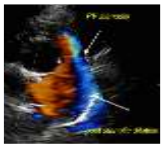
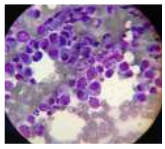
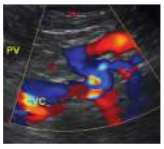
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Dutchess Faust

SPECIES

Canine

BREED

Rottweiler Mix

SEX

SF

AGE

13 years

WEIGHT

95.9 lbs.

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY

Dr. Rivera

HOSPITAL NAME

DPC VH

REFERRING VET

Dr. Rivera

INVOICE

13133

DATE

1/20/22

PRESENTING CLINICAL SIGNS

Reason for Visit: coughing few months - more frequently. Not on HWP. Gets short of breath easier. Arthritis - today was a LONG MORNING before pet got moving (adequan inj restart ? O can not remember if it helped) Growth on back that is actively bleeding (looking to see if anything to do about this) Nail trim 3 weeks ago took to Lead ER for suspect snake bite on muzzle, resolved with benadryl and gabapentin.
Abnormal PE/Chem/CBC/UA Results: Hydration: N Mentation: N EENT: N Oral Cavity: worn teeth, Lymph Nodes: N Skin: 2cm soft moveable sq mass ventral neck at manibrium 3cm moderately firm calloused dermal mass right lat hock with 0.5cm central ulcer 1cm cyst like mass lower lumbar area CV/Respiratory: No murmur, panting non-stop Abd/GI: when palpated abdomen Duchess looked like she was going to vomit, tongue turned purple and she hacked like she was clearing her throat. Hard to palpate abdomen given level of obesity Uro/Perineum: N Musculoskeletal: bcs 9/9 Neurological: N CBC: HCT 28, 3 nRBC'S - REGNERATIVE ANEMIA (SUSPECT DUE TO HEMORRHAGE GIVEN LOW ALBUMIN) CHEM ALBUMIN 1.8 GLOBS 10.3 - R/O NEOPLASIA, INFECTIOUS T4 LOW - R/O EUTHYROID SICK SYNDROME VS TRUE HYPOTHYROIDISM UA: USG 1.031, 3+ PROTEIN - R/O NEOPLASIA, CHRONIC INFECTIOUS/INFLAMMATORY, HYPERTENSION, IDIOPATHIC

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 4.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

The area of the aortic trifurcation was free of pathology.

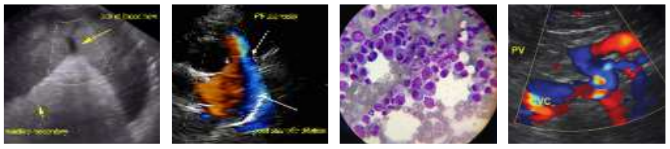
Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 8.5 cm in length. The right kidney measured 8.0 cm in length.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.57 cm width at the caudal pole and 0.64 cm width at the cranial pole. The right adrenal gland was indistinctly visualized, subjectively measuring 0.75 cm width at the caudal pole and 0.67 cm width at the cranial pole.

Spleen

The spleen exhibited primarily finely textured parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Mild generalized parenchyma heterogeneity was present without evidence of nodular changes. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. The



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parenchymal heterogeneity is likely consistent with benign changes such as extramedullary hematopoiesis or age-related remodeling with minor potential for inflammatory or neoplastic disease.

Liver/ Gallbladder

The liver exhibited subjective mild to moderate enlargement. Generalized increased parenchyma echogenicity with mild to moderate coarse echotexture and intermittent variably echogenic parenchymal nodules were present. An example of a discreet, hypoechoic nodule noted in the ventral liver parenchymal measured 2.0 cm in diameter. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction, or foreign material. The gastric body wall width measured 0.58 cm.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction, or foreign material. The duodenum wall width measured 0.52 cm. The jejunum wall width measured 0.35 cm.

Normal visible colon wall layers were present with apparent formed feces in lumen.

Pancreas

The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

Free Abdomen

No omental masses, lymphadenopathy or peritoneal effusion were present.

ULTRASONOGRAPHIC FINDINGS

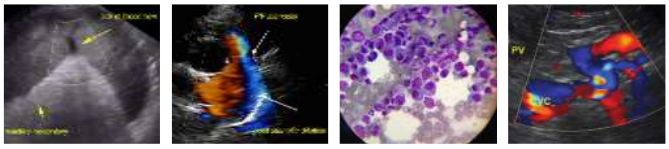
Primary Findings

- Nonspecific mild chronic renal changes
- Hepatomegaly exhibiting mildly nonuniform increased parenchymal echogenicity and intermittent, variably echogenic parenchymal nodules
- Overtly normal gastrointestinal tract
- Sonographically unremarkable spleen for age - no overt evidence of neoplasia
- Mild heterogeneous pancreas

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

UPC is recommended on a sterile urine sample, given the 3+ proteinuria.

Given the lack of reported enzyme elevations, the liver was nonspecific with considerations including vacuolar hepatopathy, chronic hepatitis / cholangiohepatitis, lipidosis, fibrosis, with areas of nodular to



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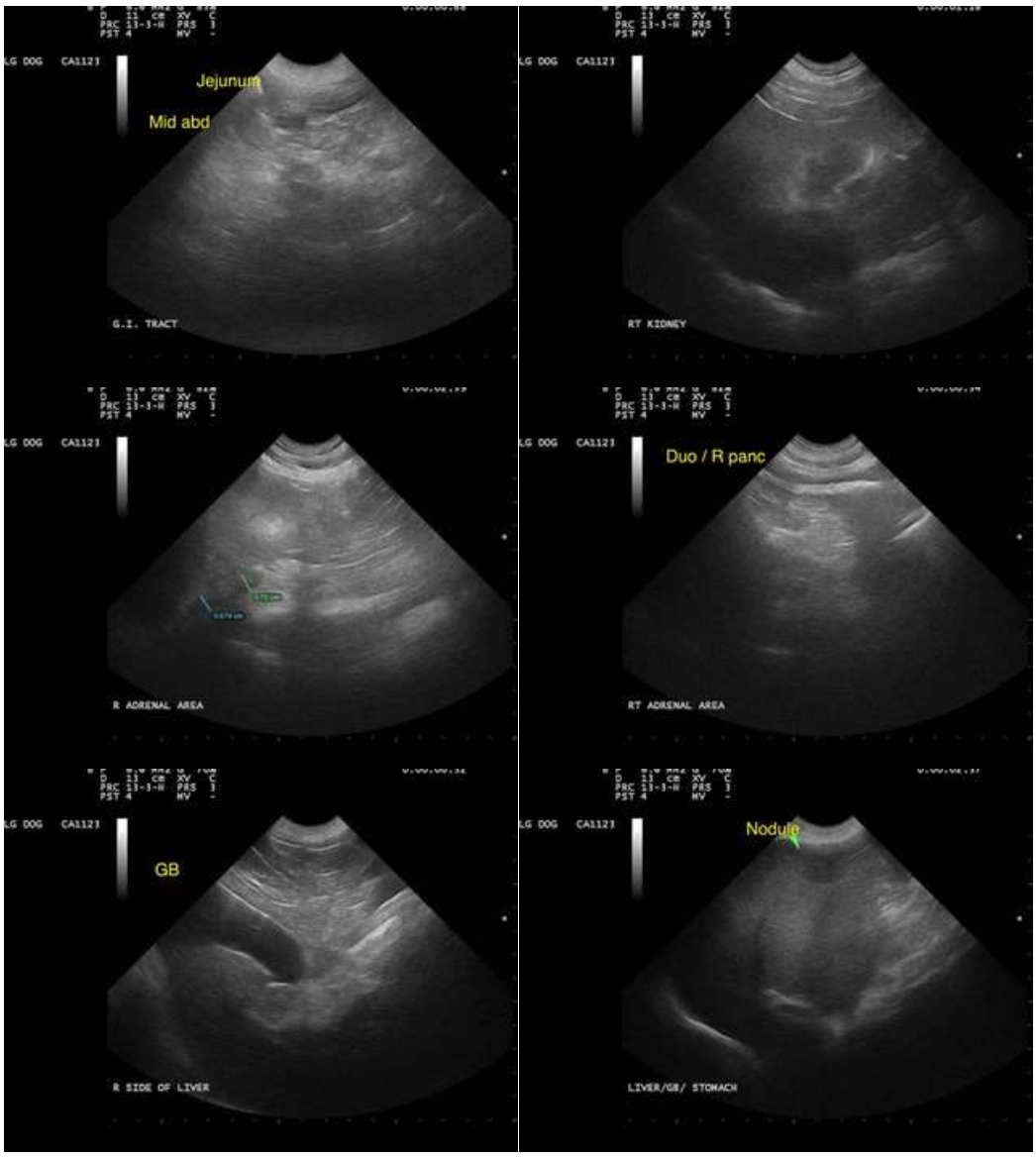
regenerative hyperplasia, hematopoiesis, or benign lipogranulomas. The potential of hepatic parenchymal or nodular neoplasia cannot be excluded.

Assuming normal clotting status, hepatic parenchymal and nodule FNA, if accessible, warranted for screening cytology. Three view chest radiographs to assess pulmonary parenchymal and cardiopulmonary status are recommended if not done. Protein electrophoresis, pending additional diagnostics, could be considered for further clarification of the hyperglobulinemia.



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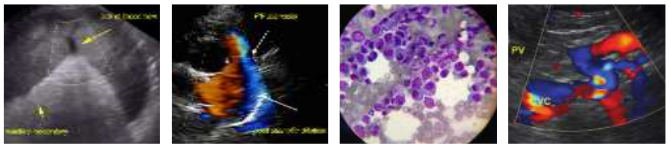

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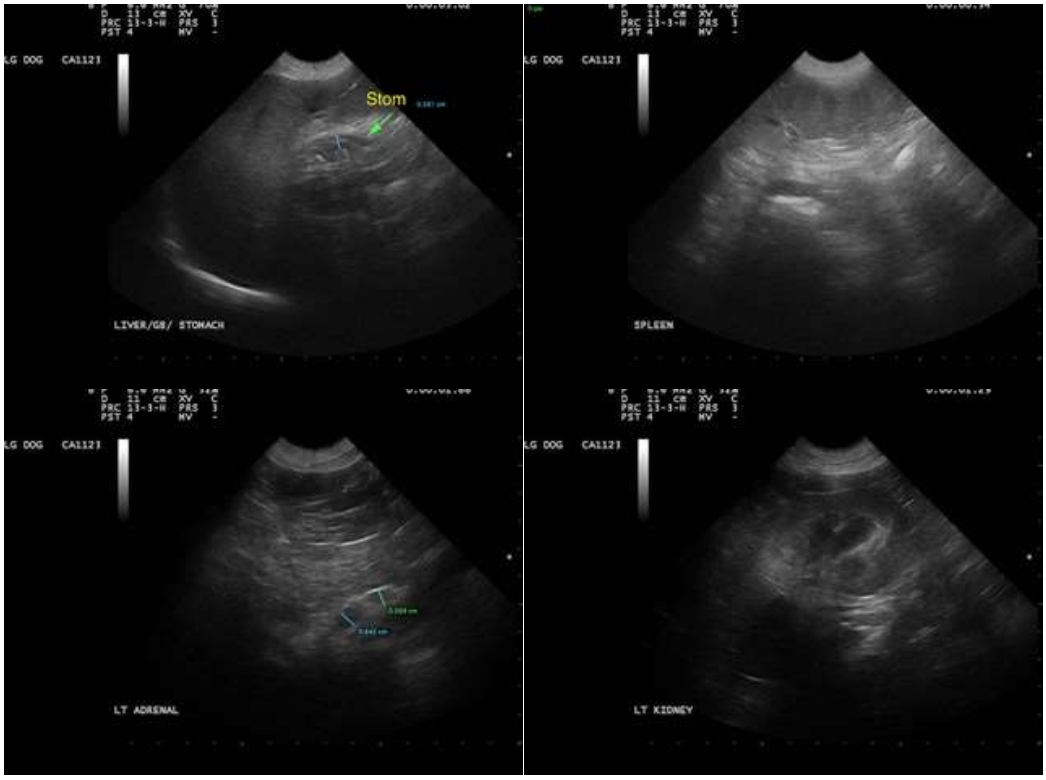

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)
info@SonoPath.com