**PATIENT**

Baxter Baker

SPECIES

Canine

BREEDGerman Shorthaired
Pointer**SEX**

Intact Male

AGE

2 Years

WEIGHT

52 Pounds

INTERPRETED BYR. McKenzie Daniel, DVM,
DABVP (Canine and Feline)**IMAGING
PERFORMED BY**

Sarah Pender, CVT

HOSPITAL NAME

SVS Imaging QC

REFERRING VET

Dr. Trammell

INVOICE

16407

DATE

7/1/22

PRESENTING CLINICAL SIGNS

History: Presented for suspected ear infection and blood in urine. After collecting urine sample and speaking with o' to get additional history, o' stated pt has had decreased appetite and has not quite been himself for ~2 weeks and has progressed to eating very little in the last ~3 days.

Abnormal PE/Chem/CBC/UA Results: Bilirubinuria - 6 (urine was dark reddish brown); estimated 6-8% dehydration on PE (3-4 second skin tent, eyes moderately sunken); CBC - HGB decreased (12.6), RBC low end of normal (5.65), HCT low end of normal (40.8%), decreased MCHC (30.9), decreased RETIC - HGB (19.4), suspected Bands, increased MONO (1.56); Chem17: increased GLOB (4.9), increased ALKP (238), increased TBIL (1.2); SNAP cPL - normal Pending leptos titer and tick panel

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**Urinary System**

The urinary bladder, trigone and cystourethral junction exhibited normal thickness and tone. Primarily anechoic urine was present in the lumen. Moderate nondependent particulate sediment was present, suggestive of cellular debris/protein given the reported hematuria. The ureteral papillae were normal. The ureters were not visible which is normal. No overt evidence of inflammatory or neoplastic mural changes were noted. No calculi noted.

No overt evidence of pathology in the area of the prostate, although indistinctly visualized.

Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pyelectasia or left/right retroperitoneal inflammation. The left kidney measured 8.7 cm in length. The right kidney measured 8.4 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 2.9 cm in length x 0.48 cm width at the caudal pole.

The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 2.3 cm in length x 0.83 cm width at the caudal pole.

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 mildly enlarged. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. 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.

The gallbladder was non-distended without evidence of inflammatory gallbladder or peripheral gallbladder criteria with anechoic content with minor luminal debris. The cystic and common bile ducts were normal. No evidence of posthepatic obstruction.

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Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained moderate retained ingesta and echogenic fluid without signs mechanical pyloric outflow obstruction. The ventral gastric body wall measured 0.38 cm.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no evidence of mechanical obstructive pattern, foreign material or loss of intestinal wall layering. The small intestinal wall measured 0.23 cm.

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

A solitary, mildly prominent to enlarged medial iliac lymph node was present. The lymph node was essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). The lymph node measured 2.3 cm x 0.74 cm width.

Focal to intermittent, mildly prominent to enlarged mesenteric lymph nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). An example of lymph node measured 2.5 cm x 0.83 cm width.

The mesenteric and medial iliac lymph nodes were not overtly consistent with neoplastic criteria.

No omental masses or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Urinary bladder sediment- suspect cellular debris/protein
- Mild hepatopathy- subjectively benign, suggestive of metabolic, reactive or vacuolar hepatopathy. Potential for occult or acute nonspecific hepatic inflammation is considered a less likely differential diagnosis. No overt evidence of hepatic neoplastic criteria, which is considered less likely.
- Minor gallbladder debris- incidental (non-mucocele)
- Retained gastric ingesta/fluid, sonographically unremarkable small bowel- possible metabolic gastric hypomotility
- Intermittent, subjectively benign mesenteric and medial iliac lymph nodes- probable lymphoid hyperplasia or minor reactive lymphadenitis

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Overall, no overt evidence of significant intraabdominal pathology, i.e., trauma, neoplastic criteria, etc. Urine culture and sensitivity on sterile urine sample is recommended. Assessment for possible hemolysis could be considered, if clinically indicated. If evidence of myoglobinuria, a thorough



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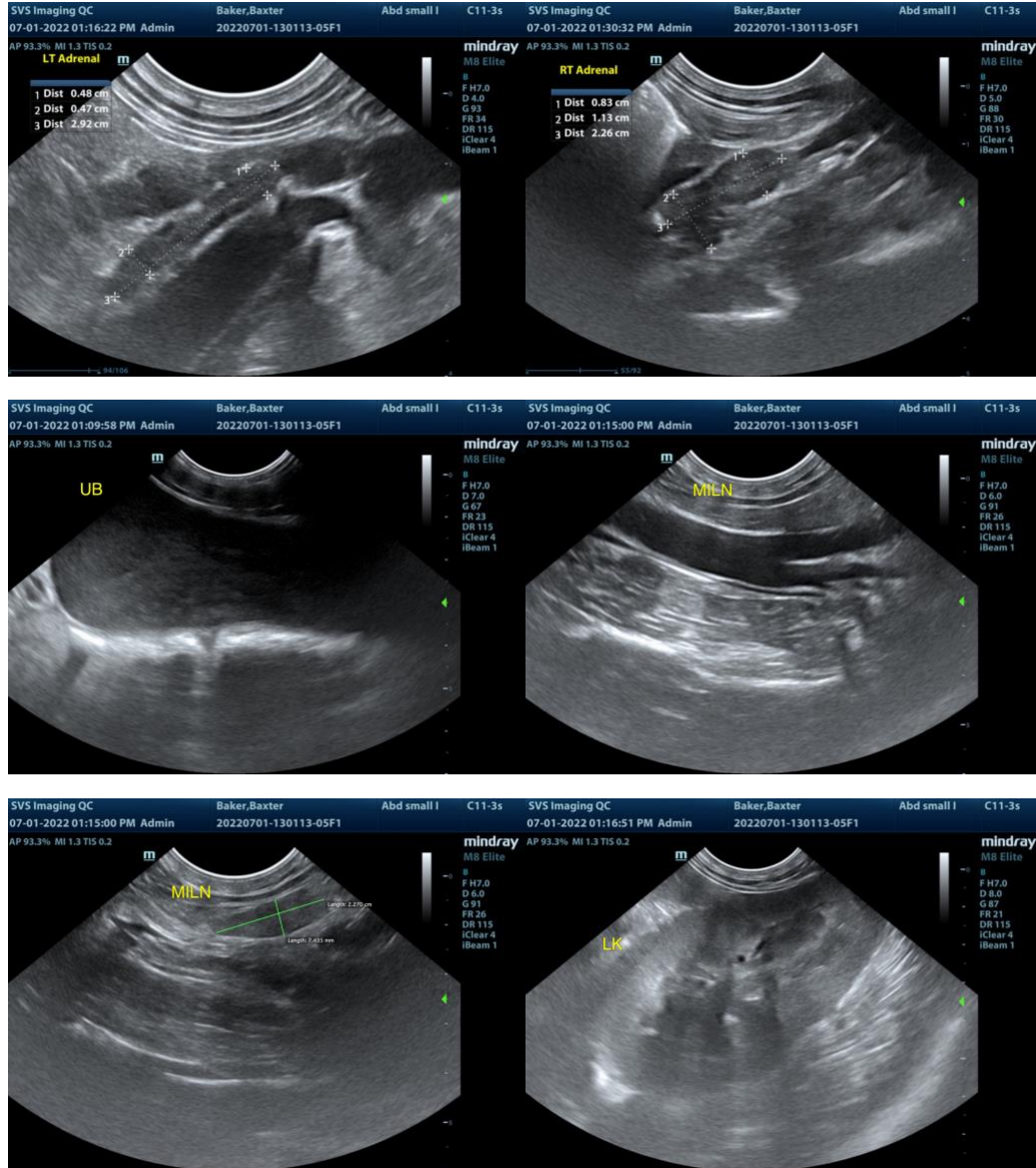
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musculoskeletal examination is suggested. Although considered unlikely, resting cortisol to rule out occult Addisons disease could be considered. Correlation with pending infectious disease testing is warranted. Pending additional diagnostics, continued gastrointestinal support, rehydration with continued monitoring of hematocrit level and liver enzymes would be reasonable. Rectal palpation of the prostate to ensure no evidence of significant prostatomegaly or pain which may indicate prostatitis is suggested.





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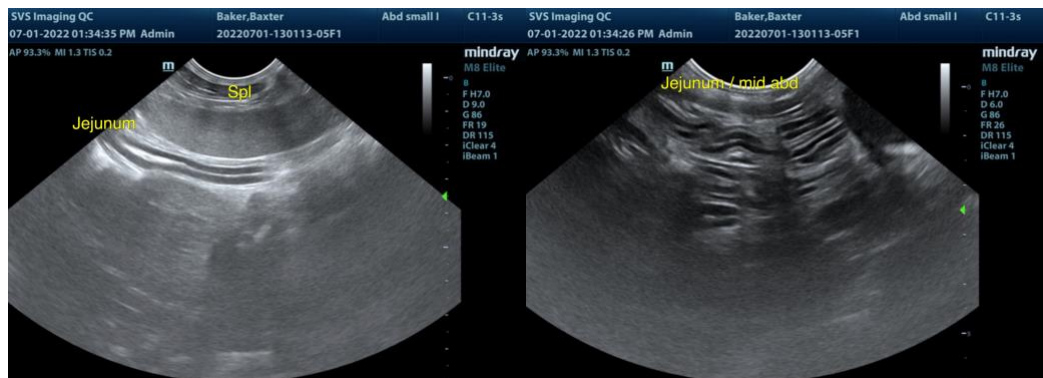
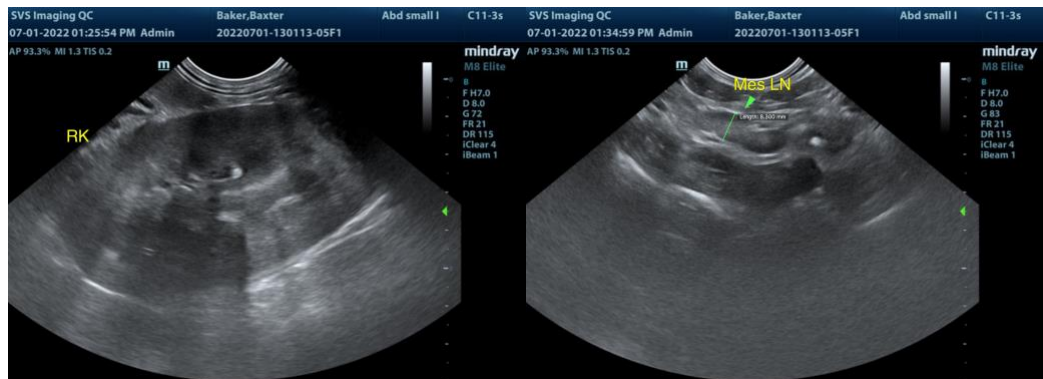
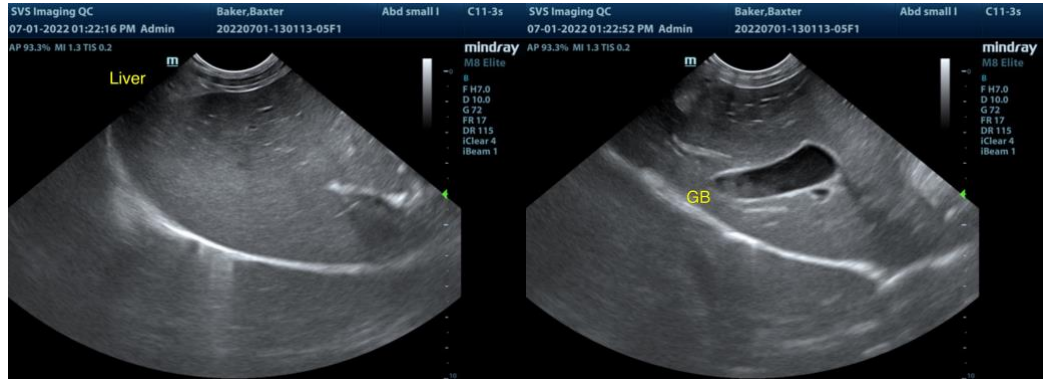
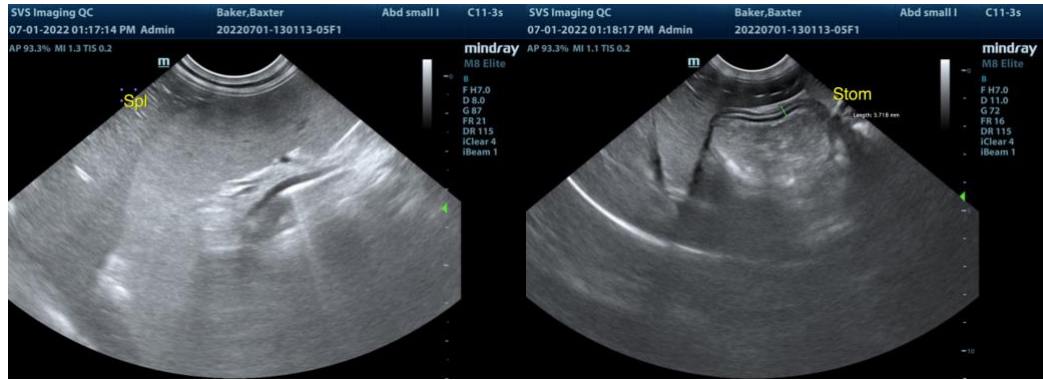
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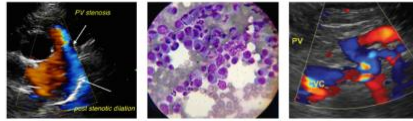
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referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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