

**PATIENT**

Debo Nunez 51877A

SPECIES

Canine

BREED

Pit Bull Terrier

SEX

Neutered Male

AGE

12 Years

WEIGHT

34.2 kg

INTERPRETED BYKathleen Sennello DVM,
MS, Diplomate ACVIM
(Small Animal Internal
Medicine)**IMAGING
PERFORMED BY**

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VETMadison Vet
Specialists - Dr. Keller**INVOICE**

39289

DATE

7/8/22

PRESENTING CLINICAL SIGNS

Patient presented initially on 7/4/22 for collapse, ataxia, vomiting, cyanosis, and facial edema. Suspected acetaminophen toxicity. He was hospitalized and discharged on 7/6. Returned on 7/7 for continued lethargy, anorexia, and PU/PD since discharge. He also vomited a large amount of water and his denamarin that morning.

Abnormal PE/Chem/CBC/UA Results: EENT: OU moderate chemosis but improved from yesterday, 3rd eyelid elevation, and mucopurulent discharge; OU blepharospasm and with erythematous conjunctiva; dark ceruminous debris AU; bilateral airflow noted out of nares with no nasal discharge or pathology seen; conscious oral examination performed; class 2 malocclusion; gingivitis 1/3 and tartar 2/3 Thorax: Grade III/VI left sided heart murmur auscultated; normal rate and rhythm; normal bronchovesicular sounds in all lung fields Lymph Nodes: No significant findings; mandibular, prescapular and popliteal lymph nodes palpated within normal limits; edema around mandibular significant but can still palpated LN WNL SDMA- 18 (0-14) BUN- 6 (7-27) ALT- 855 (10-125) ALKP- 242 (23-212) GGT- 12 (0-11) TBIL- 4.2 (0.0-0.9) USG - 1.006 PT: 14 (11-17) aPTT: 98 (72-102) NH3: 31 (0-98) PCV/TS 36%/6.4

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 (1.3 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 (6.58 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 hydronephrosis. Renal vasculature is normal.

The right kidney has a normal shape and size (6.94 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 hydronephrosis. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.80 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 0.82 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. The blood flow through the hilus and splenic parenchyma appears normal. There is a small hypoechoic nodule visualized towards the tail of the spleen measuring 0.77 cm x 0.95 cm. This lesion is on the periphery of the spleen and is relatively thin walled.

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Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is mildly 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 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 moderate fluid. 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 measured 0.51 cm. Jejunum wall measured 0.42 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

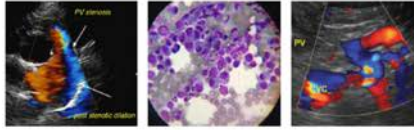
Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Small, hypoechoic splenic nodule – 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. There is some concern, as this lesion appears somewhat thin walled and is on the periphery of the spleen.
- Mildly 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. These changes can also be associated with age related remodeling.
- Moderate fluid distention of the gastric lumen – Correlate with feeding history. If the patient was adequately fasted, this could represent delayed gastric emptying or a partial pyloric outflow tract obstruction (none observed).

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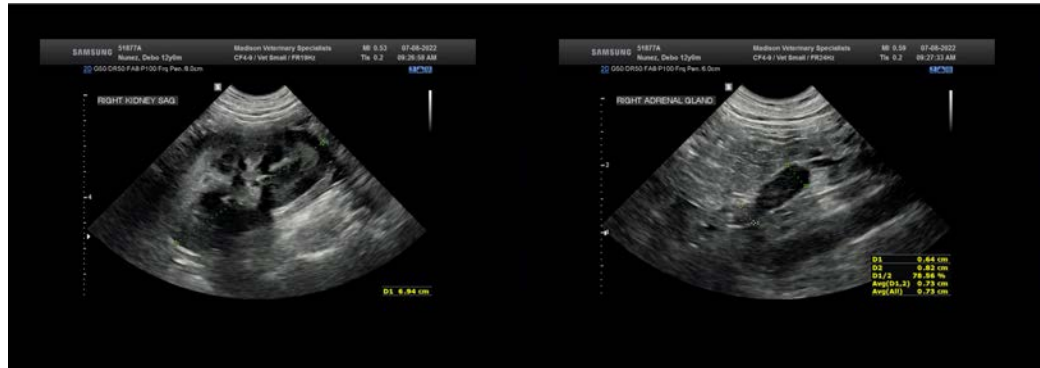
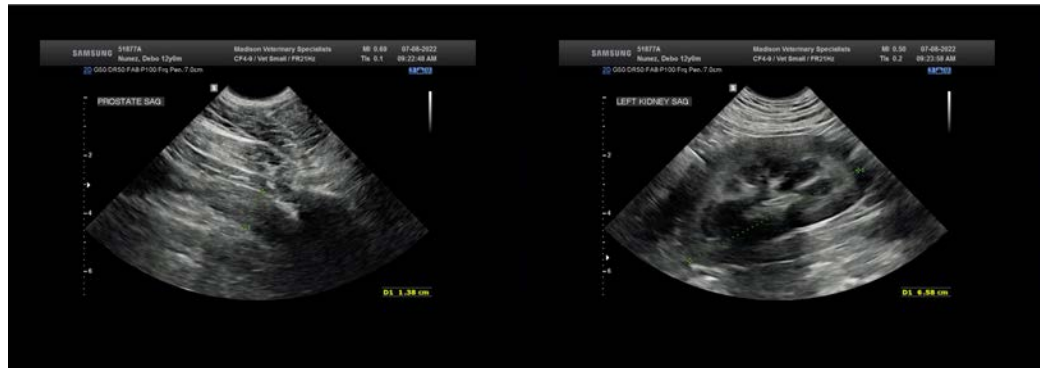
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Today's scan is relatively normal for a 12 year old pit bull. There is a small hypoechoic nodule towards the periphery of the spleen, which I suspect is not related to the current acute episode, although these peripheral lesions are more concerning for the possibility of rupture and hemorrhage. Options moving forward include continued monitoring or splenectomy. If splenectomy is performed, consider screening for babesia prior to the procedure.

The changes observed in the liver are non-specific and could be age related. Recommend continued monitoring and supportive care for possible toxicity, anaphylactic type episode, heat stroke, etc.



INVOICE

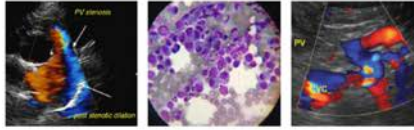
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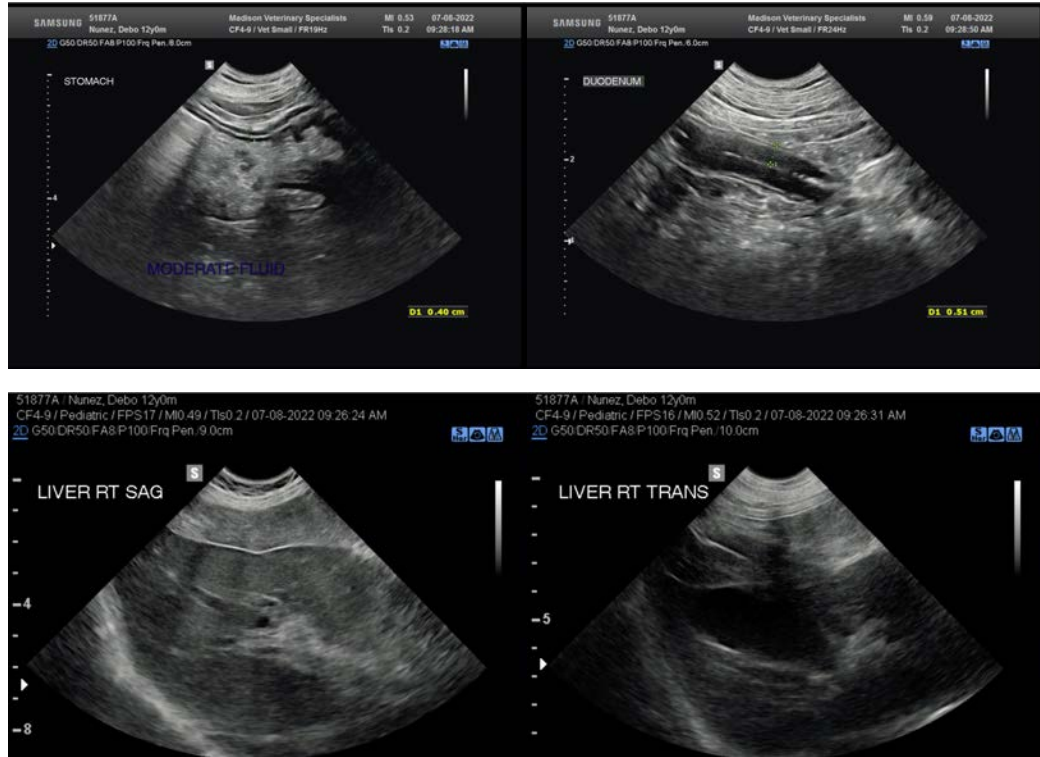
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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