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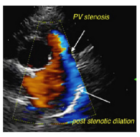

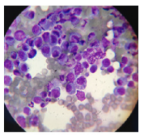
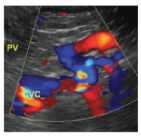

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Clinical Sonography & Telecytology
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PATIENT

Peaches Mcclenahan

SPECIES

Canine

BREED

Rat Terrier

SEX

Spayed Female

AGE

6 Years

WEIGHT

14.6 Pounds

INTERPRETED BY

Lisa Carioto, DVM, DVSc, Diplomate ACVIM

IMAGING PERFORMED BY

Dr. Gromalak

HOSPITAL NAME

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REFERRING VET

Dr. Williams

INVOICE

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4/25/22

PRESENTING CLINICAL SIGNS

About 10 days ago, the owner noticed that Peaches urinated in her kennel 3 days in a row. Although she will occasionally urinate in her kennel, it is abnormal for her to do this consecutively. She was also drinking more than usual. One week ago, the owner noticed that Peaches left eye was red and bulging. However, the following day, it seemed to be improving. The rest of the week, though, Peaches just seemed "off" - she was hyporexic, she didn't want to get out of her kennel, and she seemed "dazed". The owner noticed a scab lesion on her left shoulder. 4/21 - Seen by rDVM for the signs noted above. They repaired her shoulder laceration under injectable sedation and diagnosed her with a corneal ulcer OS. The owner recalls that her IOP's were 15 OS and 9 OD. When the owner picked her up, she felt like Peaches was very lethargic. 4/22 - Rechecked by rDVM since she was still so sedate. Owner believes bloodwork was normal. She was given SQF and maropitant SQ. 4/23 - Seen here for lethargy, weakness, hyporexia, and shaking; owner reports that she is dropping kibble when eating and hard swallowing; she is also bumping into things. - PE - P 96, mild corneal edema OS, 1 inch laceration over left caudal scapula - Fluorescein stain uptake OS - 2 pinpoint aeas with 1 laceration - POCUS - NSF - TXR- Unremarkable thorax - Rx gabapentin 100 mg PO TID - Rx tramadol 25 mg PO TID - Rx ondansetron 4 mg PO BID - Rx omeprazole 10 mg PO BID - Rx Clavamox 93.75 mg PO BID Peaches has not improved which prompted her visit here. Relevant Exam/labs/imaging results/treatments: Blind OU, anisocoia (left miotic, right mydriasis), no dazzle, non ambulatory tetraparetic, depressed/abnormal mentation

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is well distended with anechoic contents. The wall is smooth and regular. No abnormalities are present with the trigone or proximal urethra. A very small amount of free floating sediment is present, however, there is no evidence of cystoliths, polyps or a mass.

Kidneys

The **left** kidney measures at least 4.33 cm. The capsule is smooth. The definition of the cortico-medullary junction is accentuated due to increased circumferential echogenicity (hyperechogenicity) of the medulla. Very small mineralizations of the diverticulae and pelvis are present, without evidence of nephroliths or pyelectasia. The surrounding mesentery is mildly to moderately hyperechoic.

The **right** kidney measures 4.40 cm. The capsule is smooth. The definition of the cortico-medullary junction is accentuated due to increased circumferential echogenicity (hyperechogenicity) of the medulla. Very small mineralizations of the diverticulae and pelvis are present, without evidence of nephroliths or pyelectasia. The surrounding mesentery is very mildly hyperechoic.

Aortic bifurcation/trifurcation

No abnormalities observed.

Adrenal Glands

The **left** adrenal gland measures 0.63 cm at the cranial pole, 0.75 cm at the caudal pole and 1.71 cm in length. The gland is mildly to moderately enlarged, however, no abnormalities are noted with its overall architecture, echogenicity or echotexture. The phrenico-abdominal vein and surrounding vasculature are unremarkable. The peri-adrenal mesentery is mildly to moderately hyperechoic.

The **right** adrenal gland measures 0.65 cm at the cranial pole, 0.66 cm at the caudal pole and 1.60 cm in length, and measures 0.66 cm in diameter towards the center of the gland. It is enlarged and has a mild granular or coarse architecture, which may be due to nodular hyperplasia. There are no obvious signs of a mass. The phrenico-abdominal vein and surrounding vasculature are unremarkable. The peri-adrenal mesentery is very mildly hyperechoic.

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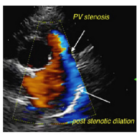
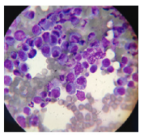
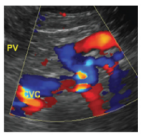

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Spleen

Mild to moderate splenomegaly, however, no abnormalities are observed with its overall architecture, echotexture, or echogenicity, and the capsule is smooth. No abnormalities are observed with its vasculature, i.e. congestion and thrombi are not identified. The surrounding mesentery is mildly hyperechoic.

Liver

Mild hepatomegaly is suspected. The liver's borders are smooth, but mildly rounded. Its echotexture is homogeneous, however, it is mildly hyperechoic, i.e. it is isoechoic to the spleen. No focal lesions are noted and no abnormalities are observed with the hepatic vessels visualized. The mesentery surrounding the liver and stomach is moderately hyperechoic.

The gallbladder is moderately dilated. The wall is within normal limits in thickness and echogenicity. A trivial amount of echogenic material is noted within the GB. The portions of the cystic and/or common bile ducts observed are not dilated or tortuous, i.e. there are no signs of an obstruction.

Gastrointestinal

A moderate amount of fluid is present within the lumen. The gastric wall is within normal limits in thickness and the wall layers are well defined. Peristalsis is considered decreased with the presence of a mild ileus.

The small intestinal wall thickness, including the duodenum, is within normal limits and the definition of the wall layers is preserved. Abnormally dilated loops of bowel are not observed.

The colonic wall is not thickened and mural detail is considered normal.

There are no obvious signs of a mass, foreign body, infiltrative disease or an obstruction in the gastrointestinal tract.

Pancreas

No overt abnormalities are observed with the parenchymal echogenicity or echotexture. There is no evidence of hyperechogenicity of the surrounding mesentery, i.e., signs of active pancreatitis are not present.

Other

Lymph nodes

No abnormalities are observed

Abdominal effusion is not visualized.

ULTRASONOGRAPHIC FINDINGS

- The hepatomegaly and diffuse hyperechogenicity are suggestive of a vacuolar hepatopathy, which may occur due to stress, as well as hyperadrenocorticism. Differential diagnoses, such as cholestasis, immune mediated hepatitis, hepatitis due to infectious causes, toxin exposure, medications, natural supplements, etc., as well as cholangitis/cholangiohepatitis, (+/- a secondary bacterial infection) cannot be excluded given the acute onset of clinical signs and the history of skin laceration on Peaches' shoulder.

- Differential diagnoses for splenomegaly include, antigenic stimulation and secondary inflammation (splenitis), for example, extramedullary hematopoiesis, hypersplenism and

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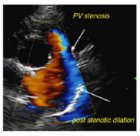

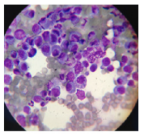
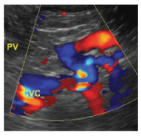

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reactive hyperplasia, as well as immune-mediated induced inflammation. Neoplasia, such as lymphoma, mast cell tumour, or other round cell tumour, is considered less likely.

- The renal changes may be due to acute renal injury or inflammation, such as glomerulonephritis. However, pyelonephritis cannot be excluded.

- Bilateral adrenomegaly, which may be due to adrenal hyperplasia secondary to stress (chronic illness), however, pituitary dependent hyperadrenocorticism (HAC), cannot be excluded with certainty. That is, Peaches' neurological signs and blindness may be due to a macroadenoma compressing the optic chiasm. She is also demonstrating Horner's syndrome, and a lesion of the caudal brainstem, which are not suggestive of HAC. The bilateral adrenomegaly may be an incidental finding, however, a pituitary mass may have already been present and she is experiencing inflammation of the central nervous system from a different cause. That is, one cannot ignore the corneal ulcer(s) and skin laceration on her shoulder and a possible infectious cause of her neurological signs, such as Coonhound paralysis or a vector borne disease. Leptospirosis should not be excluded, nor should tick paralysis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

As mentioned above, glomerulonephritis (GN) cannot be excluded. Causes of GN include leptospirosis, tick borne diseases and heartworm disease, and the appropriate tests are suggested to exclude an underlying cause.

A urinalysis and urine culture and sensitivity are suggested to exclude possible pyelonephritis. If negative, a urine protein: creatinine ratio is suggested to exclude glomerulonephritis or interstitial nephritis.

A fundic exam is also recommended, if not already performed, as is an evaluation of the blood pressure, ideally in the presence of the client to minimize the effects of stress.

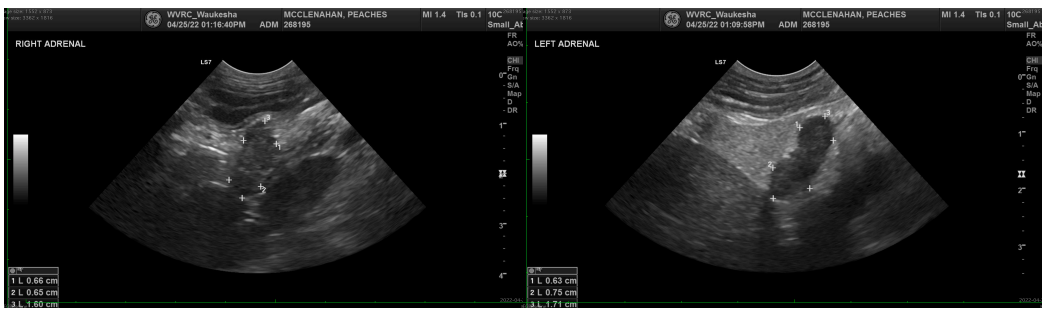
Repeating blood work would be ideal to see if parameters have changed since originally performed.

PCR testing for infectious agents is suggested.

Referral to a neurologist is suggested, however if this is not possible, treatment with ampicillin intravenously at 22 mg/kg every 6-8 hours is suggested. Clindamycin may be administered for possible toxoplasmosis or neosporosis if there is no improvement within 24 hours of initiating ampicillin.

Monitoring of neurological signs every 30 -60 minutes is strongly recommended. If a decline is observed, dexamethasone at 0.03-0.05 mg/kg IV should be administered, to decrease inflammation and swelling.

A fine needle aspirate of the spleen, +/- liver, may be considered, however, it is unlikely to be rewarding. If no other tests are yielding answers and referral is not an option then it may be performed.



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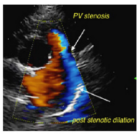

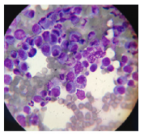

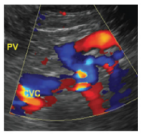

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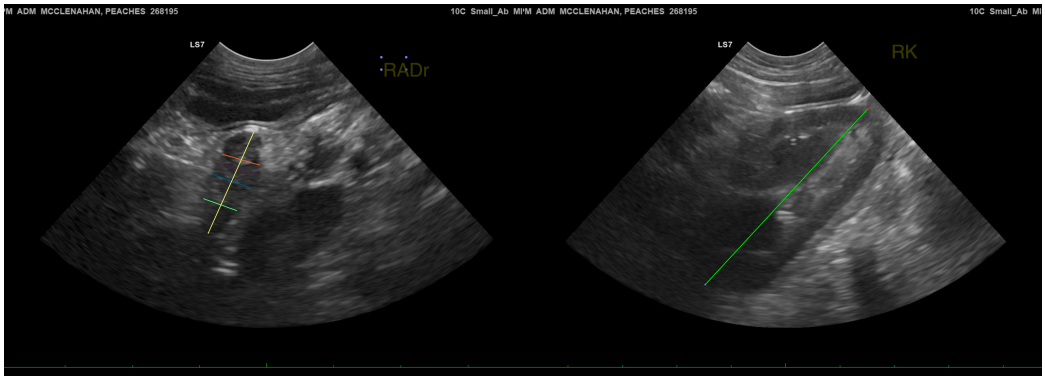

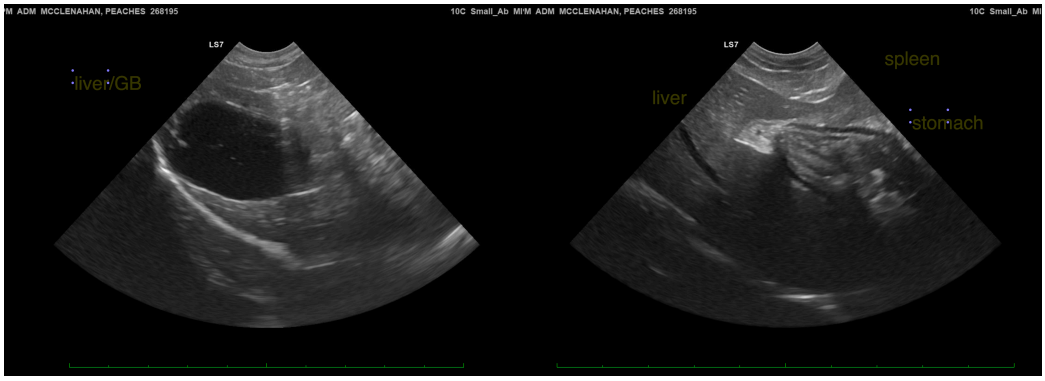

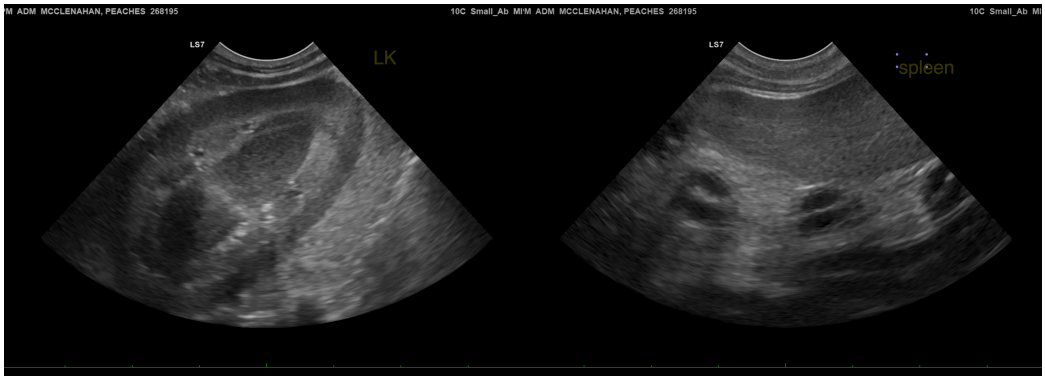

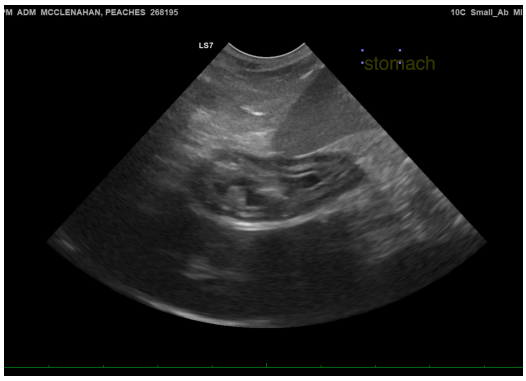

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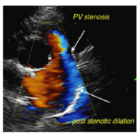

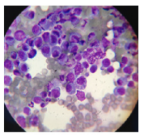
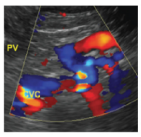

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Lisa Carioto, DVM, DVSc, Diplomate ACVIM

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