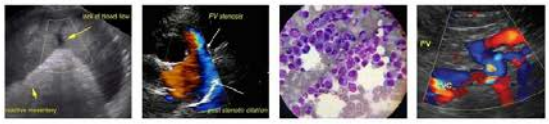
The pancreas is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

There is a small amount of free abdominal fluid. There is a diffuse mild to moderate mesenteric lymphadenopathy present with a sublumbar lymph node that is slightly hypoechoic and slightly irregular measuring 1.02 cm in with, a gastric lymph node measuring 1.48 cm in width, numerous mesenteric lymph nodes that are hypoechoic and somewhat irregular measuring approximately 1.18 cm, and a pancreaticoduodenal lymph node measuring 1.23 cm in width. The omentum is slightly hyperechoic around the enlarged lymph nodes.

ULTRASONOGRAPHIC FINDINGS

- Thrombosed splenic vessel – I suspect there is some collateral circulation that has developed and the occlusion does not appear complete.
- Moderate mesenteric lymphadenopathy – The moderate mesenteric lymphadenopathy could be 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, FIP (cats)) etc. A fine needle aspirate with cytology is



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recommended for further evaluation.

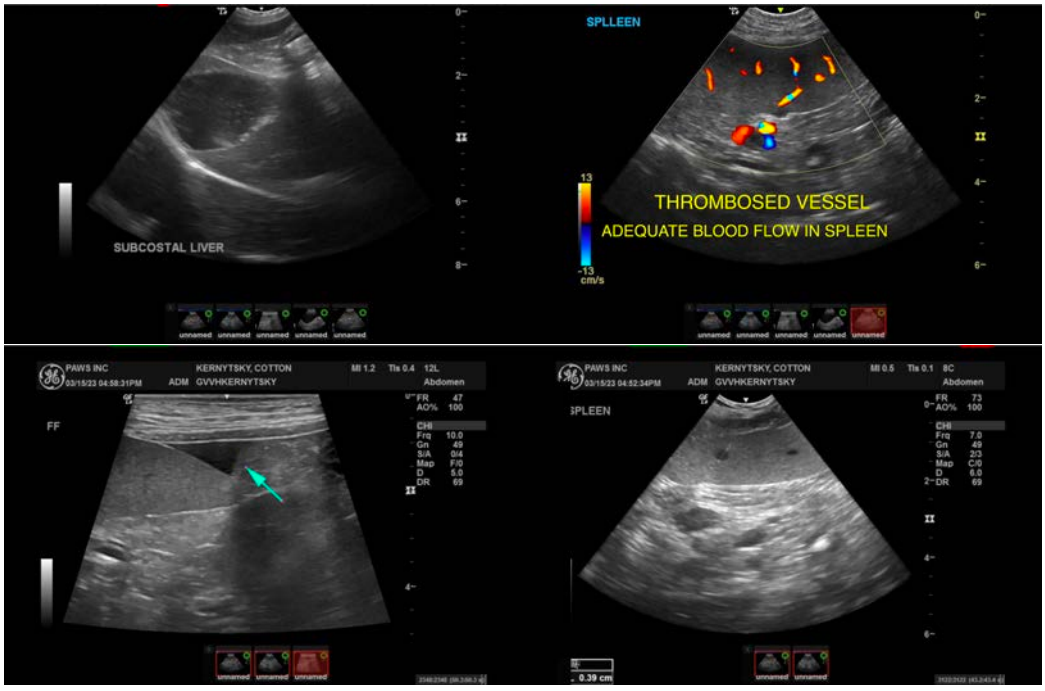
- Small volume free abdominal fluid

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is soft tissue density visualized within the splenic vessel. This is most consistent with a thrombosed vessel. There is minimal associated inflammation, and the spleen appears adequately perfused with no inflammation, so this could possibly be an old lesion or a partial occlusion. These lesions are most commonly thought to occur secondary to inflammatory disease/hypercoagulable states. Consider such differentials as protein losing nephropathy/enteropathy, severe liver disease, DIC, autoimmune disease such as IMHA/ITP, and neoplasia.

In this individual, the priority is trying to determine the nature of the lymphadenopathy noted. If all peripheral lymph nodes are enlarged, consider an aspirate. The submandibular lymph nodes are sometimes somewhat unreliable due to secondary inflammation associated with the oral cavity. If a peripheral lymph node is not helpful, there are many superficial abdominal lymph nodes that could be sampled. If these lymph nodes are inflammatory, then additional diagnostics should be pursued, looking for a source of systemic inflammation, looking for any evidence of infection, autoimmune disease, etc. Ultimately, if no invasive sampling is considered, you may want to consider starting Plavix therapy and recommend reevaluation of the spleen with ultrasound in approximately two weeks.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.



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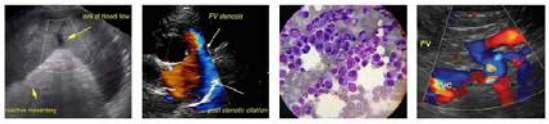

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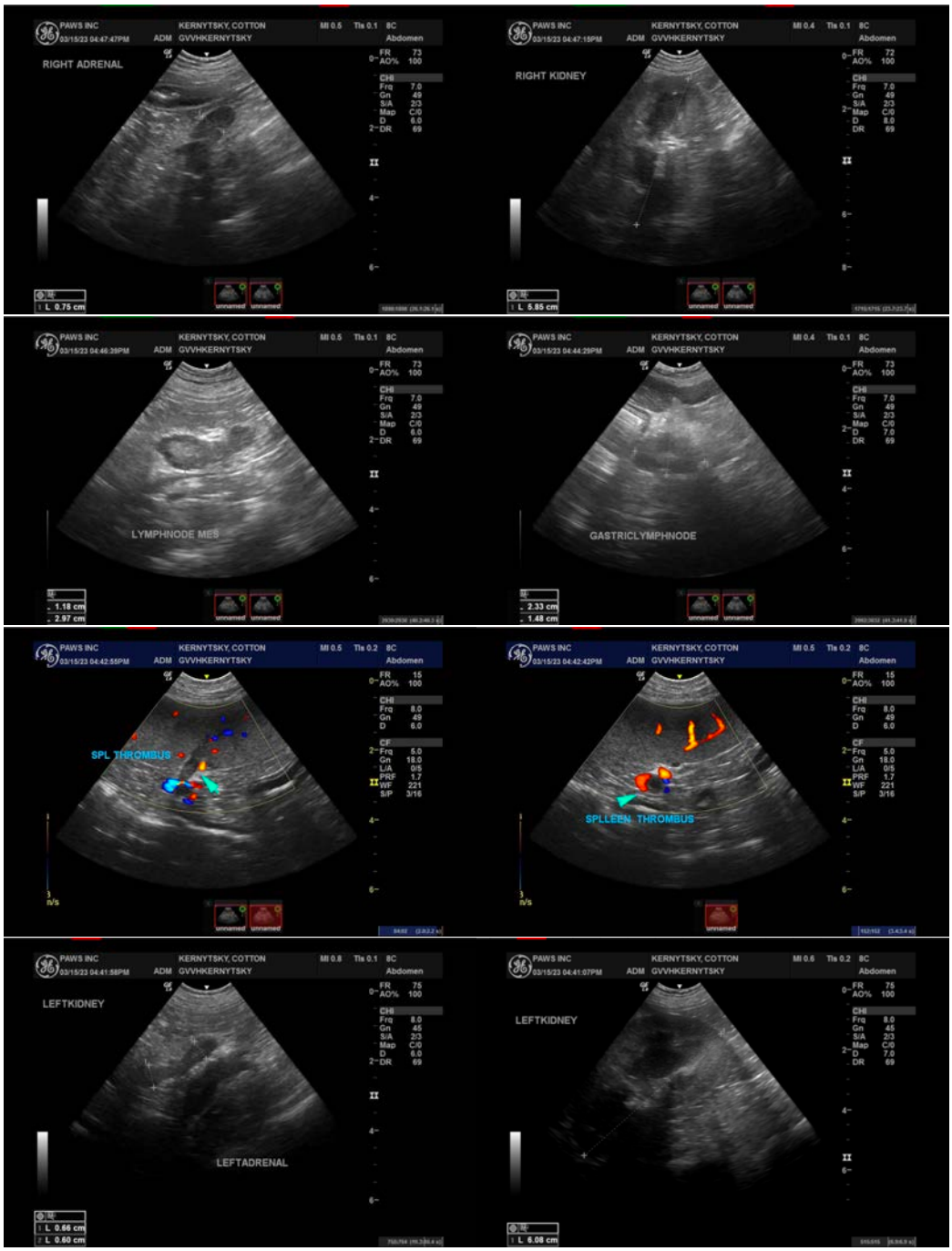

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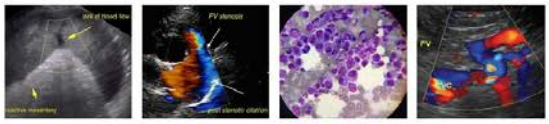

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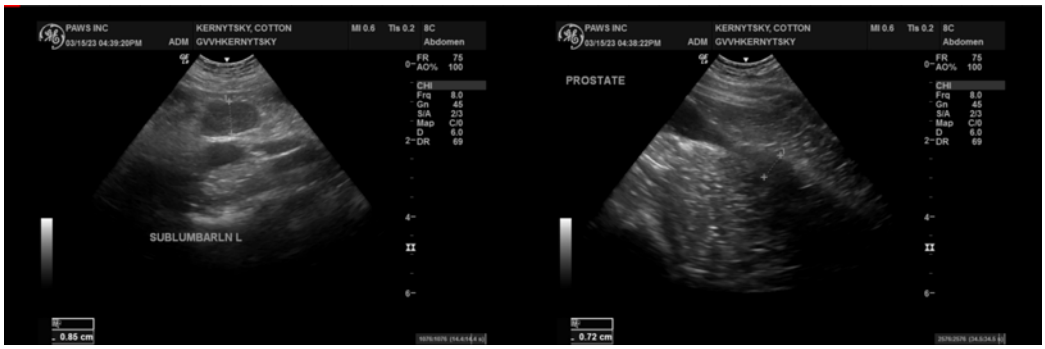

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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