SonoPath
Clinical Sonography & Telecytology
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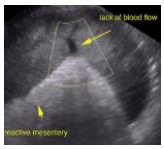
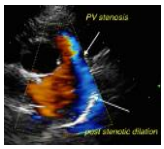
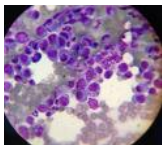
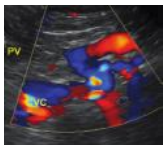





SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Macy Liden

SPECIES
Canine

BREED
Labrador Retriever

SEX
FS

AGE
10 yr

WEIGHT
35 kg

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

IMAGING PERFORMED BY
Dr. Callihan

HOSPITAL NAME
Animal Emergency Care

REFERRING VET
Dr. Ryan

INVOICE
10961ag

DATE
06/26/2022

PRESENTING CLINICAL SIGNS

History: S: Macy presented for inappetence and lethargy. She has not eaten over the past 3 days and has become increasingly lethargic. Saturday (yesterday) she was seen by her rDVM who performed bloodwork and sent out a 4DX test (results not available yet) They found her to have elevated kidney values and low platelets. She was started on doxycycline. Since seeing her rDVM she had worsened dramatically and was no longer ambulatory so was brought to ER

Abnormal PE/Chem/CBC/UA Results: Nonambulatory, obese, numerous lipomatous sc masses; some nodular dermal masses on extremities (variably sized 3-7mm) BP 30 mmHg systolic CBC/CHEM17/LYTES: Severe thrombocytopenia : 0 K/uL Azotemia : BUN 81, Creat 5.9 Hyponatremia 141; Hyperkalemia 8.3 : Ratio 17 USG 1022 Bacterial rods present in urine Lepto SNAP : Negative Thoracic Radiographs: Normal thoracic radiographs Baseline Cortisol <0.5 ug/dL 1. Thrombocytopenia R/O ITP vs neoplasia vs tickborne (less likely with 0 platelets) 2. Na:K ratio 17 R/O Addisons (primary vs secondary) vs pseudoaddisons (GI Dz, whipworms) 3. Azotemia R/O prerenal from addisons Dz vs primary renal 4. Hypotension likely secondary to hypovolemia An ACTH stim test was performed and afterward, Dex SP 0.5 mg/kg was given IV, with plan for continuing 0.2 mg/kg IV until able to take oral meds.

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 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 6.5 cm in length. The right kidney measured 7.5 cm in length.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

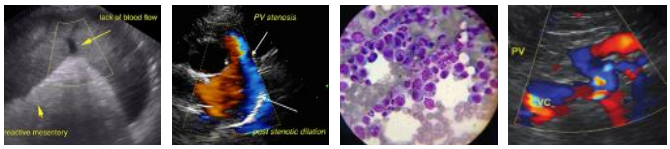
The left adrenal gland was indistinctly visualized yet exhibiting potential for mild subnormal size and isoechoic parenchyma compared to adjacent omentum. The left adrenal gland measured 0.32 cm width at the caudal pole and 0.36 cm width at the cranial pole. The right adrenal gland was not definitively visualized.

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. 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. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to



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benign parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion. 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 contained mild luminal gas with no signs of ileus, obstruction or foreign material. The ventral gastric body wall measured 0.65 cm in width.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. Minor segmental areas of small intestinal ileus. The lumen of the small intestine was empty with no signs of obstruction or foreign material. The small intestine wall measured 0.34 cm in width.

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

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

No omental masses, overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Mild age related / chronic kidneys
- Subjective subnormal left adrenal gland (right adrenal was not definitively visualized)
- Mild gastroenteritis pattern

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No overt significant visceral pathology i.e. neoplasia, significant renal, pathology, GI / urinary obstruction. Empirical therapy for occult Addison's Disease and supportive care is warranted pending ACTH stim test. The kidneys did not appear to be end stage although a possible acute kidney injury may be possible if Addison's Disease is ruled out. Urine C/S on sterile urine sample is suggested even though no urinary bladder sediment or evidence of pyelonephritis. A definitive cause of the thrombocytopenia was not evident. A CBC pathology review and correlation with recent 4DX test could be considered. Platelet rich plasma, if available, may be indicated. Continued GI support is suggested pending additional diagnostics.

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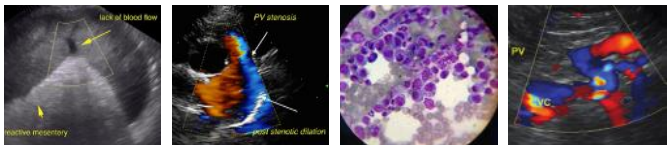

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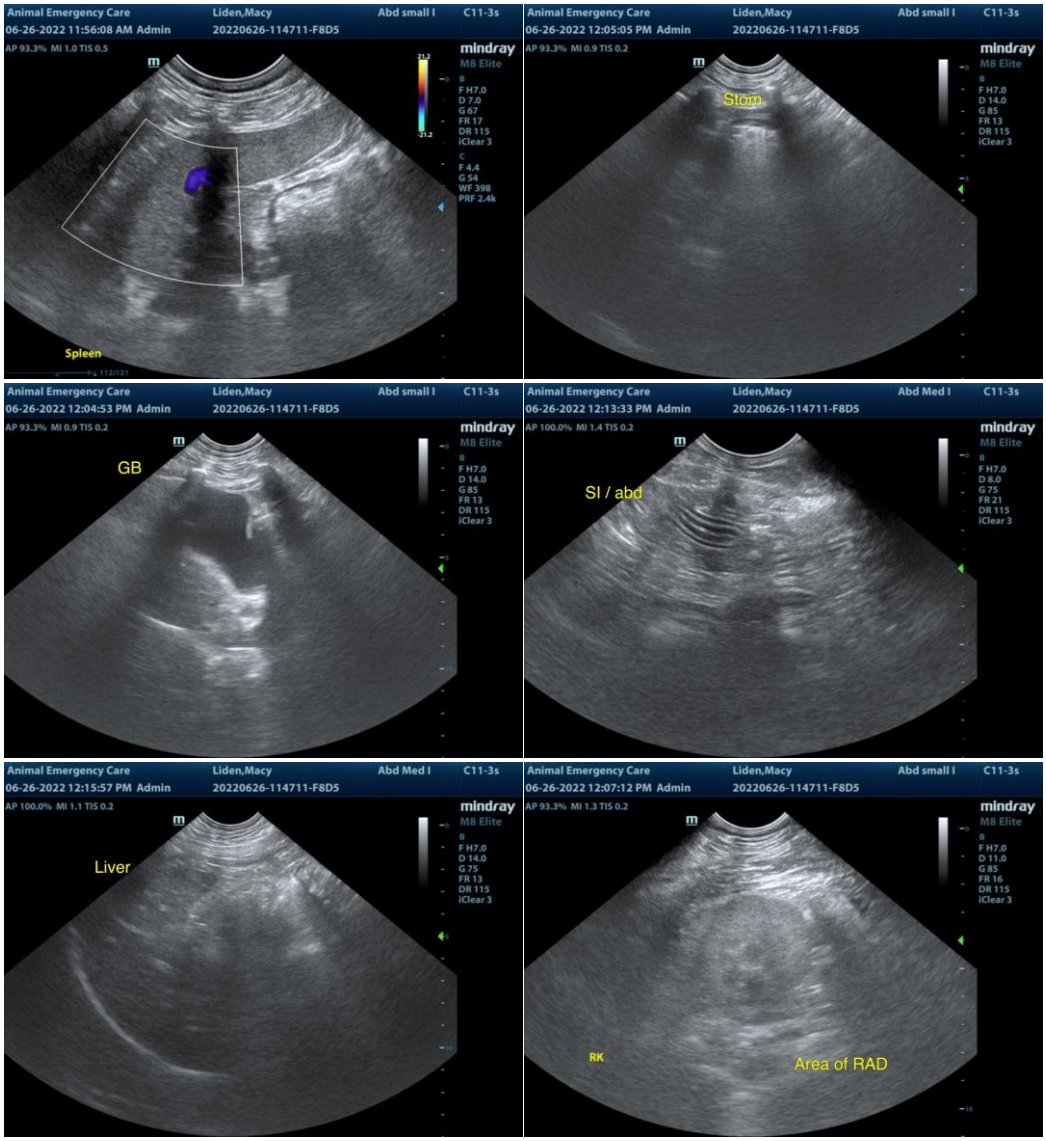

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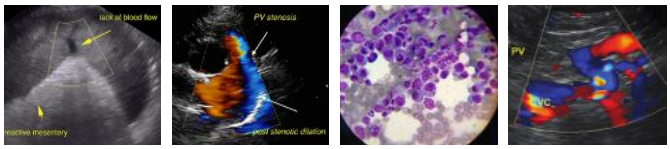

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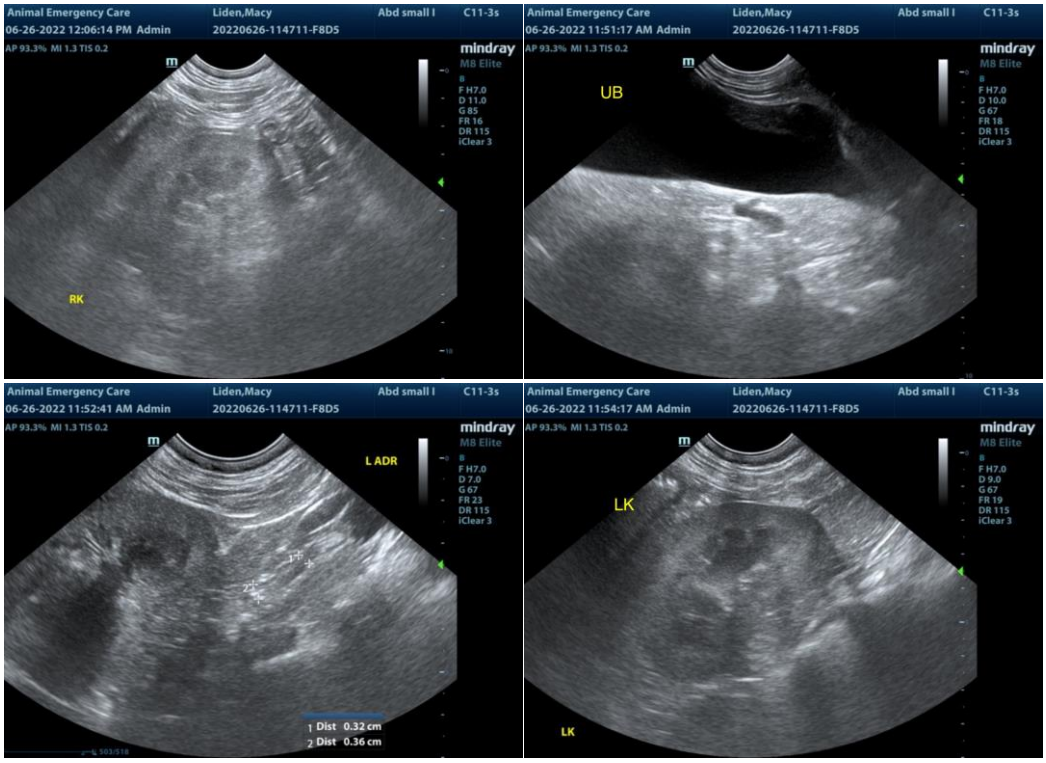

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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