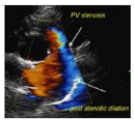
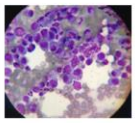
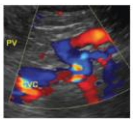




PATIENT

Maximus Rose

SPECIES

Canine

BREED

Lab

SEX

NM

AGE

11 yrs

WEIGHT

125 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Sarah Pender, CVT

HOSPITAL NAME

SVS Imaging QC

REFERRING VET

Dr. Doerscher

INVOICE

14695

DATE

8/24/22

PRESENTING CLINICAL SIGNS

Presented for blood from mouth and ears. P has a HX of chronic otitis that I'm not sure has ever resolved for years. P has had fairly awful dental disease for years as well. Last BW was 2 years ago. Abnormal PE/Chem/CBC/UA Results: Upon presentation noted blood-tinged saliva and appearance of likely bilateral tooth root abscesses at 108 and 208, Grade 4 dental disease, gums oozed small amt of blood when pressed. P fairly resistant to oral exam but no other abnormalities noted orally. Was oozing bloody saliva after oral exam. No MM petechia noted. Bilaterally as well, there were polyps attached to the aural folds and P has chronic otitis with a mixed bacterial/yeast flora. P is morbidly obese with several presumed lipomas, can barely stand and can't be in a sitting position long so abdominal palpation is nearly impossible. CBC 3.1, HCT 27%, Plts 11,000 (pathologist thought <10% on manual count) When attempting to lay lateral for scan patient turned cyanotic and extreme respiratory distress. Scan was done with patient sternal on oxygen flow by.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and cystourethral junction 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 was noted.

The residual prostate was free of overt pathology, although indistinctly visualized.

The area of the aortic trifurcation was free of pathology.

Normal size and margination were 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 pelvic dilation. The left kidney measured 8.1 cm in length. The right kidney measured 7.0 cm in length.

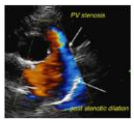
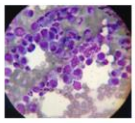
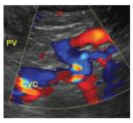
Adrenal Glands

The left adrenal gland was not definitively visualized owing to patient conformation.

A mildly nonhomogeneous to hyperechoic nodule was present in the mid to cranial right adrenal gland. The nodule appeared to mildly distort the adrenal capsule, yet without evidence of parenchyma escape or vascular invasion. The nodule did not exhibit signs of mineralization. The nodule measured 1.6 cm x 0.97 cm. The overall right adrenal gland measured 2.6 cm length x 1.78 cm width at the cranial pole and 0.53 cm width at the caudal pole.

Spleen

The spleen was overall normal in size with areas of mild medial capsule asymmetry. Subtle generalized splenic parenchyma heterogeneity was noted with a solitary, mildly expansive splenic nodule measured 2.4 cm in diameter.

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Liver/ Gallbladder

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 mild, nondependent, mildly hyperechoic gallbladder debris. The gallbladder was otherwise normal. The cystic duct and common bile ducts were normal without evidence of dilation.

Gastrointestinal

The stomach presented intact yet mildly prominent to thickened gastric walls with mild retained anechoic pyloric fluid. The ventral gastric body wall width measured 0.9 cm.

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.

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

Pancreas

The parenchyma of the pancreas base and right pancreatic limb was hyperechoic to adjacent omental fat with diffuse parenchyma remodeling. The capsule of the pancreas was mildly asymmetrical in contour without evidence of peripancreatic inflammation. These changes may suggest chronic inflammation, fibrosis, or saponification if previous history of pancreatitis. No overt signs of pancreatic neoplasia.

Free Abdomen

No omental masses, lymphadenopathy, or evidence of peritoneal effusion were noted. An increased amount of omental fat was noted.

ULTRASONOGRAPHIC FINDINGS

- Nonspecific splenic nodule - multiple etiologies are possible including hyperplasia, hematopoiesis, granuloma, focal splenitis, small hematoma, neoplasia
- Intact yet mildly prominent to thickened gastric walls with possible mild gastric hypomotility, sonographically unremarkable small bowel
- Subjective mild vacuolar hepatopathy pattern, mild gallbladder debris (non-mucocele)
- Hyperechoic pancreas - possible chronic pancreatitis or pancreatic fibrosis
- Right adrenal nodule - suspect adenoma

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The gastric presentation is sonographically suggestive of gastritis with potential for mild gastric hypomotility. This finding is nonspecific, given the lack of reported signs such as vomiting or inappetence. Potential for early infiltrative gastric criteria is considered less likely.

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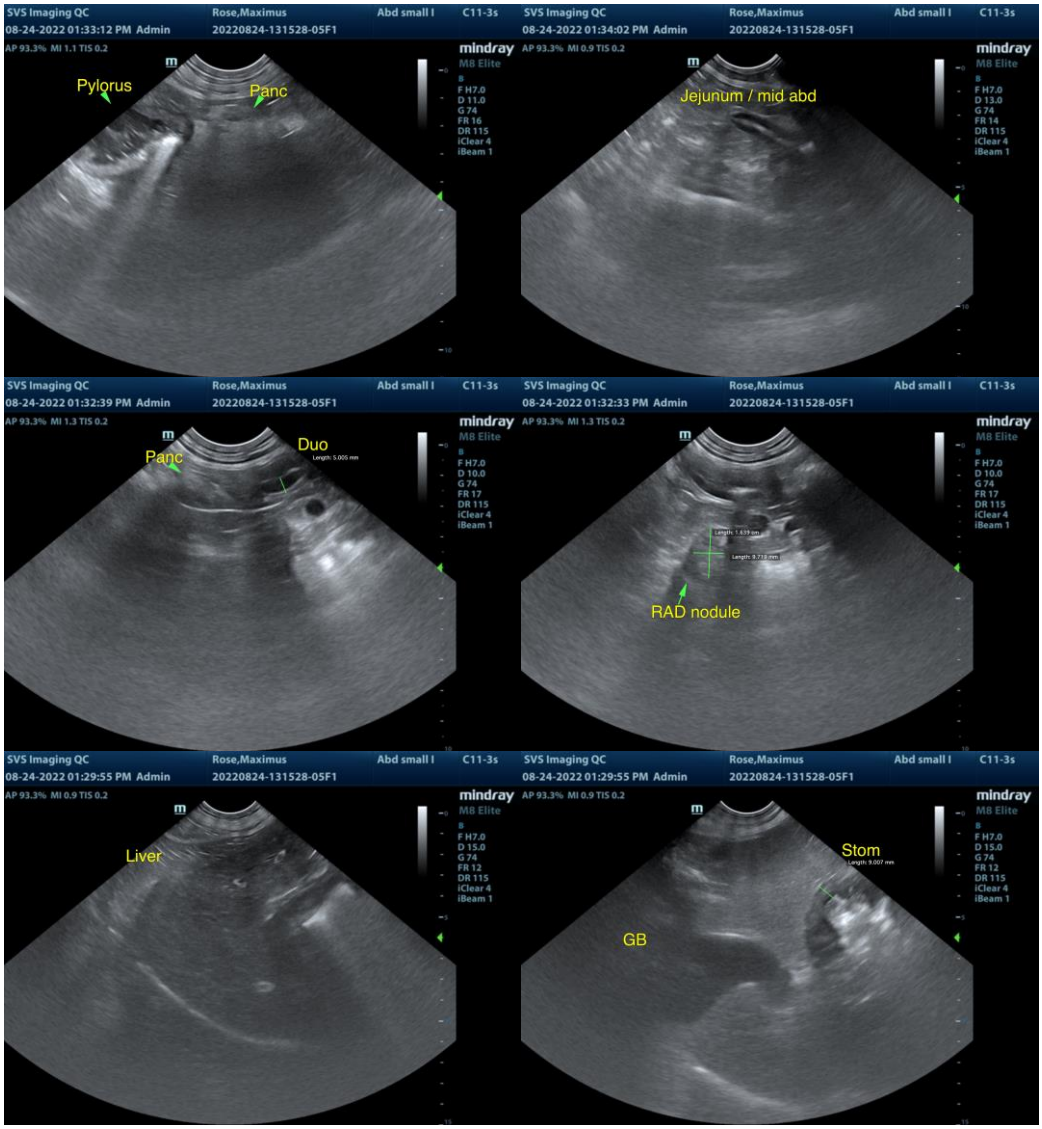
Ultrasound-guided FNA of the splenic nodule, assuming normal clotting status and using a 25-gauge needle, could be considered for further assessment. Sonographic monitoring of the splenic nodule for evidence of progression would be a more conservative approach. A Spec cPL could be considered. If possible, systemic BP assessment for evidence of hypertension, which may allude to a right adrenal pheochromocytoma, is recommended. Likewise, in addition to sonographic monitoring of the splenic nodule, sonographic monitoring of the right adrenal nodule for evidence of progression would be ideal.



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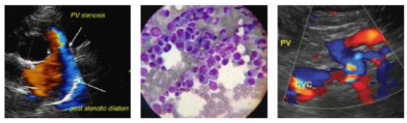

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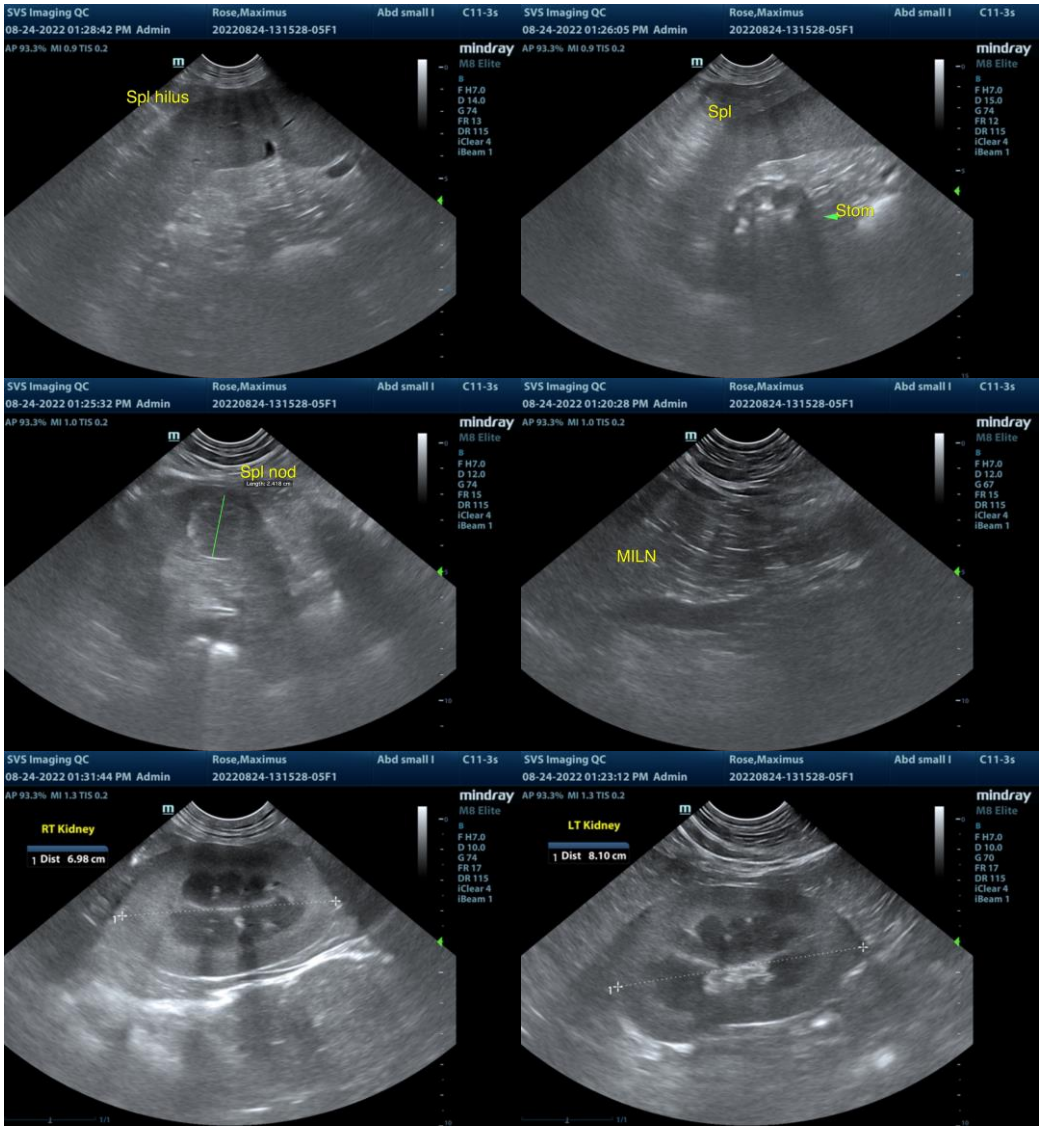

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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