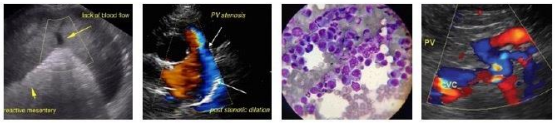

PATIENT

Lucky Salemka

SPECIES

Canine

BREED

Cocker Spaniel

SEX

Neutered male

AGE

14 years

WEIGHT

18 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Crystall Hill

HOSPITAL NAME

Preston Animal Clinic

REFERRING VET

Dr. Freedman

INVOICE

10320ag

DATE

04/08/2022

PRESENTING CLINICAL SIGNS

History: Ongoing bouts of lethargy, vomiting, diarrhea over the past few months. History of hypothyroidism, otitis externa chronically. Thyro tabs 0.5ml PO SID ongoing; cerenia 1.8ml SQ, tylosin 400mg PO SID, Forti flora 1 package SID PO, gabapentin 200mg PO SID-BID

Abnormal PE/Chem/CBC/UA Results: No recent full BW. Last done in Jan 2022 . SDMA and T4 done today. T4 - 12nmol/L, SDMA 12 ug/dL. Dr. Stephanie Gerritesen did BW (full CBC, biochem in Jan 2022), results as follows: SG: 01-11-22 at 7:53p: CBC - Trending increase in lymphocytosis (moderate increase); moderate neutrophilia with a slight left shift. Lymphocytes and Platelets continue to be elevated (moderate). RBCs just barely WNL (low normal), which could extend into borderline anemia over time. Pathologist's comment - toxic changes seen in neutrophils, suggesting infectious or non-infectious inflammation. Mature lymphocytosis noted, "..and can be associated with chronic antigenic stimulation from any source including as a response to infectious agents such as ehrlichia, immune-mediated /inflammatory disorders, hypoadrenocorticism and neoplasia. However, as the patient has a prior history of lymphocytosis, lymphoproliferative disease (chronic lymphocytic leukemia or circulating neoplastic cells from small cell lymphoma) could be considered." Can try repeating CBC in a few weeks to see if this is significant or consider flow cytometry to differentiate between reactive vs. neoplastic causes. Thrombocytosis would suggest consistent inflammation. Chemistry - Glucose is mildly low, likely artefact from the sample sitting. Chloride is mildly decreased I suspect from vomiting. ALP remains elevated but is stable between past samples. May also be increased from underlying suspected pancreatitis. Major concern is in CBC, and determining whether these changes are bacterial/viral or non-infectious in origin (neoplasia, other)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, 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 was 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 loss of corticomedullary symmetry and definition expected for the age of the patient. Multiple small cortical cysts present in both kidneys. No evidence of pelvic dilation was present. The left kidney measured 5.8 cm in length. The right kidney measured 6.3 cm in length.

The area of the aortic trifurcation was free of pathology.

The area of the residual prostate was free of pathology.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.62 cm width at the caudal pole and 0.74 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 0.47 cm width at the caudal pole and 0.65 cm width at the cranial pole.

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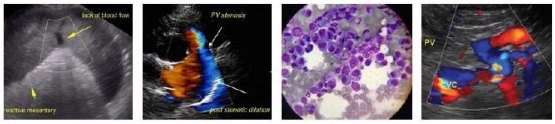

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Spleen

The spleen exhibited mild enlargement and subtle generalized parenchymal heterogeneity with a solitary mild expansive yet nondisruptive nonhomogeneous to hypoechoic nodule noted in the mid lateral spleen measuring 2.9 cm in diameter. Concurrent probable medial parenchymal myelolipomas were present. The capsule was primarily smooth and regular without apparent expansion.

Liver

The liver presented enlarged in size. The parenchyma of the liver exhibited generalized mild remodeling. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion. No overt hepatic masses or nodules were noted.

The gallbladder was non-distended in size with primarily anechoic luminal content and mild gallbladder debris. 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 small intestine exhibited primarily intact wall layering with 1:3 muscularis/mucosa ratio with segmental areas of mild jejunal nonspecific mucosal speckling along with minor jejunal ileus. A focal segment of small intestine was present in the mid to caudal abdomen exhibited mild to moderate mural hypertrophy, decreased mural echogenicity and loss of distinct wall layering measuring up to 0.87 cm in width. The lumen of the small intestine was empty with no signs of obstruction or foreign material.

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

Pancreas

The left limb of the pancreas presented hypoechoic to heterogeneous echogenicity compared to adjacent omental fat. Mild asymmetrical capsule margination was present with mild variable parenchymal swelling and mild peripancreatic reactivity / inflammation. No overt evidence of neoplasia.

Free Abdomen

Generalized increased omental fat with suspect omental lipomas were observed. Concurrent increased generalized omental echogenicity and small pocket of scant free fluid noted between cranial spleen and caudal left liver. No evidence of overt lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

- Mild chronic renal changes with cortical cysts.
- Mild splenomegaly with focal mild expansive nodule-hyperplasia, hematopoiesis, splenitis, hematoma, infection, infarction or neoplasia possible.
- Vacuolar hepatopathy pattern with mild parenchymal remodeling.
- Mild gallbladder debris (non-mucocele).
- Suspect chronic active pancreatitis.
- Nonspecific enteritis pattern with focal to segmentally thickened mid to caudal abdominal small bowel-inflammatory enteropathy/IBD with potential for emerging small bowel mural mass.
- Increased omental fat and suspect lipomas with increased omental echogenicity, focal scant perihepatic/perisplenic free fluid.

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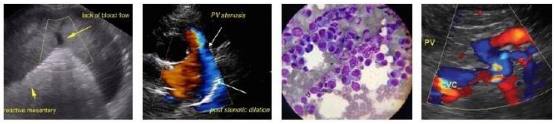

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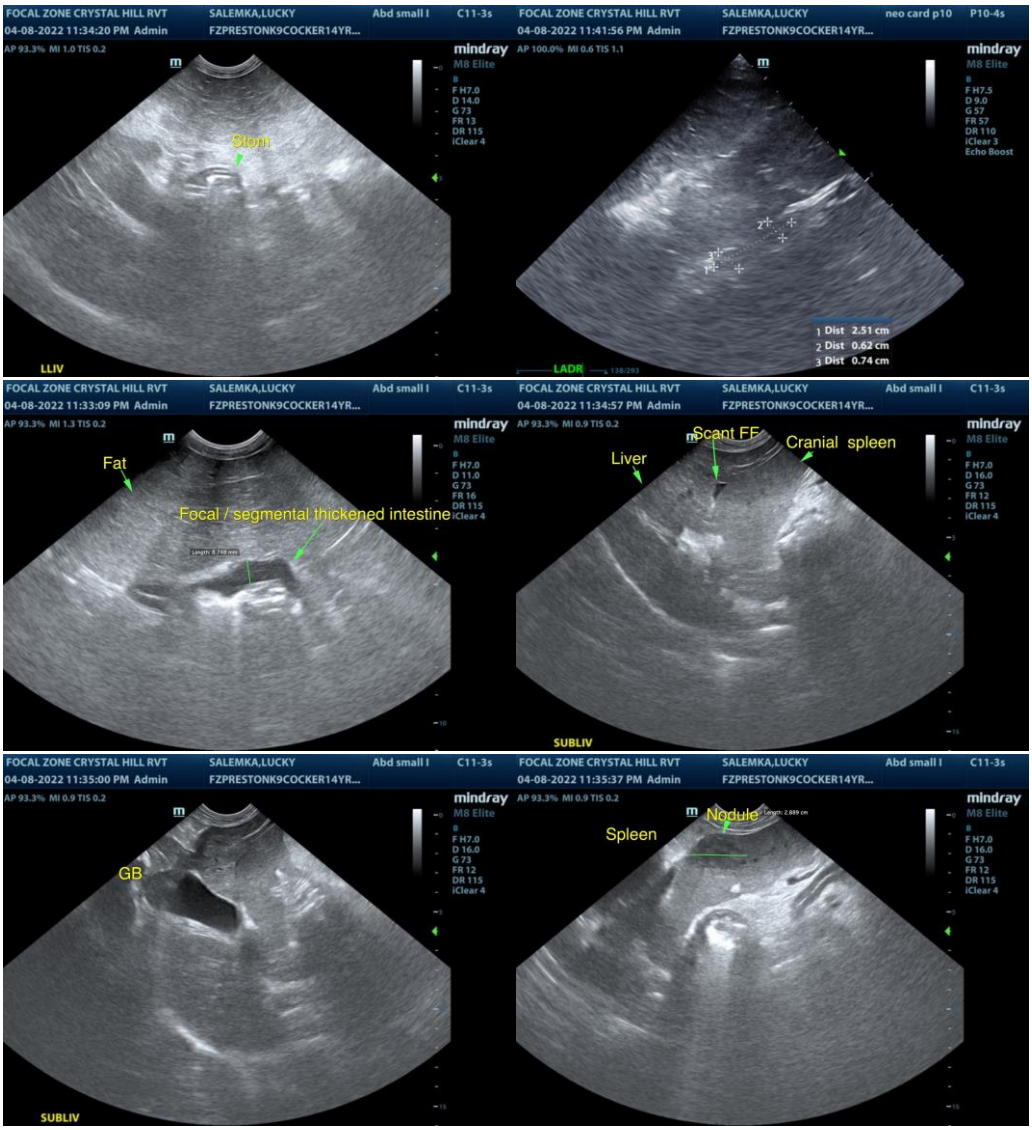
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Assuming normal clotting status and using a 25g needle a hepatosplenic FNA specifically in the area of the splenic nodule for screening cytology is recommended. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. Given the chronic gastrointestinal signs in this patient and contributing factors such as suspected chronic active pancreatitis, dietary indiscretion/food hypersensitivity, IBD, dysbiosis or small bowel mural mass intestinal neoplasia are all possible in this case. Intestinal biopsies would be required for definitive diagnosis. Correlation with full repeat lab work recommended.



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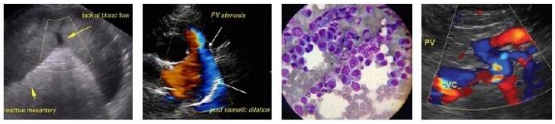

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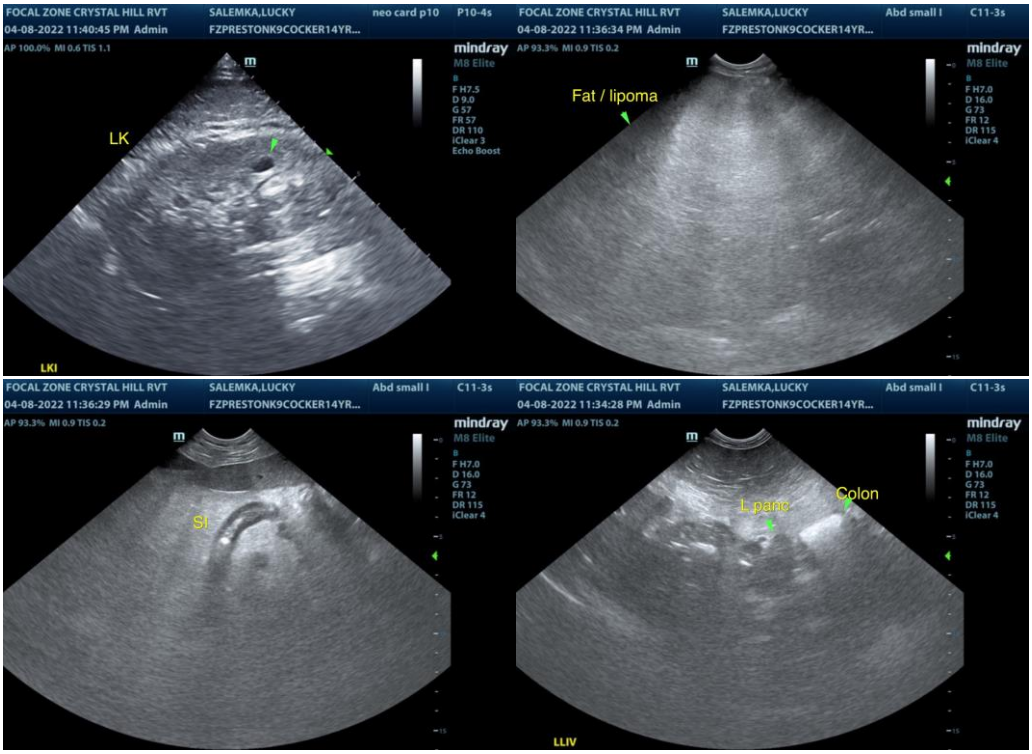

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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