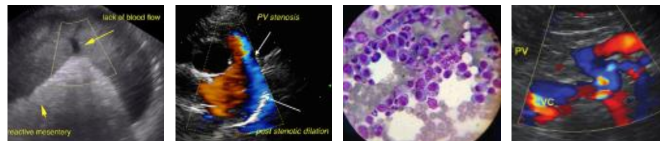
SonoPath

Clinical Sonography & Telecytology

EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Terra Katten

SPECIES

Canine

BREED

Aussie

SEX

FS

AGE

10y

WEIGHT

51lb

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Harmon

HOSPITAL NAME

Willamette Veterinary Hospital

REFERRING VET

Dr. Harmon

INVOICE

11080ag

DATE

07/10/2022

PRESENTING CLINICAL SIGNS

P has HX of seizures starting in February (at age 9.5yr)-unremarkable CBC and CHEM 17 at that time, re-presented and started on phenobarbital in April due to seizures (CBC and CHEM 17 also normal at that time). P presented 7/8 with 5 day history of diarrhea, lethargy and hyperoxia, fever on presentation, fever continues to wax and wane in hospital along with intermittent abdominal pain.

Started on LRS, changed to levetiracetam, Unasyn, metronidazole concern for idiosyncratic phenobarbital reaction, vs sepsis vs other

Abnormal PE/Chem/CBC/UA Results

Fever, intermittent abdominal pain, splenomegaly on palpation,

7/8 CBC = moderate non-regen anemia HCT 23.3%, low HgB 7.9, severe leukopenia WBCs 1.28k, sever neutropenia 0.44k, lymphopenia 0.44k, thrombocytopenia 22k

Chem10 = ALP 663, all other wnl. BG 99.POC = lytes and lactate wnl. K 3.6parvo snap = negativeSlide agglutination = negative

OSU Slide Differential and Morphology =

Interpretation: Moderate macrocytic hypochromic regenerative anemia Marked leukopenia with degenerative, left shift, toxic change and atypical cells Moderate to marked thrombocytopenia

Comment: Findings are highly concerning for consumptive disease and possible underlying septicemia. No history is provided, this these findings should be interpreted in conjunction with all clinical parameters. Coagulation parameters are likely warranted to rule out DIC. Atypical circulating cells may be associated with marked toxicity and reactivity.

Labs 7/9 - CBC completed - HCT 24.4 (prev 23.3), WBC 0.9 (prev 1.28), neut 0.1 (prev 0.24), Eos 0.02 (prev 0), Mono 0.38 (prev 0.57), Plt 21 (prev 22), MPV 21.8. Plateletcrit static at 0.05

cPL- WNL 128.3

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

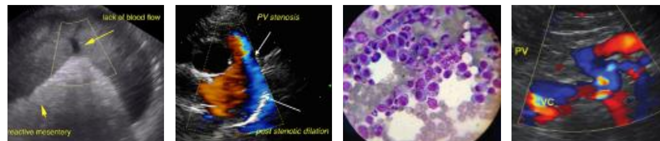
The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of 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 6.8 cm in length. The right kidney measured 7.0 cm in length.

The area of the aortic trifurcation was free of pathology.

No evidence of pathology in the area of the uterine remnant.

Adrenal Glands



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The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.53 cm width at the caudal pole and 0.54 cm width at the cranial pole. No overt evidence of pathology in the area of the right adrenal gland.

Spleen

The spleen exhibited mild generalized enlargement with a finely textured to mildly non homogeneous 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.

Liver

The liver presented mildly enlarged in size. 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 in size with primarily anechoic luminal content and mild particulate nondependent nonorganized debris. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact yet mildly prominent wall layering with a normal wall layer ratio. The lumen of the stomach was empty with small pockets of luminal gas and minor retained anechoic fluid. No signs of ileus, obstruction or foreign material. The gastric body wall measured 0.55 cm in width.

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. The small intestinal wall measured 0.36 cm in width.

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

Pancreas

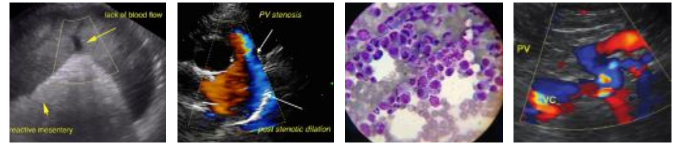
The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

Free Abdomen

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

ULTRASONOGRAPHIC FINDINGS

- Mild symmetrical splenomegaly - uniform parenchyma and contour is maintained, normal vascularity, no masses / nodules, hyperplasia / hematopoiesis owing to anemia, splenitis possible, neoplasia considered less likely
- Vacuolar Hepatopathy pattern, normal GB - subjectively benign
- Gastroenteritis - subjectively mild



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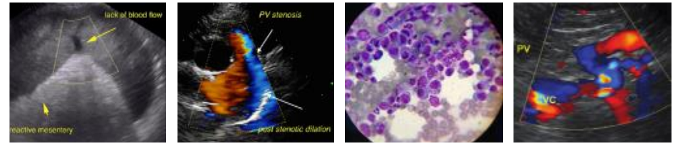
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

An obvious cause of abdominal pain, fever, and CBC abnormalities ie neoplasia/mass, abscess / peritonitis, pancreatitis, GB disease was not definitively evident. Screening FNA of the spleen / liver for cytology assuming normal clotting status could be considered primary to ensure benign changes are present. Enterotoxaemia or infectious gastroenteritis possible. 3 view chest rads are suggested if not done. Infectious disease serology could be considered if clinically indicated. Given the severe neutropenia and concern / risk for sepsis, antibiotics are indicated. Fresh fecal analysis to rule out ova / Giardia and empirical aggressive GI support is recommended.



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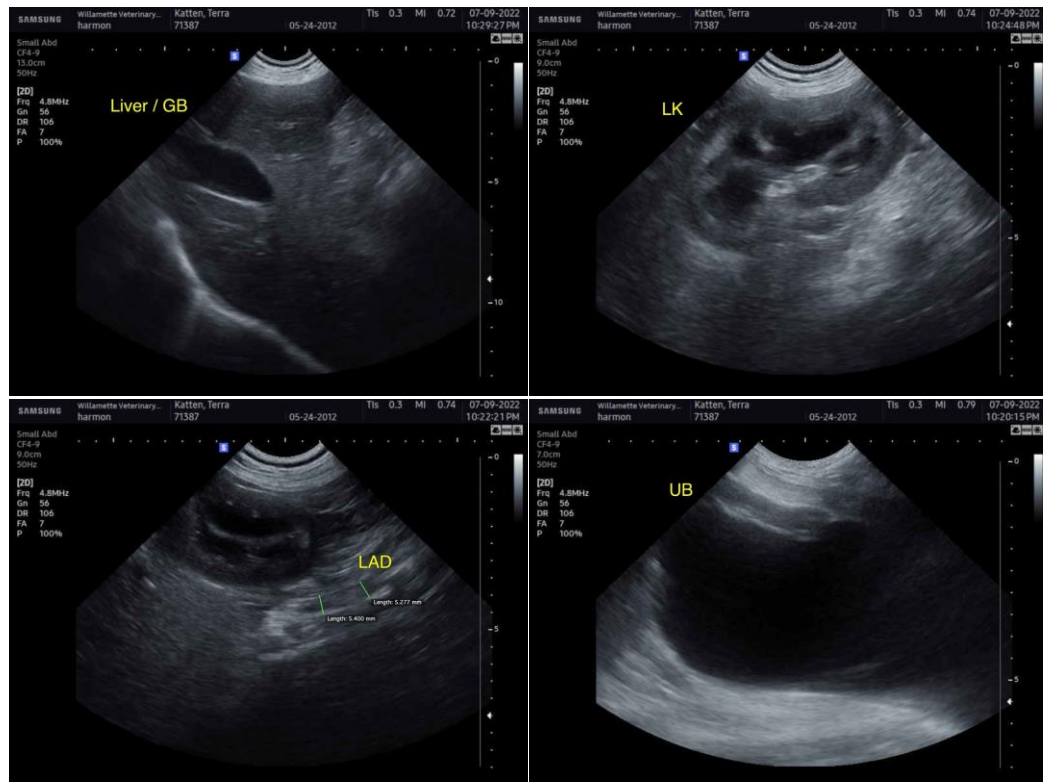

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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