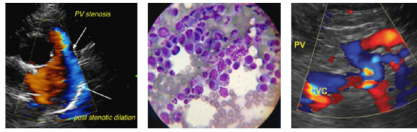
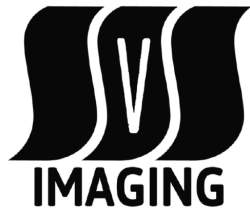


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SVS Mobile Imaging CT 262-366-5970
fredgromalak@gmail.com

**PATIENT**

Axl Severini 49111A

SPECIES

Canine

BREED

English Springer
Spaniel

SEX

Neutered Male

AGE

10 Years 2 Months

WEIGHT

24.4 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Tom McNeill

HOSPITAL NAME

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Specialists - Dr. Resop

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PRESENTING CLINICAL SIGNS

Axl was evaluated at MVS on 3/5/22 for vomiting and decreased appetite. His ALT was mildly elevated at 274, he had a mild hyperbilirubinemia at 2.0, albumin 2.1. He was found to be Lyme positive. Owners elected outpatient therapy at this time. He was given SQ fluids, maropitant, and was discharged with doxycycline and gabapentin. Axl was rechecked with rDVM yesterday. He has gained 1.5 lbs and has a tight distended abdomen that she suspects is full of fluid. Bloodwork was rechecked - albumin is now 2.0, his SDMA is normal (12), total bilirubin is decreased from previous (now 0.9; range 0-0.3), WBC decreased from previous and is now WNL (10,075) and liver values are increased from previous (ALT now 424, AST 219). Axl is still eating, but slower. No vomiting, except for one time he vomited grass. No diarrhea.

Abnormal PE/Chem/CBC/UA Results: Large amount of free fluid in AFAST, determined to be a pure transudate.

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 (1.17 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 (6.54 cm). Overall echogenicity is slightly hyperechoic with poor 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 (6.3 cm). Overall echogenicity is slightly hyperechoic with poor 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 0.73 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 0.64 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

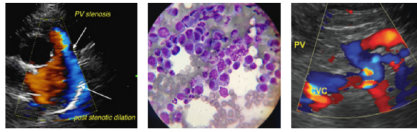
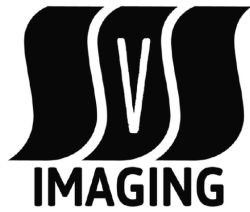
The spleen is large in size. The spleen echotexture is heterogenous and mottled, the splenic capsule is smooth with no irregularities. In the caudal third of the spleen, there is a soft tissue structure within a branch of the splenic artery, most consistent with a clot. This measures 1.02 cm in length x 0.39 cm in width. Blood flow is somewhat turbulent proximal to this tissue, but appears to bypass it normally, and the spleen appears adequately perfused.

Liver

The liver is subjectively normal in size, and hypoechoic with smooth peripheral margins. The parenchyma is severely 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.

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The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are 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 uniform diameter with minimal fluid distension. Wall thickness is increased. Bowel loops follow a typical curvilinear path. Some areas have reduced detail of wall layering. Duodenum wall measured 0.52 cm. Jejunum wall measured 0.44 cm, 0.32 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 prominent and hypoechoic as compared to the surrounding isoechoic mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

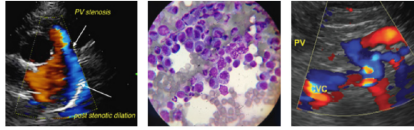
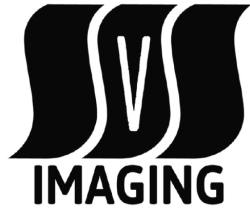
There is a large amount of anechoic free abdominal fluid. There is no lymphadenopathy noted. The omentum appears uniformly hyperechoic.

ULTRASONOGRAPHIC FINDINGS

- Large, mottled spleen with suspected small thrombus – 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. Perfusion of the spleen appears normal despite the presence of this possible clot.
- Hypoechoic, prominent pancreas – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.
- Hypoechoic, severely 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.
- Decreased corticomedullary distinction in both kidneys – Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis.
- Mild small intestinal wall thickening – The mild small intestinal wall changes may be a normal variant in this patient or could be consistent with an inflammatory process (e.g., inflammatory bowel disease). This is very likely edematous change due to the large amount of free abdominal fluid.
- Large volume free abdominal fluid.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a large volume of free abdominal fluid present, and the history reports hypoalbuminemia, but this level of hypoalbuminemia is typically not low enough to cause ascites on its own. The spleen appears large and mottled, and there is a small thrombus visualized within one of the branches of the splenic artery. Blood flow to the spleen appears adequate at this time, but there is concern for a hypercoagulable state, and risk for this clot to continue to get larger. If there is a thrombus in this location, it is also possible that there are other thrombi contributing to result in abdominal effusion. Consider a fine needle aspirate of the spleen.

The liver is hypoechoic and severely mottled. No focal lesions are visualized. Recommend a liver function test, and consider a fine needle aspirate of the liver.

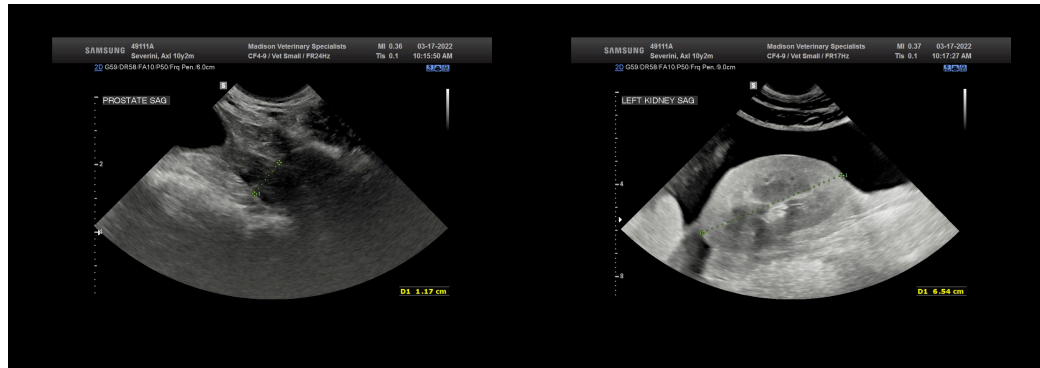
Both kidneys appear hyperechoic with a loss of corticomedullary distinction. The history reports a positive lyme test. Recommend a urine protein/creatinine ratio and a blood pressure to further evaluate for a protein losing nephropathy.

The small intestine appears subjectively thickened. This can be a common finding when there is a large amount of ascites due to some edema, but in this situation, a protein losing enteropathy could also be present. Consider a GI panel to Texas A&M for a qualitative PLI, TLI, cobalamin and folate to further evaluate for evidence of small intestinal disease.

Recommend 3-view thoracic radiographs to evaluate for concurrent intrathoracic disease, and a cardiac ultrasound to look for evidence of pericardial effusion or right-sided heart disease.

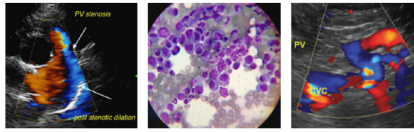
Consider submitting a fluid sample for a fluid analysis and cytology to try to determine if this is a pure transudate or a modified transudate, etc.

Hopefully with these test results you'll have a better idea of the source of the ascites. If this is still unclear, you could consider a contrast CT scan of the abdomen to look for further areas of infarction, small mass effects, etc. I would consider at least starting a platelet inhibitor such as Plavix, and close monitoring of the infarct in the spleen.



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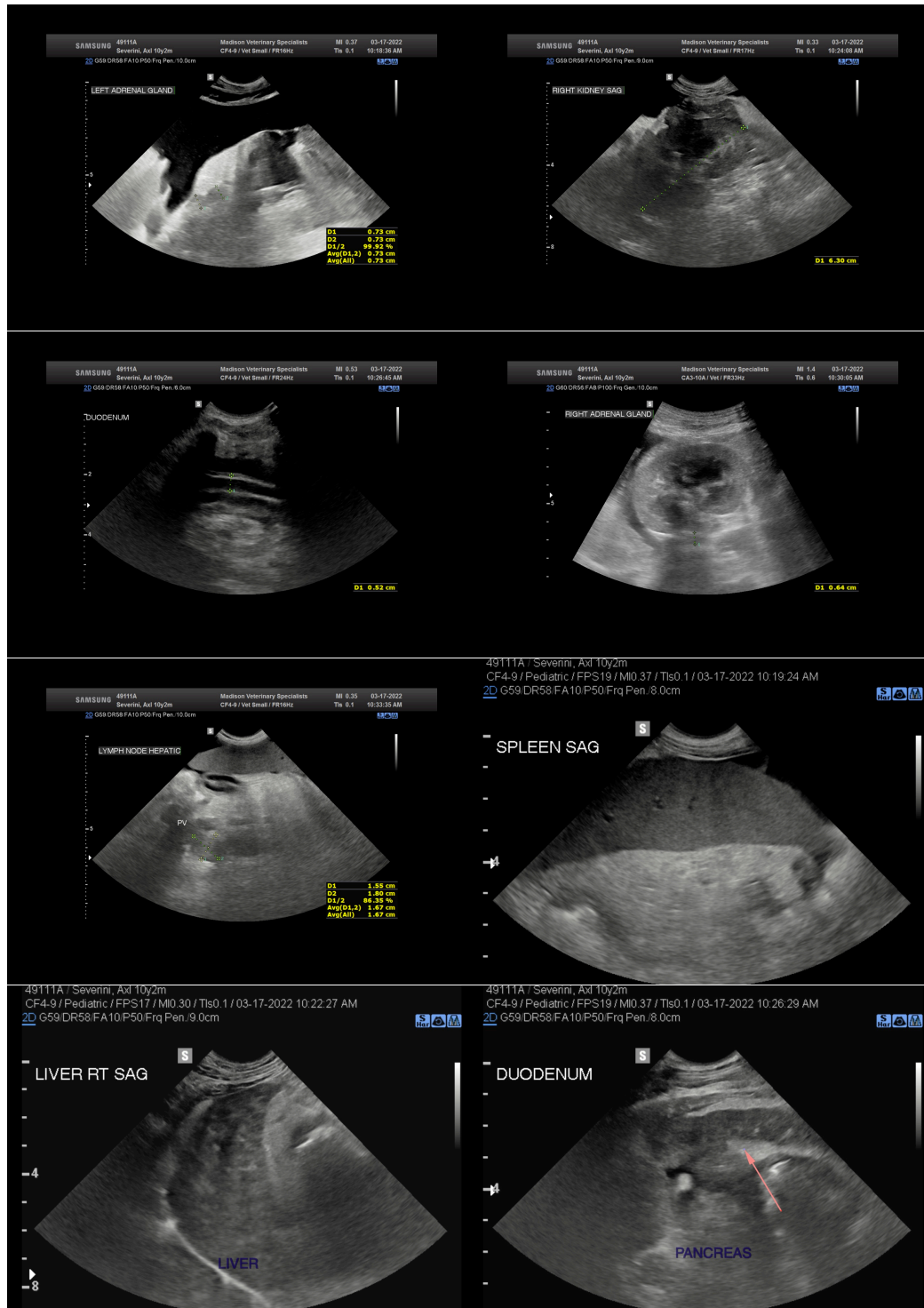
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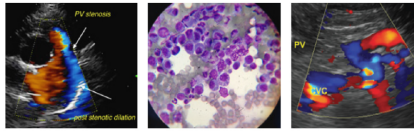
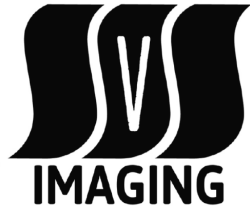
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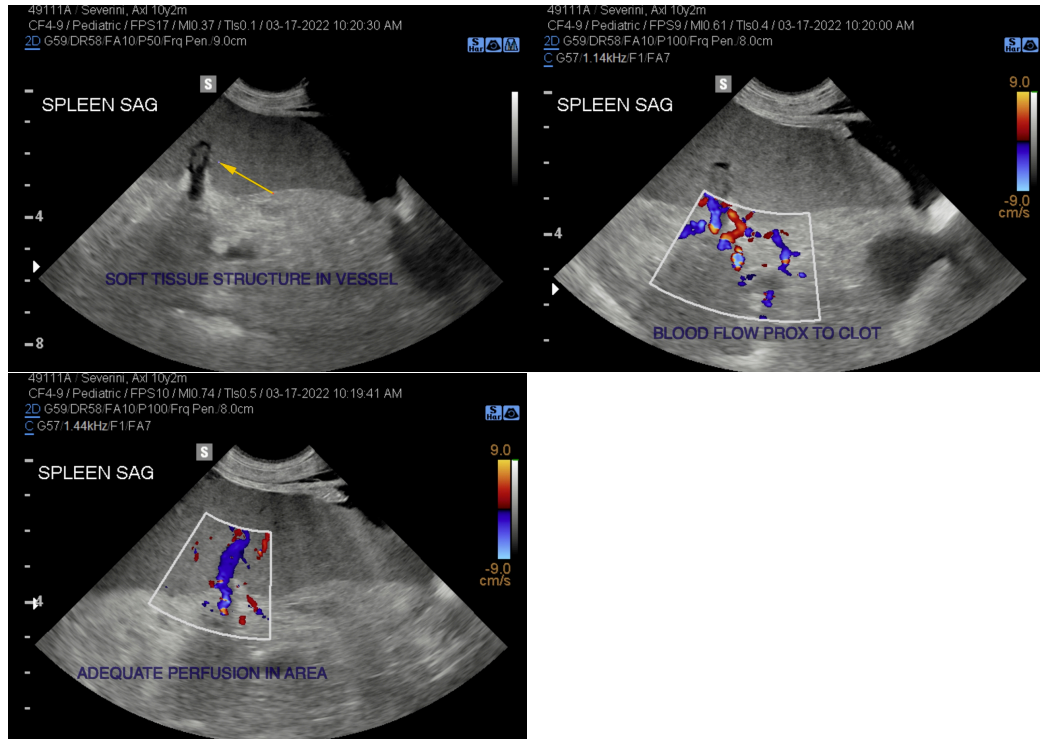
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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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