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Clinical Sonography & Telecytology
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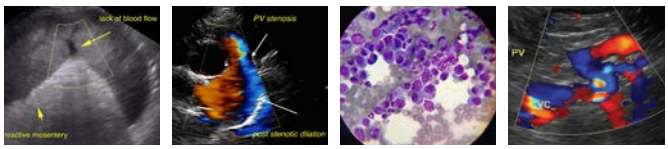

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1-800-838-4268 info@sonopath.com

PATIENT
Kevin McGillivray

SPECIES
Canine

BREED
American Bulldog X

SEX
Neutered Male

AGE
3 Years

WEIGHT
30.7 kg

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

IMAGING PERFORMED BY
JSS

HOSPITAL NAME
King Hopkins PH

REFERRING VET
Dr. Latoya Brown

INVOICE
42577

DATE
11/6/22

PRESENTING CLINICAL SIGNS

Kevin is a 3 yr old neutered American Bulldog mix dog that presented as a drop off for 48 hour hospitalization - Owner is concerned that they can't give meds and he is not pooping or eating. He initially presented at rDVM on Nov. 1 with the complaint of lethargy, with abdominal pain, lack of appetite, nausea & vomiting yellow/food/water. He also has been having explosive and frequent bowel movements, tarry feces, large volumes of watery stool with mucus. Called rDVM to get records, got verbal P is up to date with rabies and Dapp vaccine overdue for Lepto & Lyme since 2020, also had comprehensive T4 blood work. Currently on Aventi GI, Famotidine, Metronidazole, Amoxi-Clav, Aventi Liver, GI low fat

Abnormal PE/Chem/CBC/UA Results: Mucous membranes: slightly icteric, slightly tacky CBC: neutrophilia, lymphocytosis, thrombocytopenia CHEM: markedly elevated ALP, ALT, TBil cPL: Normal Rad findings: hepatomegaly on lateral view (only 1 view taken)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen. No sediment or calculi. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

No evidence of pathology in the area of the residual prostate.

The area of the aortic trifurcation was free of pathology.

The kidneys were normal in size and margination with adequate corticomedullary border demarcation and maintained 1:3 cortex/medulla ratio. A solitary, thinly walled cyst was noted in the medial right kidney, containing anechoic fluid, measuring 3.3 cm in diameter. The left kidney measured 7.0 cm. The right kidney measured 7.3 cm.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.52 cm at the cranial pole and 0.48 cm at the caudal pole. The right adrenal gland was not definitively visualized.

Spleen

The spleen exhibited potential for mild enlargement. Generalized mild parenchymal heterogeneity noted. A soft tissue echo was potentially in the splenic vein, which may suggest possible emerging non-obstructive splenic vein thrombus.

Liver

The liver was moderately enlarged. The hepatic parenchyma revealed diffuse reduced echogenicity compared to the spleen and renal cortical parenchyma with a mild coarse echotexture. Increased portal vein prominence was evident. The capsule of the liver was normal in margination. Distinct masses or nodules were not evident. Increased yet mildly indistinct portal vascular borders noted. Subtle evidence of mild asymmetrical caudal hepatic capsule contour. The gallbladder was non-distended in size with primarily anechoic luminal content. The gallbladder wall is mildly prominent to hyperechoic in appearance. No evidence of peripheral inflammation. The cystic and common bile ducts were normal.

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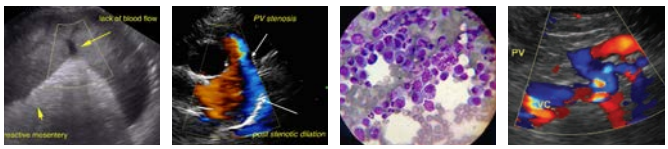

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Gastrointestinal

The stomach presented intact yet mildly prominent wall layering. Empty lumen without evidence of retained ingesta, fluid, or foreign material.

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.

Normal visible colon wall layers were present with apparent formed feces in the descending colon. Semiformed to soft fecal matter noted in the ascending to transverse colon.

Pancreas

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

Free Abdomen

Intermittent, mildly prominent isoechoic mesenteric lymph nodes present. The lymph node was essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5).

Generalized mild increased omental echogenicity. Mild, primarily cranial abdominal peritoneal free fluid noted.

PRIMARY FINDINGS

- Acute hepatopathy – non-specific, suspect acute hepatitis/cholangiohepatitis (viral, bacterial, Leptospirosis, toxin), metabolic, reactive, or vacuolar hepatopathy, non-obstructive cholestasis, non-cardiogenic hepatic congestion, occult neoplasia all potentials.
- Mild gallbladder debris and suspect mild cholecystitis (non-mucocele)
- Mild gastroenterocolitis pattern

SECONDARY FINDINGS

- Right kidney cyst
- Mild cranial abdominal peritoneal free fluid
- Heterogeneous spleen with possible emerging non-obstructive splenic vein thrombus – subjectively benign.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Further assessment of the liver may include (assuming normal clotting status) hepatic FNA cytology as well as Leptospirosis titers/PCR. Clotting profile advised to assess for possible emerging hypercoagulable state. Empirically, and pending hepatic cytology, aggressive therapy for hepatitis/cholangiohepatitis would be reasonable, which may include hepatosupportive medications, IBD fluid support, appropriate antibiotic protocol, as needed gastrointestinal support, and assessment of clinical and hepatic response. Sonographic monitoring of both the liver and possible emerging splenic vein thrombus would be ideal.

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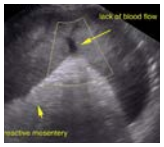
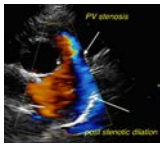
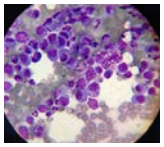
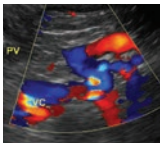

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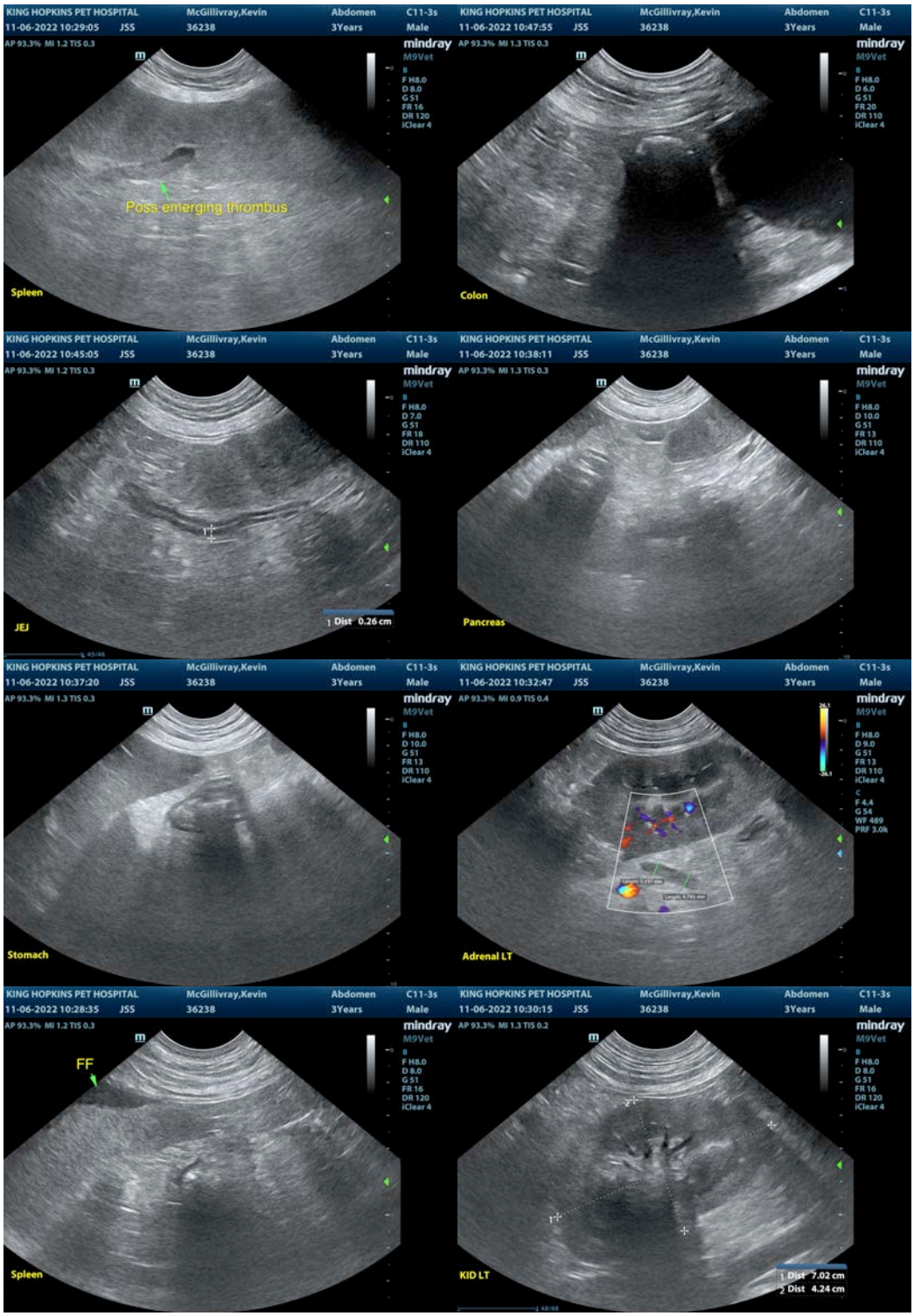

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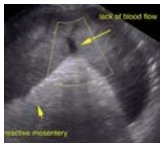
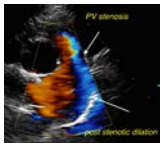
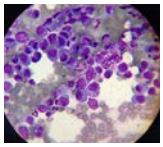
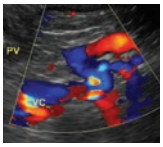

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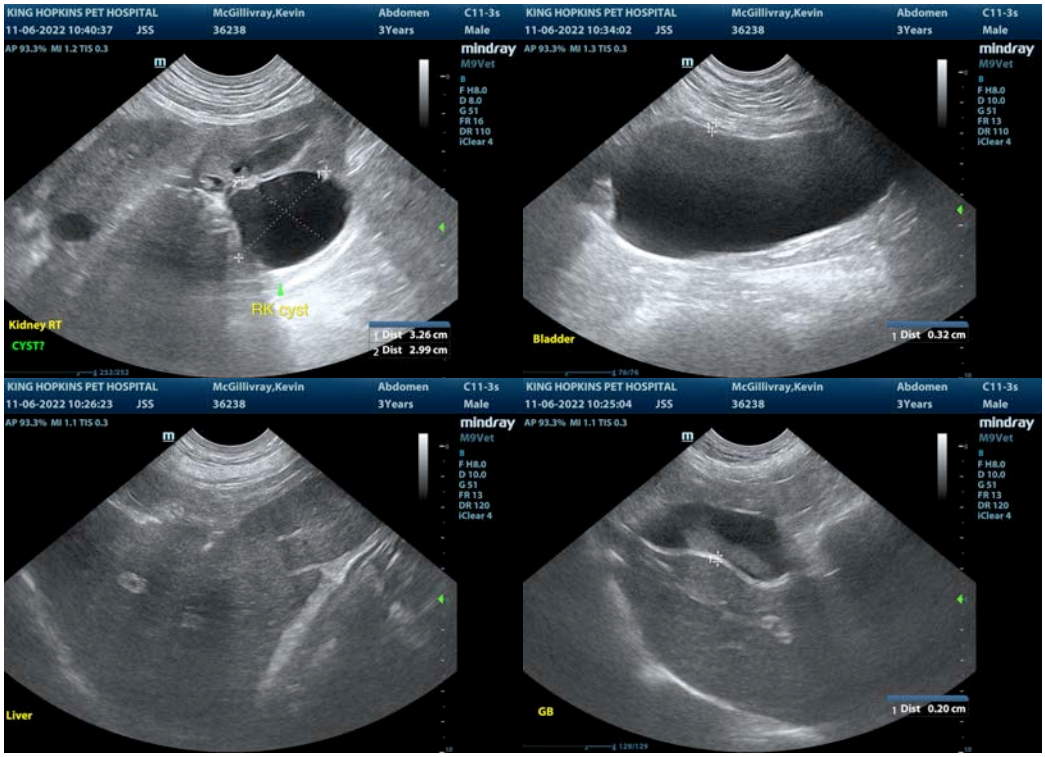

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

info@SonoPath.com