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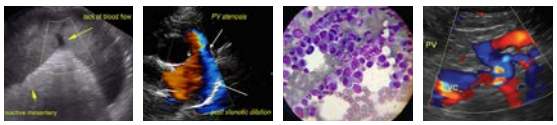


ANIMAL SOUNDS NW
MOBILE VETERINARY ULTRASOUND
IMAGING PERFORMED BY
AnimalSoundsNW.com 541-357-9423

PATIENT

Storm Rea

SPECIES

Canine

BREED

Border Collie

SEX

Spayed Female

AGE

11 Years

WEIGHT

47 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Jenna Walsh, CVT

HOSPITAL NAME

Q Street AH

REFERRING VET

Dr. Bretschneider

INVOICE

38046

DATE

5/26/22

PRESENTING CLINICAL SIGNS

loss of appetite for 3 days, panting (which is abnormal for her), gums are light pink Current Medications ampicillin and dexamethasone Radiographic Findings possibly enlarged spleen Primary Question/Differential to Be Answered in This Exam cause of sickness
Abnormal PE/Chem/CBC/UA Results: WBC very high = 93 thousand, Lymphocytes = 29 thousand (up to 4.8 normal), Monocytes = 8 thousand (up to 1.5 normal), Neutrophils = 56 thousand (up to 12 normal). Platelets are low, having that rechecked. chemistry is all normal

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 (5.99 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 (6.43 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 0.60 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.

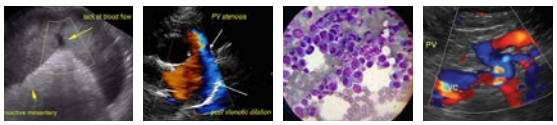
The right adrenal gland is normal in size. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size, echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. There is a very subtle hypo- to isoechoic nodule measuring 1.4 cm near the tail of the spleen.

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. There is a hypoechoic parenchymal solid nodule visualized measuring 3.44 cm x 1.46 cm. There is a cystic structure visualized deep in the liver, measuring approximately 2.5 cm in diameter.



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The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a moderate amount of non-organized echogenic debris. 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. There is a 2.39 cm shadowing structure within the gastric lumen. There is no evidence of an obstruction.

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 right limb of 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 wisp of free fluid visualized between liver lobes. There is no lymphadenopathy. The omentum is mildly hyperechoic in the right cranial region of the abdomen.

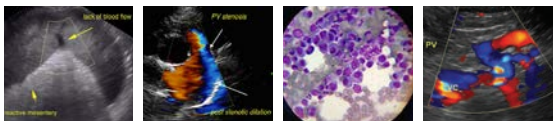
PRIMARY FINDINGS

- Small, ill-defined, hypoechoic nodule on the tip of the spleen – There is a non-cavitated, hypoechoic splenic nodule visualized. Differentials include lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis.

- Large, heterogeneous liver with a hypoechoic intraparenchymal lesion – 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. The significance of this is difficult to determine if liver enzyme elevations are not present. If liver enzyme elevations are present, I would recommend a liver function test and a fine needle aspirate of the liver.

- Moderate gallbladder sludge – The significance of the aggregated gallbladder sludge is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting.

- Small, non-obstructive shadowing material within the gastric lumen – correlate with feeding history, medications, etc. Anything that could cause a shadow. Correlate with abdominal



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radiographs. Recommend continued monitoring.

- Hypoechoic, prominent pancreas – The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

SECONDARY FINDINGS

- Decreased corticomedullary distinction in both kidneys – The bilateral renal findings are consistent with age-related change.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The lesions observed on today's scan are relatively non-specific and mild. No obvious gastrointestinal lesions are visualized to explain the reduction in appetite. The liver appears somewhat large and heterogeneous with a hypoechoic nodule. The significance of this is difficult to assess in the absence of liver enzyme elevations.

Additionally, the pancreas is mildly prominent, which could be consistent with mild current pancreatitis or a previous episode of pancreatitis. Consider a GI panel to Texas A&M for a quantitative PLI, TLI, cobalamin and folate to further evaluate the pancreas and small intestine.

There is a small nodule on the spleen. I would be surprised if this was significant enough at this time to cause symptoms, but a fine needle aspirate of the spleen could be considered.

There is a small amount of shadowing material within the gastric lumen. There is no evidence of an obstruction. Correlate these findings with abdominal radiographs and history, as this could represent a pill or some other minor structure.

There is a significant leukocytosis reported in the history. Recommend pathologist review to look for atypical cells. If this is just a broad leukocytosis, then typically inflammatory or reactive disease is most likely. There is not a significant amount of inflammation noted in the abdomen. Recommend 3-view thoracic radiographs, rectal exam, good oral exam, etc. Unless absolutely necessary, I might hold of on steroids until a diagnosis can be obtained.

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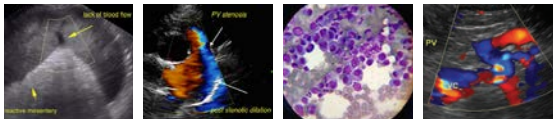

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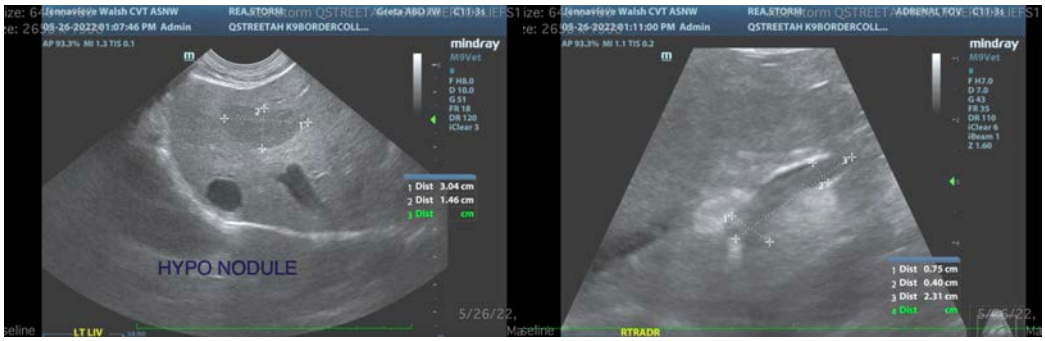

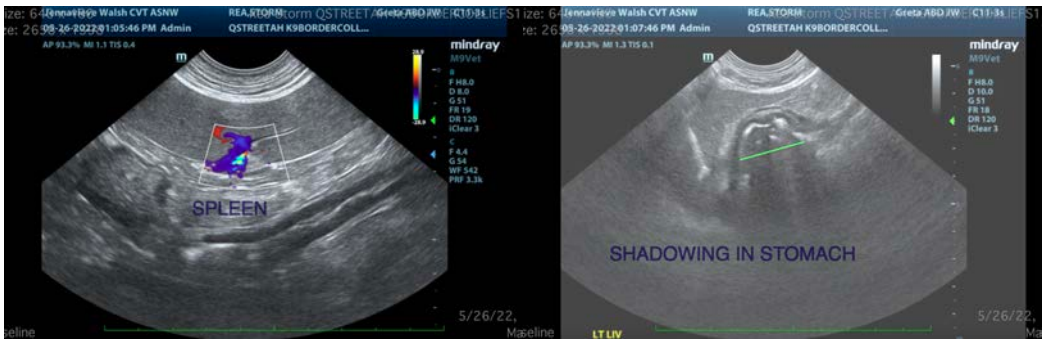

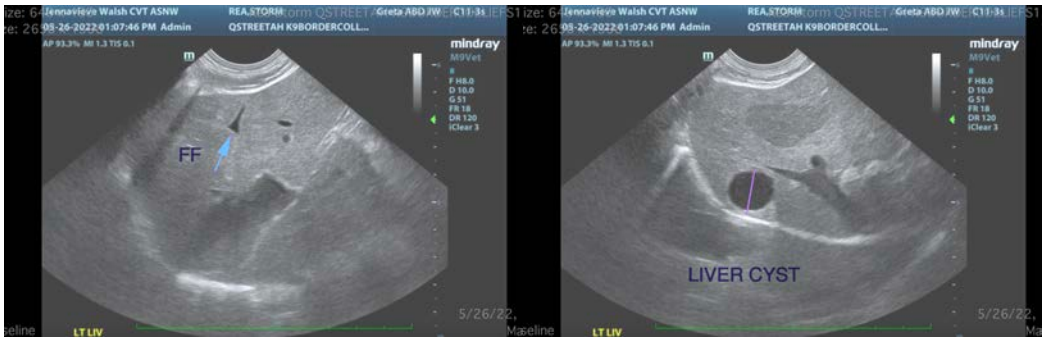

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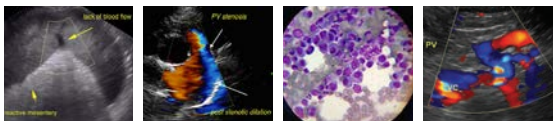

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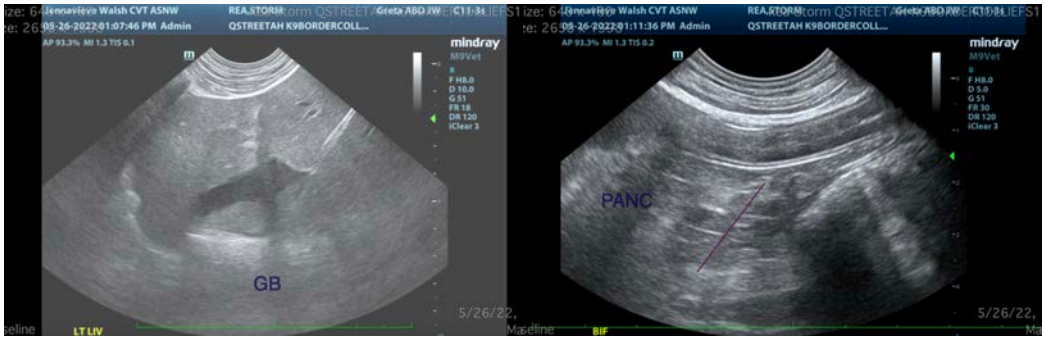

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

kathleen.sennello@sonopath.com