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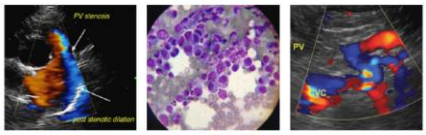

SonoPath
Clinical Sonography & Telecytology
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PATIENT

Landry Peetoom
55520A

SPECIES

Canine

BREED

Pitbull

SEX

FS

AGE

10yr

WEIGHT

26.7kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VET

Madison Veterinary Specialists Dr. Alucard

INVOICE

12542ag

DATE

12/26/2022

PRESENTING CLINICAL SIGNS

Landry presented to the MVS Emergency Service on Dec 25, 2022, at 11:00am, for evaluation of lethargy, abdominal swelling, and inappetance. Landry was seen at her primary care on Thursday, December 22, 2022, for possible ingestion of a chicken bone as she has a history of eating garbage. The pcDVM ruled this out with an x-ray. Harold has noticed swelling around her belly since Thursday as well. She normally has ~2 bowel movements daily but has not had a bowel movement since Friday. She urinated this morning for the first time since Friday and it was orange in color according to Harold. She has been lethargic, shaking, and restless since yesterday. Landry has also been having urinary accidents in the home this morning which is unlike her. She has not eaten since Thursday evening but she has been drinking occasionally. Current medications: Metronidazole 500mg, 1 tab q12hrs Ursodial 250mg, 1 tab q24hrs Cerenia 60mg, 1 tab q24hrs hepatic support supplement Landry was admitted for hospitalization and IV fluid therapy. Administered some barium for concern for GI bleed. Abdomen has continued to distend over the past 24 hours.

Abnormal PE/Chem/CBC/UA Results: 12/25: Glu 156, Alb 2.2, BUN 38, Phos 7, ALT 402, ALP 275, GGT 14, T. Bili 3.6, CL 104, HCT 30, Retic 183.3k, WBC 23.44k, Neu19.38k, Mono 1.83 k AFAST - moderate, diffuse effusion x4 quadrants Abdominocentesis yielded clear yellow-tinged fluid- TP 0.2, rare cells 12/26: Glu 121, SDMA 23, BUN 49, Alb 2.1, ALT 347, ALP 235, GGT 16, T. Bili 4.5, CL 108, PCV 32%

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder was mildly distended in size with subjective normal tone. The trigone, cystourethral junction, and visible pelvic urethra to a depth of 3 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 were noted.

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 6.7 cm in length. The right kidney measured 7.3 cm in length

The area of the aortic trifurcation was free of pathology.

The area of the iliac trifurcation was free of pathology including no evidence of medial, iliac or sublumbar lymphadenopathy.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.50 cm width at the caudal pole and 0.44 cm width at the cranial pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.61 cm width at the caudal pole and 0.51 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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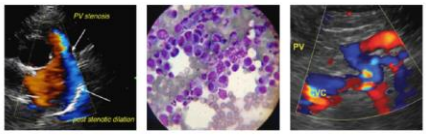

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parenchymal heterogeneity is likely consistent with benign changes such as extramedullary hematopoiesis or age related remodeling with minor potential for inflammatory or neoplastic disease.

Liver/Gallbladder

The liver was subnormal in size with secondary indistinct visualization. Irregular to nodular parenchyma exhibiting moderate coarse architecture with evidence of parenchymal remodeling and regional to generalized asymmetrical capsule contour was present. The hepatic and portal vasculature were normal in appearance without signs of congestion. No overt evidence of hepatic masses was noted. The gallbladder/common bile duct were not definitively visualized.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with mild luminal gas and no signs of ileus, obstruction or foreign material.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. Mildly prominent duodenum walls were present. 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 lumen.

Pancreas

The pancreas was indistinctly visualized owing to regional increased peripancreatic omental artifact as well as peritoneal free fluid. Potential for mild heterogenous left pancreatic limb possible.

Free Abdomen

Moderate volume anechoic peritoneal free fluid and generalized mild uniform hyperechoic mesentery was present. No evidence of significant lymphadenopathy or omental masses.

ULTRASONOGRAPHIC FINDINGS

- Subnormal liver with irregular to nodular parenchyma - consistent with advanced, potential emerging end stage liver disease
- Moderate volume free fluid and uniform mild hyperechoic mesentery - given reported albumin levels, appears to be secondary to advanced hepatic disease / portal hypertension likely
- Mild age related kidneys
- Normal GI tract, possible mild gastroduodenitis

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Sonographically the appearance of the liver is consistent with chronic advanced potential emerging end stage hepatopathy with considerations including nonspecific chronic hepatitis, vacuolar hepatopathy, fibrosis, cirrhosis, neoplasia (less likely) or other hepatopathy. This is likely the primary contributing factor to the patient's peritoneal effusion with potential portal hypertension given the current reported ALB level. No overt evidence of intra-hepatic shunt although this cannot be definitively excluded.

Effusion analysis +/- C/S if inflammatory cells (non-reported) and bile acids could be considered. Liver FNA if normal clotting status warranted although may not be accessible given liver size. GI panel and full urinary work up could be considered to assess for occult disease as a contributing factor. Very guarded to unfavorable prognosis given liver appearance and effusion indicated.

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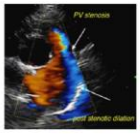
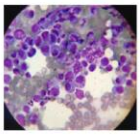
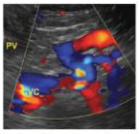

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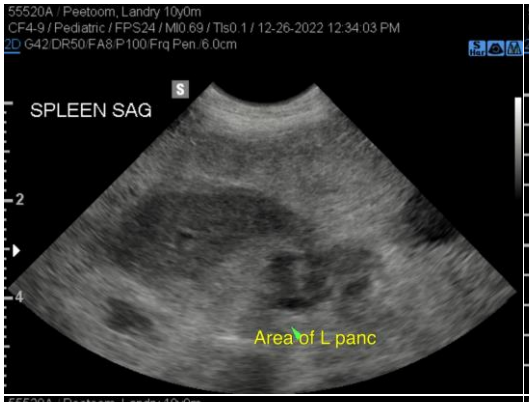

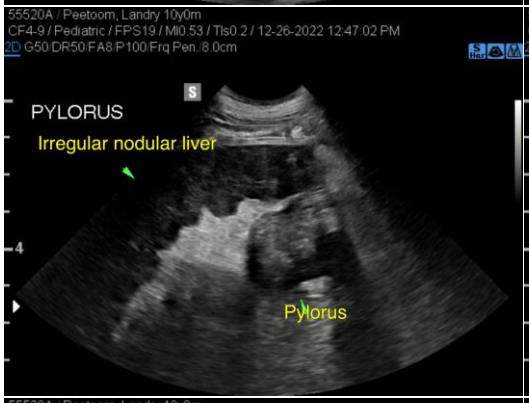

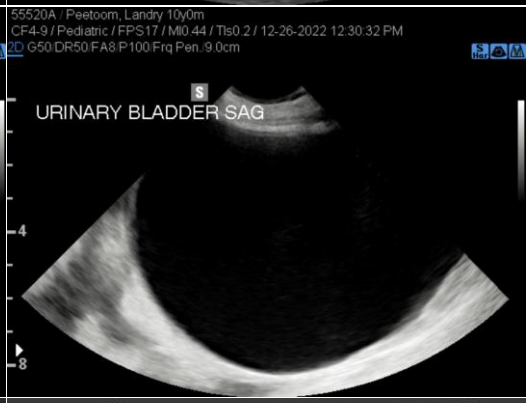

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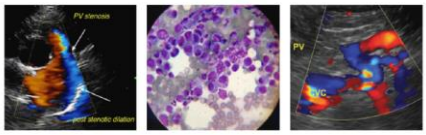

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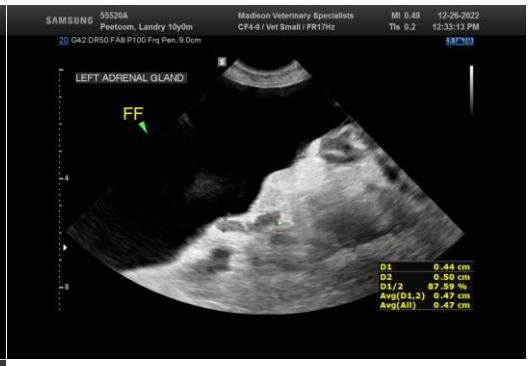

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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