



PATIENT

Quinn Barry

SPECIES

Canine

BREED

Yorkshire Terrier

SEX

Intact Male

AGE

11 Year

WEIGHT

14.7 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Kelly Vazquez

HOSPITAL NAME

Westwood Regional
VH

REFERRING VET

Dr. Hartwick

INVOICE

16899

DATE

8/19/22

PRESENTING CLINICAL SIGNS

History: Patient presents for coughing, increased respiratory rate, and new decreased appetite, inappetance, vomiting today with blood clots. Grade 1 murmur, respiratory PCR negative. CXR: diffuse nodular pattern. Current meds: Azithromycin, now off after negative respiratory PCR results. Abnormal PE/Chem/CBC/UA Results: Chem 17: Alk. Phos. 19, amylase 1593. CBC: WBC 16.86. CPLI: normal. Coagulation panel: cit-PT: 13 secs (WNL) and cit-aPTT: 98.0 seconds (higher end but still WNL).

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone and cystourethral junction exhibited normal tone. Mild nonuniform thickening of the urinary bladder wall was present. The ventral urinary bladder wall measured 0.4 – 0.5 cm in width. Multiple cystic calculi with distal acoustic shadowing were present in the dependent lumen. An example of a calculus measured 0.55 cm width. Aortic trifurcation was normal.

No overt pathology in the area of the prostate.

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 4.2 cm in length. The right kidney measured 4.4 cm in length.

Adrenal Glands

The bilateral adrenal glands were normal in size. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The left adrenal gland measured 0.35 cm width at the caudal pole and 0.48 cm width at the cranial pole. The right adrenal gland measured 0.28 cm width at the caudal pole and 0.66 cm width at the cranial pole. No evidence of adrenomegaly or tumors.

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 parenchymal heterogeneity is likely consistent with benign changes such as extramedullary hematopoiesis or age-related remodeling with minor potential for inflammatory or neoplastic disease. No evidence of splenic nodules or masses.

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 benign parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion. No evidence of hepatic nodules or masses.

The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.



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Gastrointestinal

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The stomach exhibited intact yet mild to variably prominent wall layering. The lumen of the stomach was empty with mild luminal gas. No overt evidence of gastric mural masses. The pylorus wall measured 0.46 cm. The gastric body wall measured 0.30 cm.

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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.

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

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The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia. This is likely consistent with age-related pancreatic changes and considered incidental.

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Free Abdomen

No evidence of omental masses, intraabdominal lymphadenopathy or peritoneal free fluid.

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Transdiaphragmatic view of the caudal thorax revealed moderate to significant transdiaphragmatic comet tail artifact, which is echogenic sound wave interference within the caudal lung fields. The caudal lung fields should not be visualized by sonogram, unless pathology is present. General considerations may include alveolar lung disease, such as neoplasia, thromboembolic disease, granuloma, chronic inflammatory disease with microconsolidation or other. An example of caudal thoracic peridiaphragmatic nodule measured 1.2 cm in diameter. No overt evidence of concurrent caudal thoracic free fluid.

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ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Mild prominent gastric walls- suspect gastritis
- Moderate to significant transdiaphragmatic comet tail artifact with caudal thoracic to peridiaphragmatic nodules

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Secondary Findings

- Multiple cystic calculi with probable concurrent cystitis
- Bilateral mild chronic renal changes
- Age-related hepatosplenic changes- no evidence of hepatosplenic neoplastic criteria

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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Obvious evidence of primary intraabdominal neoplastic criteria as an obvious cause of thoracopulmonary metastasis was not evident. The possibility of gastric microulceration or early infiltrative disease cannot be definitively excluded. If peripheral pulmonary nodule is accessible, ultrasound guided FNA for cytology and further assessment could be considered. Strong concern for a neoplastic process, regarding the caudal thoracic and peridiaphragmatic nodules, is warranted, although other potential etiologies are possible. Gastroprotectant protocol and as needed gastrointestinal support would be reasonable. Urine culture and sensitivity is recommended, if clinically indicated.

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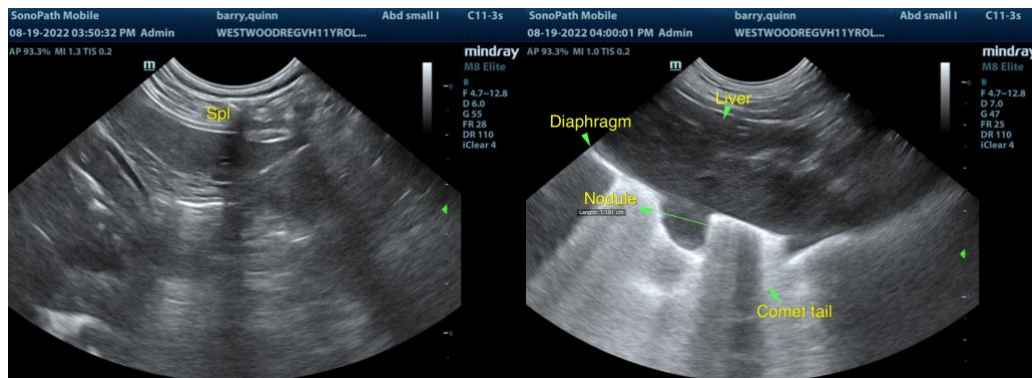
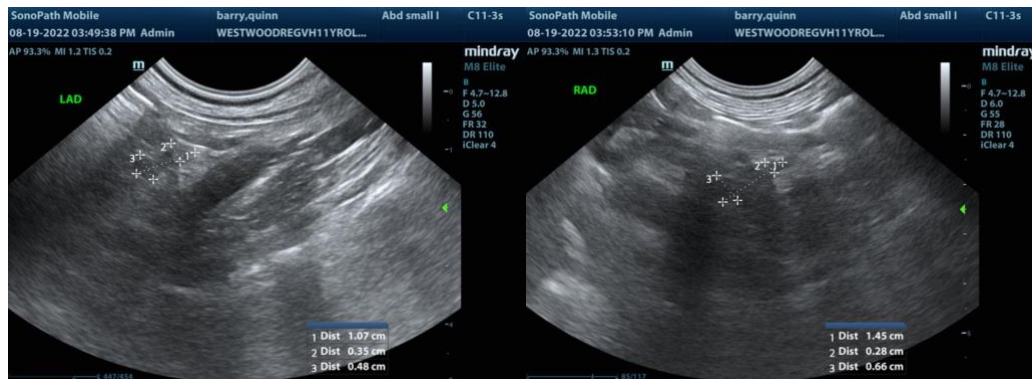
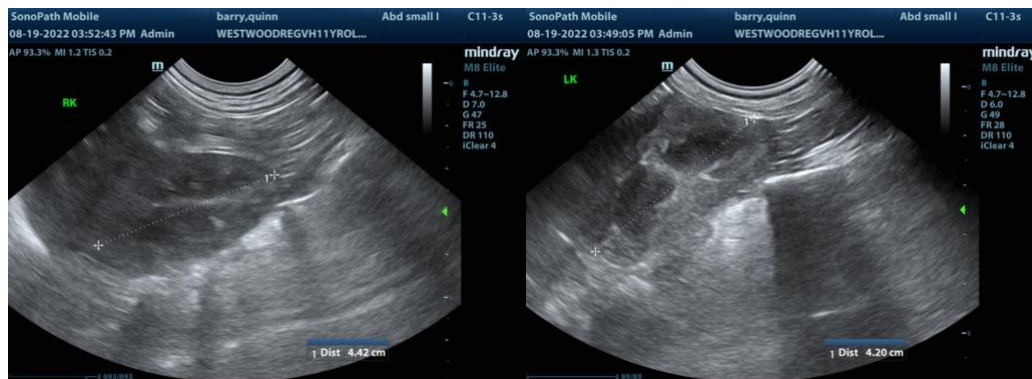
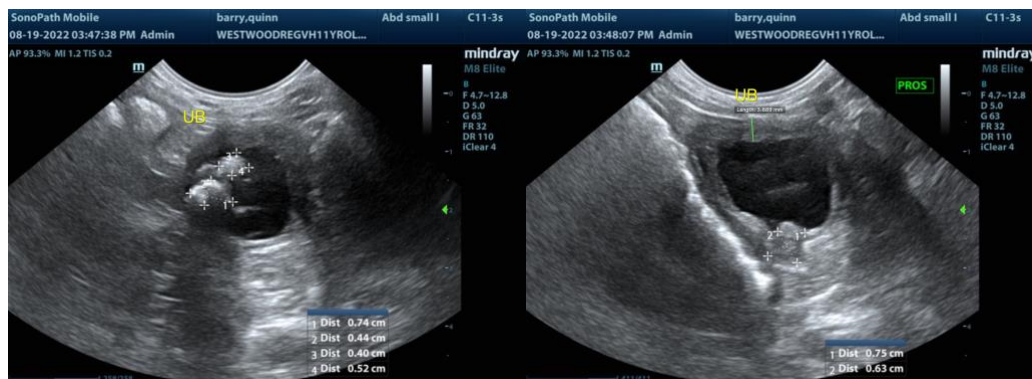
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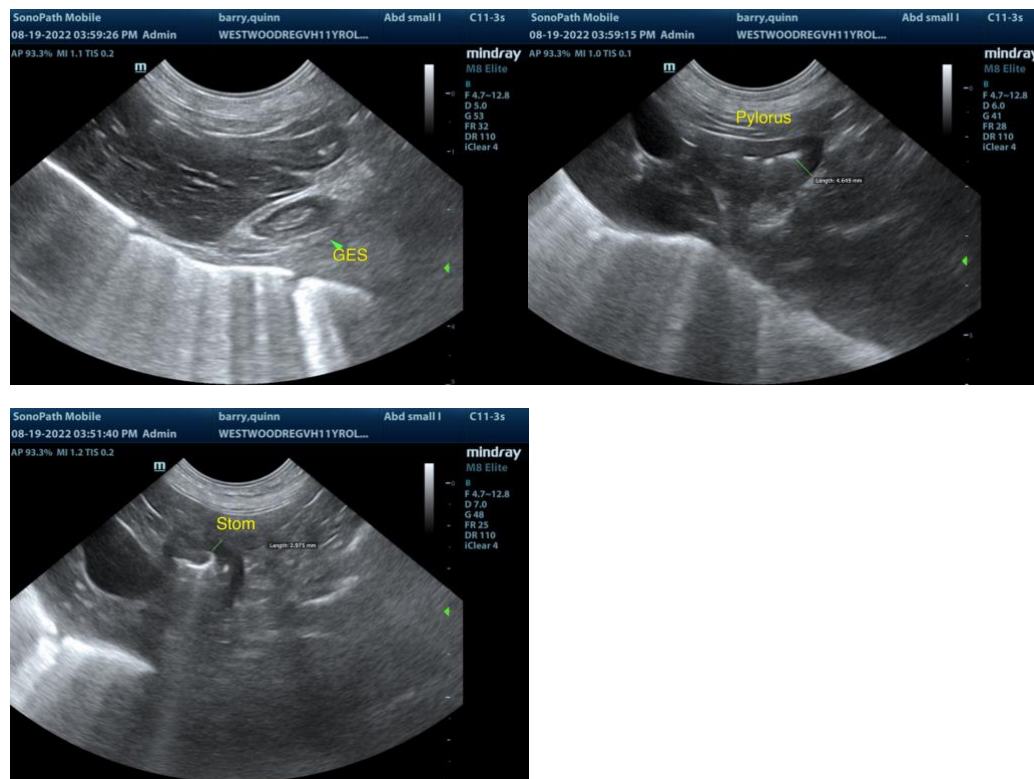
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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