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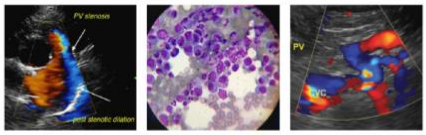

SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

PATIENT

Bodi Mooney 242743

SPECIES

Canine

BREED

Shar Pei

SEX

Neutered Male

AGE

8 Years 3 Months

WEIGHT

23.4 kg

INTERPRETED BY

Lisa Carioto, DVM, DVSc, Diplomate ACVIM

IMAGING PERFORMED BY

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VET

WVRC – Dr. Mazulis

INVOICE

37474

DATE

5/6/22

PRESENTING CLINICAL SIGNS

Previous diagnoses / reason for recheck: -Langerhans cell histiocytosis -Allergic Dermatitis -Dermal and SQ nodules - new - open Other concurrent non-dermatologic conditions: - splenic nodule - entropion - dry cough since surgery in Jan - resolved - hyporexia - PUPD - anemia, thrombocytopenia, neutrophilia, lymphopenia - decreased T4 and free T4 Pruritus score (per owner; 0-10): 7/10 Symptoms present in other pets/humans within the household: no Current diet: various human food Current medications: - prednisone 20mg PO SID - doxycycline 150mg PO BID - niacinamide 500mg PO BID - DISCONTINUED on 5/4/22 - generic modified cyclosporine 150mg PO SID - DISCONTINUED on 5/4/22 - Ultraoil supplement on food
Abnormal PE/Chem/CBC/UA Results: CBC: - Moderate leukocytosis = 17.9 K/uL (4.4-14.6) - moderate neutrophilia = 14645 /uL (2394-7514) - mild lymphopenia = 536 /uL (675-5305) - mild monocytosis = 2679 /uL (88-1024) - mild microcytic, normochromic anemia - RBC = 3.9 M/ul (5.2-8.1) - HCT = 23% (39-58) - MCV = 58 fL (61-75) - mild thrombocytopenia = 119 K/uL (165-430) Reticulocyte Count (complimentary): - RBC = 3.9 M/ul (5.2-8.1) - Reticulocyte = 29082 /uL (0-100000) Chemistry Panel: - elevated AST = 72 U/L (11-46) - mildly elevated ALP = 759 U/L (8-196) - mildly elevated GGT = 10 U/L (<9) - mild hyperglobulinemia = 3.9 g/dl (2.2-3.7) PT = 7.1 seconds (7-12) PTT = 13.1 seconds (8.5-15.5)

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 noted with the trigone or proximal urethra, and there is no evidence of sediment, cystoliths, polyps or a mass.

Prostate

The prostate is homogenous and measures 1.40 cm, which is within normal limits for a neutered male.

Kidneys

The **left** kidney measures 6.21 cm. The capsule is smooth. The cortex is mildly hyperechoic and a mild loss of the normal definition of the cortico-medullary junction is present. Very small, punctate mineralizations of the diverticulae and pelvis are present, without evidence of nephroliths or pyelectasia. The surrounding mesentery is not hyperechoic.

The **right** kidney measures 6.79 cm. Findings are similar to the left kidney.

Aortic bifurcation/trifurcation

No abnormalities observed.

Adrenal Glands

The **left** adrenal gland measures 0.54 cm at the cranial pole, and 0.57 cm at the caudal pole. No abnormalities are noted with the gland's overall architecture, echogenicity or echotexture. The phrenico-abdominal vein and surrounding vasculature and mesentery are unremarkable.

The **right** adrenal gland measures 0.69 cm at the cranial pole, and 0.46 cm at the caudal pole. The cranial pole is mildly "plump", however, a mass or discrete nodule is not observed. No abnormalities are noted with the gland's overall architecture, echogenicity or echotexture. The phrenico-abdominal vein and surrounding vasculature and mesentery are unremarkable.

Spleen

Splenomegaly. Presence of multiple masses

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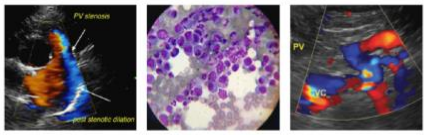

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1. solid, homogeneous, 3.56 cm x 2.96 cm
2. moderately heterogenous, with both echogenic (variable degrees of hyperechogenicity in ill-defined “patches” and areas of hypoechogenicity). Anechoic, cavitary lesions are not observed, however, hypoechoic nodules are present, 5.60 cm x 7.39 cm, very mildly vascularized
3. solid, very mildly heterogeneous, 4.17 cm x 4.53 cm
4. solid, homogeneous 1.55 cm x 1.78 cm; it does not disrupt the integrity of the capsule

The capsule is irregular and disrupted by the presence of the masses. Moderate perivascular cuffing consistent with myelolipomas is observed, which is not considered clinically significant. No abnormalities are observed with its vasculature, i.e. congestion and thrombi are not identified.

Liver

High index of suspicion of hepatomegaly, however, size is better characterized at the time of the ultrasound or with radiographs. Liver borders are smooth and sharp to very mildly rounded. A diffuse, mildly coarse or granular echotexture is observed. The liver is also mildly, but diffusely hyperechoic. It remains hypoechoic to the spleen, however. Multiple, punctate, hyperechoic foci are dispersed haphazardly throughout the parenchyma, which are most likely due to mineralizations. The walls of the portal veins are hyperechoic, which may occur secondary to inflammation, fat, mineralization and fibrosis. Perivascular cuffing is present, which may be due to fat, as well as some mild mineralization. There is no evidence of hepatic congestion.

The gallbladder wall is within normal limits in thickness and echogenicity. A small amount of echogenic material is present 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

The gastric wall is within normal limits in thickness and the wall layers are well defined. No obvious abnormalities are observed with its peristalsis. An in-depth evaluation of the stomach is difficult to perform due to the gas present, however, no obvious abnormalities are noted.

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. No abnormalities are observed with the ileo-cecal-colic junction.

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 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

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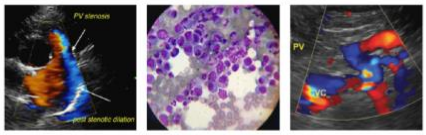

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- Multiple splenic masses, which were noted at the time of Bodi's previous abdominal ultrasounds. As per the sonographer, today's evaluation of the spleen and rest of the abdomen does not reveal significant changes from the prior study, other than the largest splenic mass appears larger than previously measured. Differential diagnoses for the more heterogeneous masses include organized hematomas, extramedullary hematopoiesis, nodular and lymphoid hyperplasia, and histiocytic sarcoma. The latter is much less likely given the chronicity with which Bodi has had the masses. The more solid masses may be attributed to nodular and lymphoid hyperplasia, and extramedullary hematopoiesis. It is also possible that Bodi's masses are combination of all three processes.

- The mild, but diffuse hyperechogenicity of the liver, and mildly coarse or granular echotexture may be due to vacuolar and reactive hepatopathies, respectively. The vacuolar hepatopathy may be due to the chronic administration of prednisone, and possibly cholestasis, as well as stress and chronic disease. Other differential diagnoses for a diffusely hyperechoic liver include, hepatitis and cholangitis/cholangiohepatitis. These are considered much less likely.

- Very mild renal changes are present, which are suggestive of age related degeneration. A component of the increased echogenicity of the cortex may be due to an underlying glomerulonephritis, or interstitial nephritis. There are no obvious signs of pyelonephritis, however, it cannot be excluded despite the absence of sonographic signs, particularly in a patient receiving steroids chronically.

- One cannot exclude low grade, chronic, intermittent gastrointestinal hemorrhage as the cause of the microcytic, normochromic, non-regenerative anemia and the mild thrombocytopenia. Although no obvious lesions are noted with the stomach, one cannot exclude gastric erosions, which may occur with the chronic administration of steroids. An in-depth evaluation of the stomach was difficult to perform due to interference of the ribs and gas.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Ideally, a splenectomy would be performed as both a diagnostic and therapeutic procedure. Although the masses may be benign, one or more masses may rupture and cause hemorrhaging.

If possible, a decrease in the dose of prednisone is suggested to help decrease the risk of GI bleeding. An increase in the dose of cyclosporine may be required if the dose of prednisone is decreased.

Gastroprotectants are suggested to help improve blood flow to the stomach mucosa and recovery of any erosions that may be present. They will likely be required in conjunction with the use of prednisone.

A re-evaluation of a PCV and TS is suggested in 7-10 days to ensure the gastroprotectants are effective. However, a full CBC is ideal, if possible to assess the RBC morphology, platelet count and other red blood cell parameters.

A blood pressure, urinalysis, +/- urine culture, are suggested to monitor renal function and for changes that may be suggestive of subclinical bacteriuria. If negative, a urine protein: creatinine ratio may be considered to exclude glomerulonephritis, however, a false positive is possible, or a component of a positive UPC ratio, due to systemic inflammation caused by Bodi's dermatologic problems.

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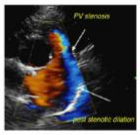
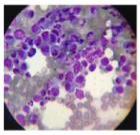
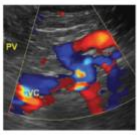

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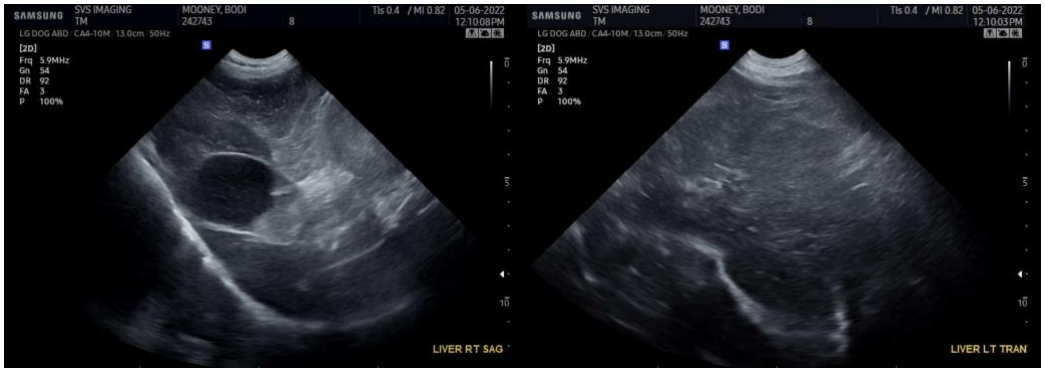

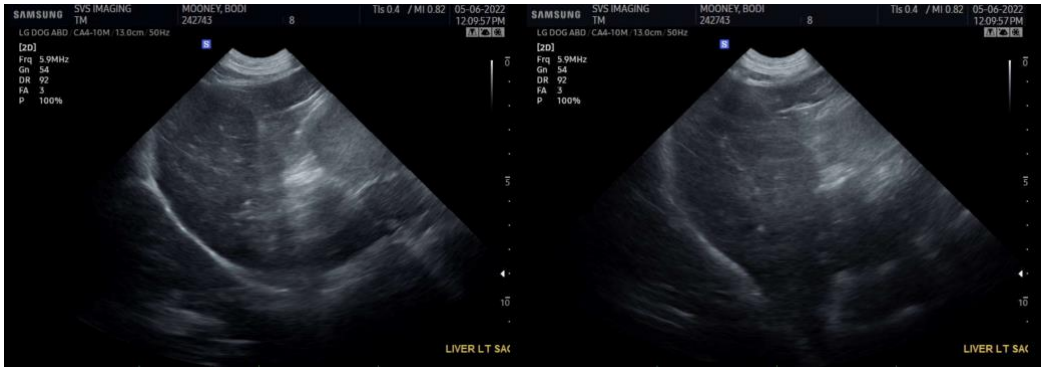

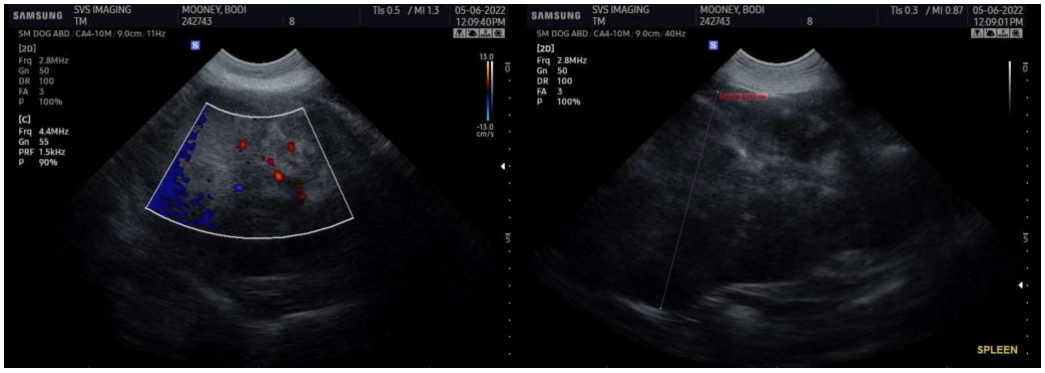

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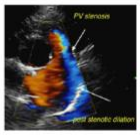
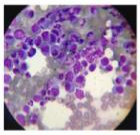
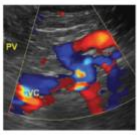

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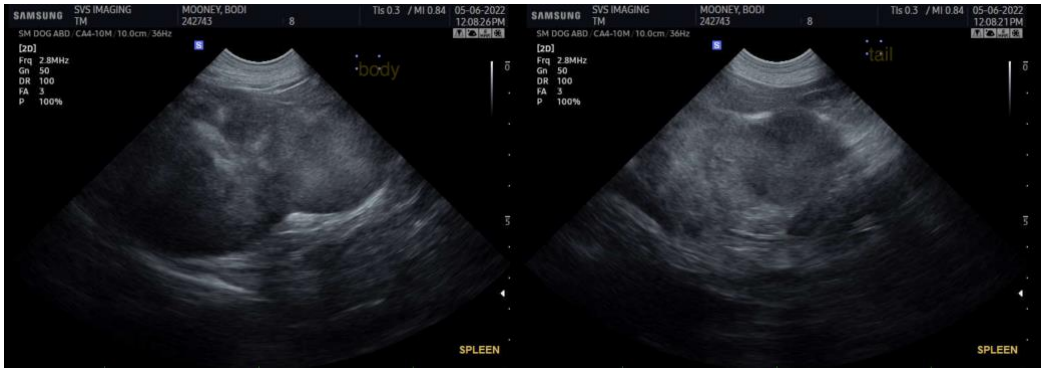

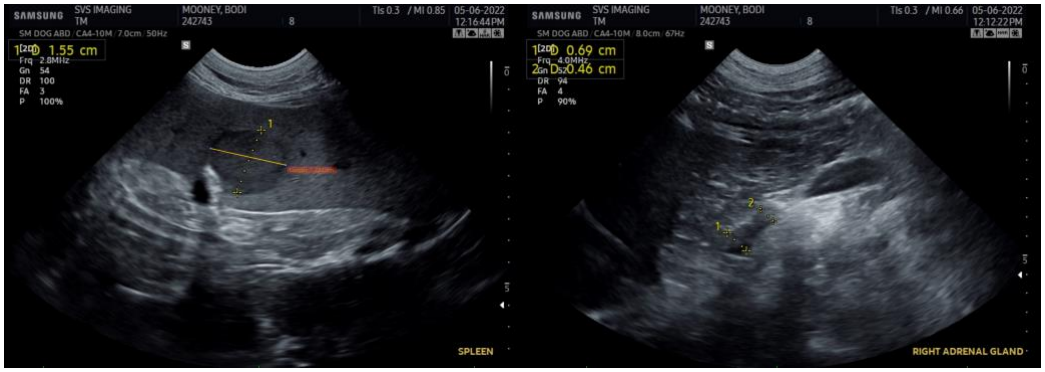

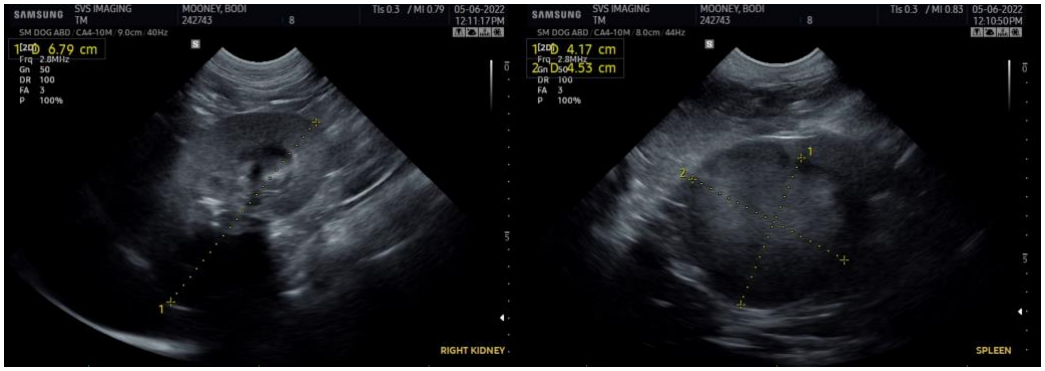

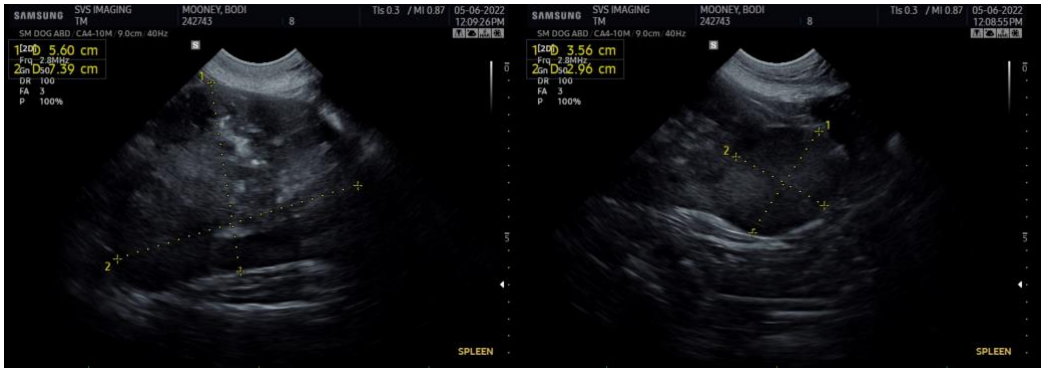

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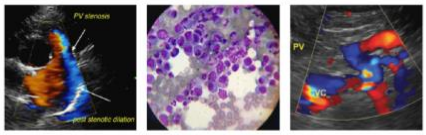

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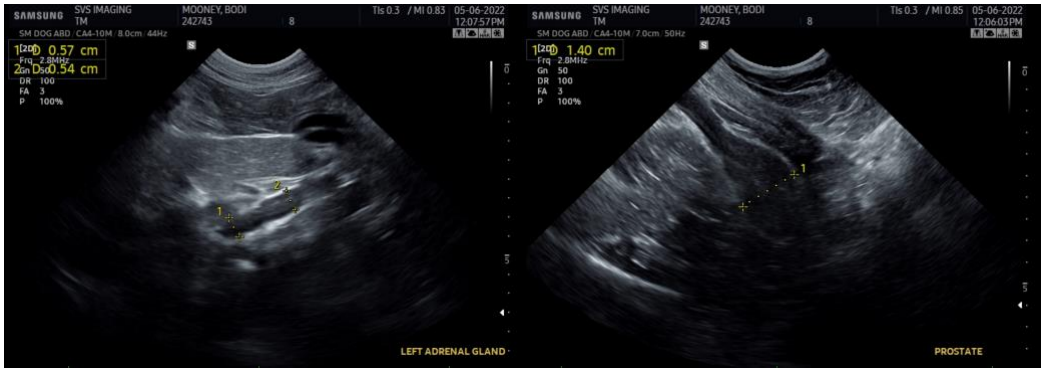

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Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

Eric Lindquist, DMV, DABVP, Cert. IVUSS, CEO of SonoPath.com

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