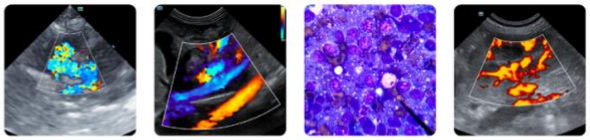

PATIENT

Apollo Rivera

SPECIES

Canine

BREED

Malamute

SEX

Neutered Male

AGE

9 Years

WEIGHT

82.2 pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Jessica Bailes

HOSPITAL NAME

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PRESENTING CLINICAL SIGNS

acute onset lethargy, generalized pruritis and decreased appetite. Initial exam - patient febrile w/ severe conjunctivitis OU and rash ventral abdomen. Initial BW: hypoalbuminemia w/ elevated SDMA and isosthenuria. Fever resolved w/ carprofen, conjunctivitis resolved w/ neopolydex. Rash resolved w/ Benadryl. Lethargy/pruritis/decreased appetite persisted. recheck BW: worsening hypoalbuminemia, NEW elevated TBILI, ALP.

Abnormal PE/Chem/CBC/UA Results: Progressive minor weight loss, NEW focal oral ulcers above 104/204 on most recent exam - fever resolved; rash on ventrum resolved Thoracic rads: NSF Accuplex: negative Most recent labs: SC: Alb 2.2 (previous, AlP 294, Tbili 0.6 (previous 0.2), SDMA 25.6 (previous 19.3), Creat 1.4. All other UR. CBC: WBC 23.8, Neut 15708, Eos 5236, Hct 38 (previous 45). Resting cortisol: WNL @ 2.7

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 2.0 cm) appear normal with no evidence of wall thickening, mucosal irregularities or masses. In the dependent portion of the urinary bladder, there are numerous hyperechoic shadowing foci most consistent with a pile of small stones/mineralized debris.

The prostate is normal in size (1.29 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 (6.74 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. There are pinpoint small cortical mineralizations present.

The right kidney has a normal shape and size (5.95 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. There are pinpoint small cortical mineralizations present.

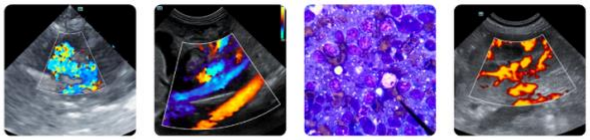
Adrenal Glands

The left adrenal gland is normal in size measuring 0.59 cm at the cranial pole and 0.59 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 0.54 cm at the cranial pole and 0.58 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 large in size The spleen echotexture is heterogenous and mottled, the splenic capsule is irregular in shape. There are numerous coalescing hypoechoic, somewhat moth-



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eaten lesions, which appear mostly to involve the periphery of the spleen. These are highly concerning for splenic infarcts. Although hypoechoic nodules can have a similar appearance, recommend evaluation with Power Doppler. Additionally, there is soft tissue echogenicity visualized within the splenic vein and lack of color flow on Doppler most consistent with a splenic thrombus.

Liver

The liver is subjectively large in size, and 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 gall bladder 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 large fluid/shadowing ingesta. It measures at a normal thickness of <0.7 cm 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. Correlate findings with the feeding history. If the patient was adequately fasted, this could represent delayed gastric emptying or partial outflow tract obstruction (non-visualized).

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal to moderate 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 (0.44 cm in wall thickness) and the jejunum measured as normal (0.34 cm) Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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 mottled in the right limb 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

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Large irregular mottled spleen with suspected splenic infarcts and a thrombus in the splenic vein- 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.

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- Large heterogenous liver- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, infiltrative neoplasia (less likely) or other hepatopathy.
- Shadowing calculi visualizing in the dependent portion of the urinary bladder. Correlate with a urinalysis, culture and radiographs.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

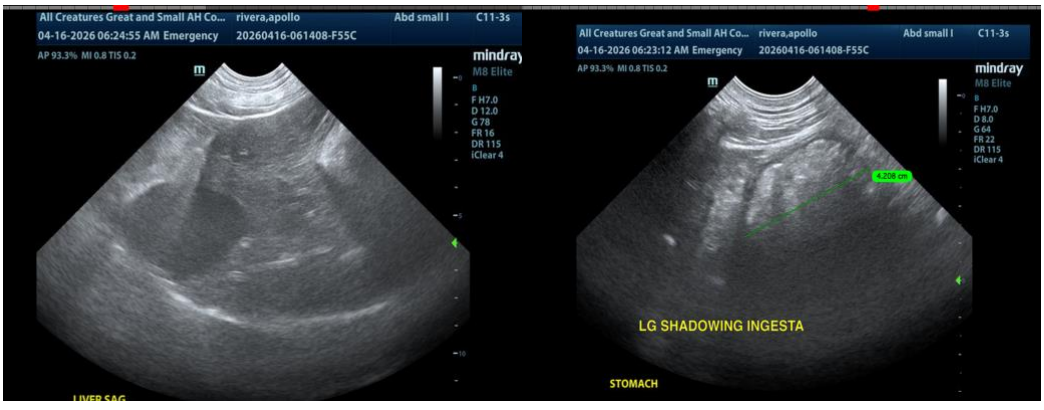
The spleen is large, mottled and irregular with hypoechoic regions highly concerning for infarcted areas. Additionally, there's a thrombus in the splenic vein. This finding in combination with the hypoalbuminemia, fever, rash/vasculitis reported would increase my concern for sepsis and/or underlying neoplasia.

Recommend a fine needle aspirate of the spleen and evaluation the splenic parenchyma with color doppler to try and assess how vascular the spleen is. It's very possible that splenectomy will be strongly recommended if the patient is stable enough. Recommend a urine culture and blood cultures. If a new murmur is present, recommend an echocardiogram looking for endocarditis as a source of sepsis (this could be causing the elevation in bilirubin reported). No other lesions were visualized in the abdomen today to explain these findings.

Recommend three view chest radiographs looking for evidence of metastatic disease, pneumonia, etc.

Common causes for a hypercoagulable state/thrombosis would include neoplasia, protein-losing nephropathy, (recommend a urinalysis, culture and a urine protein creatinine ratio), hyperadrenocorticism, autoimmune disease, etc. Depending on patient status, antithrombotic therapy could be recommended after surgery.

Recommend referral to an emergency/specialty care center for further assessment, surgery consultation, possible surgery and critical care, if possible.



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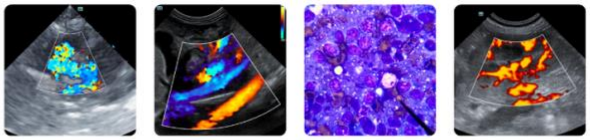

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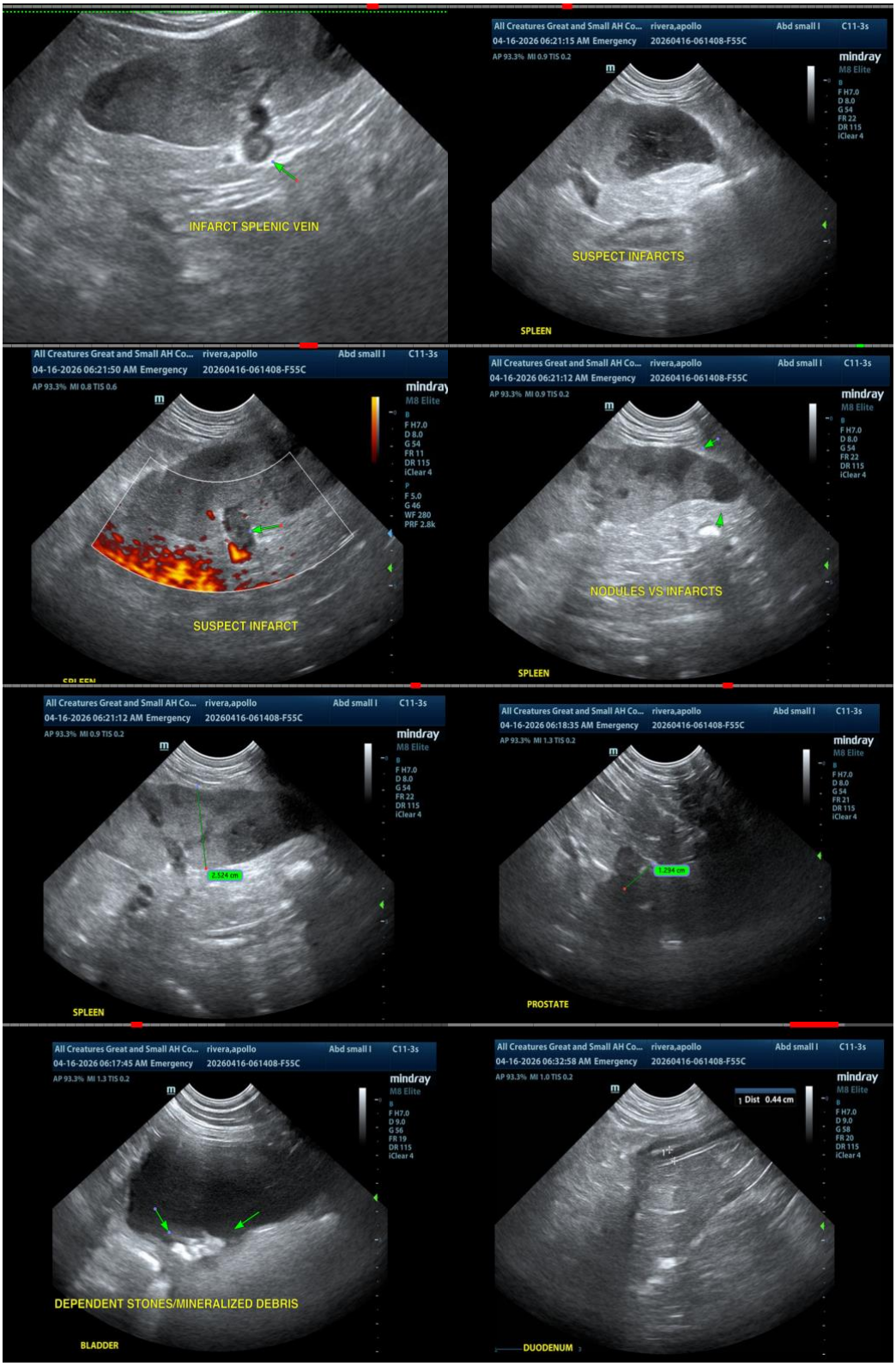

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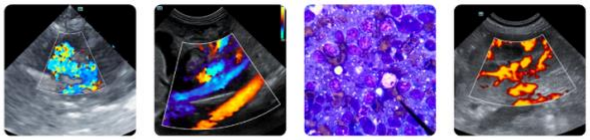

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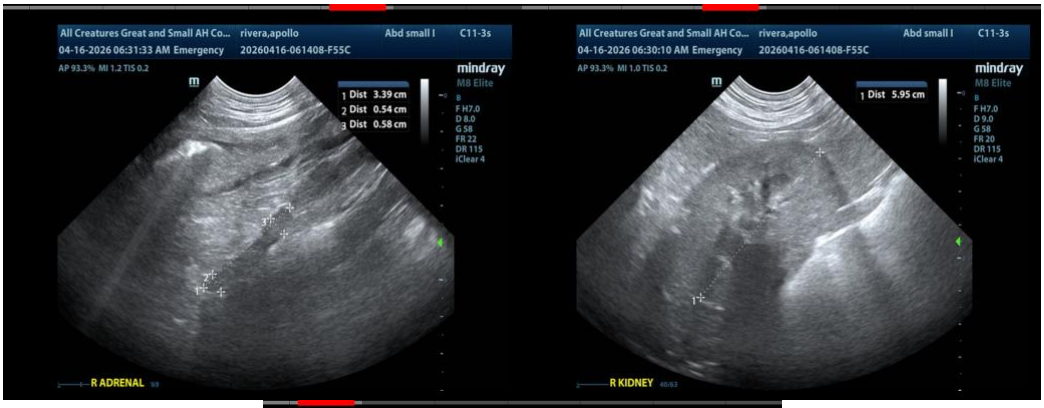

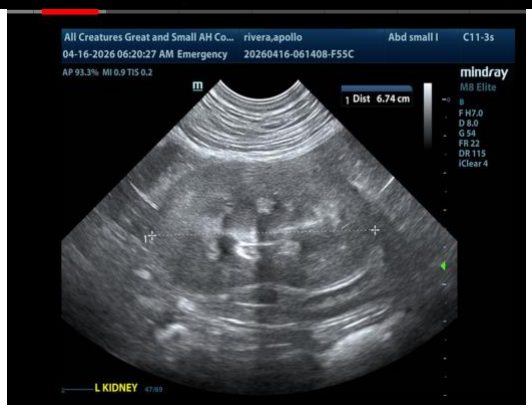

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

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