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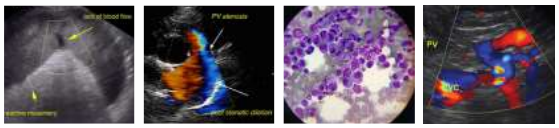


ANIMAL SOUNDS NW
MOBILE VETERINARY ULTRASOUND
IMAGING PERFORMED BY
AnimalSoundsNW.com 541-357-9423

PATIENT

Bart Slay

SPECIES

Canine

BREED

Golden Retriever

SEX

Neutered Male

AGE

10 years

WEIGHT

79.2 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Jenna Walsh, CVT

HOSPITAL NAME

South Willamette VC

REFERRING VET

Dr Willamen

INVOICE

12312

DATE

9/27/21

PRESENTING CLINICAL SIGNS

Presented for mild lethargy, weight loss (6lbs)Current Medications carprofen intermittently for DJD Abnormal PE/Chem/CBC/UA Results: Mild regenerative anemia, leukocytosis, monocytosis, mild decrease platelets

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 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 was noted.

No overt pathology was noted in the area of the residual prostate or aortic trifurcation.

Normal size and margination were 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 7.1 cm in length. The right kidney measured 7.1 cm in length.

Adrenal Glands

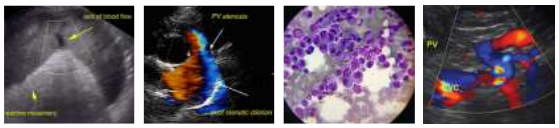
The bilateral adrenal glands were normal in size. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The left adrenal gland measured 0.40 cm width in the cranial pole and 0.80 cm width in the caudal pole. The right adrenal gland measured 0.39 cm width in the cranial pole and 0.92 cm width in the caudal pole. No evidence of adrenal hyperplasia or tumors was noted.

Spleen

The spleen exhibited primarily finely textured parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Mild generalized parenchyma heterogeneity was present. Mid splenic, subtly expansive, mildly hypoechoic to nonhomogeneous, nodular lesion was present, measuring 2.9 cm x 2.0 cm. Concurrent, non-expansive, well-demarcated hypoechoic nodule was noted adjacent to the hilus, measuring 0.67 cm in width. 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.

Liver/ Gallbladder

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



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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.

Transdiaphragmatic view revealed comet tail lung pattern, which is echogenic sound wave interface with microconsolidations within the caudal lung field. The lung field should not be visualized by sonogram unless pathology is present. Chest radiographs are recommended to rule out alveolar/lung disease such as neoplasia, thromboembolic disease, chronic inflammatory disease with microconsolidation. Suspect small, potential nodules were noted in the caudal thorax along the thoracic side of the diaphragm.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained minor, retained, echogenic, nonshadowing ingesta and chyme most consistent with post prandial presentation without signs of ileus, obstruction or foreign material. The gastric body wall measured 0.37 cm 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 duodenum wall measured 0.42 cm 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 were evident.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Nonspecific hypoechoic to nonhomogeneous splenic nodules to focal nodular lesion - hyperplasia, hematopoiesis given the anemia, previous infarctions, infection, or neoplasia possible
- Hepatic parenchymal remodeling - subjectively benign
- Transdiaphragmatic comet-tail artifact with suspect caudal thoracic to peri diaphragmatic nodules

Secondary Findings

- Mild chronic renal changes
- Mild retained gastric ingesta / chyme

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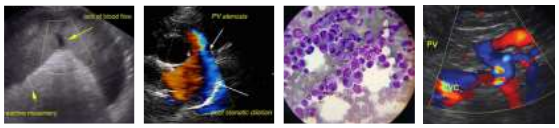

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Ultrasound guided splenic cytology (obtained at the time of ultrasound without complication) Is warranted for screening cytology and further clarification. Three view chest radiographs are recommended, given the transdiaphragmatic comet-tail artifact and potential caudal thoracic nodules, if not done. No overt evidence of gastrointestinal mural pathology as a potential cause of ulceration.

The presence of mild gastric ingesta / chyme is nonspecific and may correlate with most recent meal ingestion potential for mild metabolic gastric stasis is possible if document NPO.

CBC pathology review and a GI panel to include PLI/TLI/Cobalamin/Folate if clinically Indicated, given the patient's weight loss, may be considered. Assessment for evidence of autoagglutination is suggested.

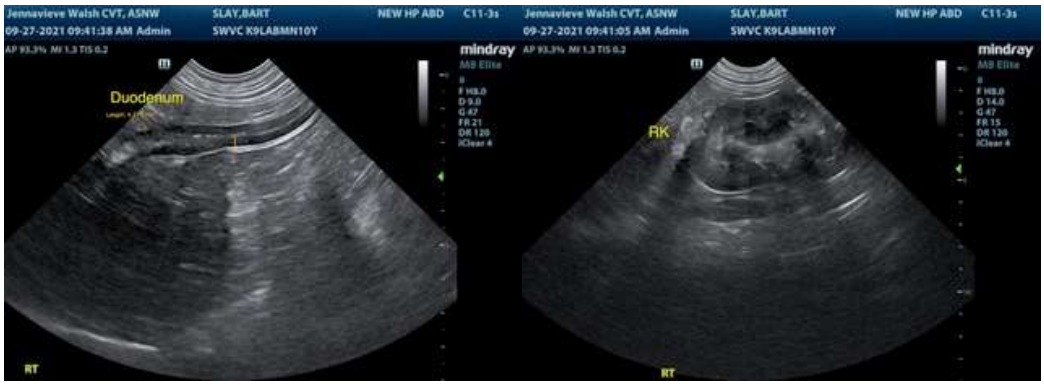
Some or all of the of following protocol may be considered empirically.

(*Note: ensure no underlying neoplasia as IMHA/Evans syndrome can occur as paraneoplastic manifestation especially in lymphoma/round cell neoplasia***)**

Anemia +/- thrombocytopenia with spherocytes/autoagglutination in dogs and hyperbilirubinemia, bilirubinuria. (*NOTE: cats do not get spherocytes in IMHA*)
Consider Onion/Garlic derivative ingestion if Heinz bodies present.

Prednisone (K9) Prednisolone (Feline): 2 mg/kg Sid/Bid initially x 3 weeks then attempt taper
Aspirin 0.5 mg/kg Sid owing to hypercoagulable state
Sucralfate 0.5-1 g po tid dogs, 0.5 g bid cats in slurry
Doxycycline if infectious suspected clinically or based on CBC path review:
Dogs, Cats: 10 mg/kg p.o. q24h with food or water bolus in cats

Long-term management dogs: Azothiaprine 2 mg/kg Sid or Cyclosporine 10mg/kg po sid bid



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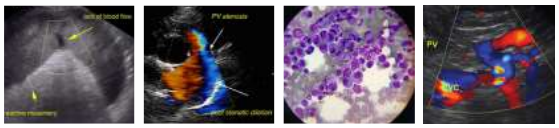

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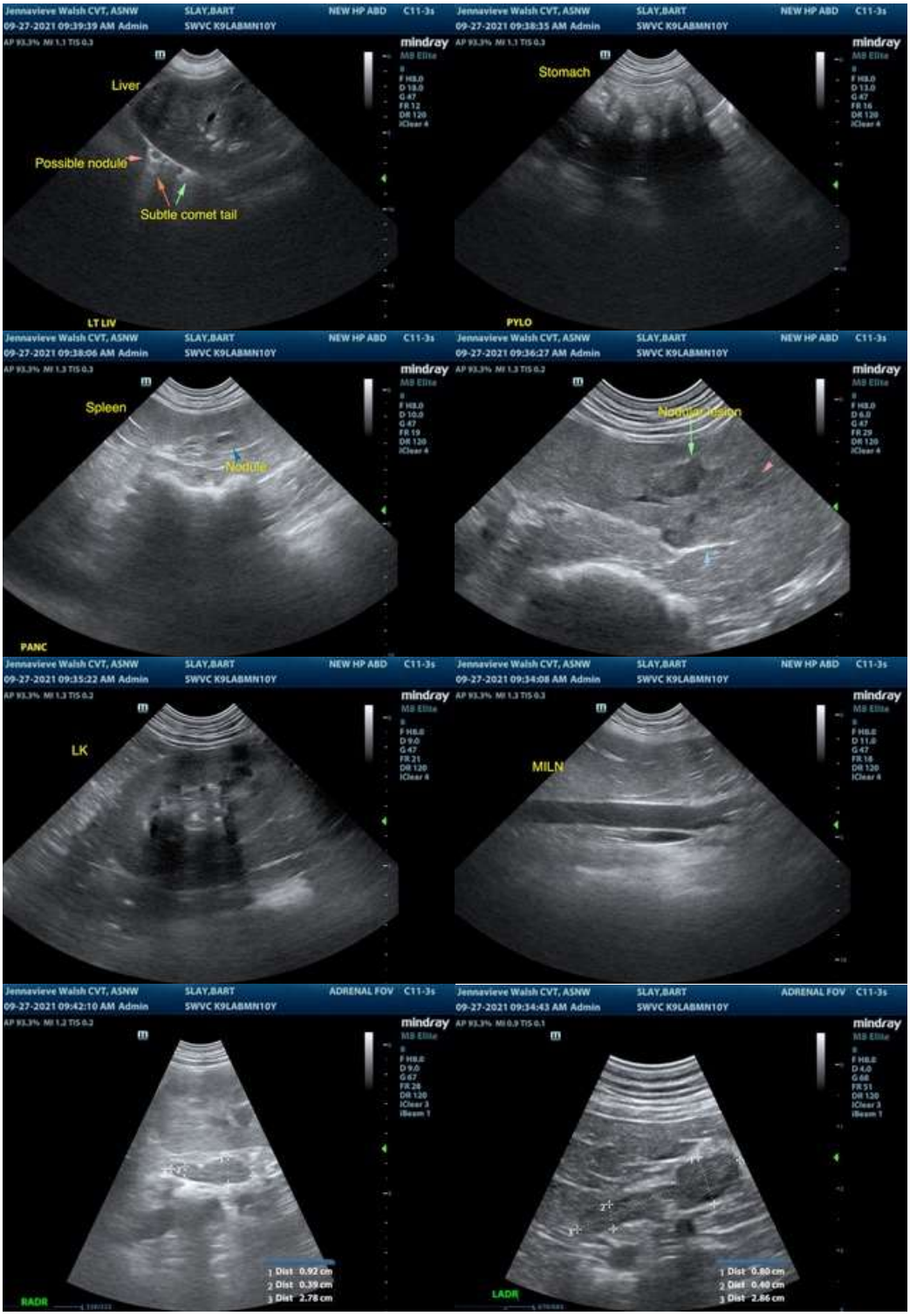

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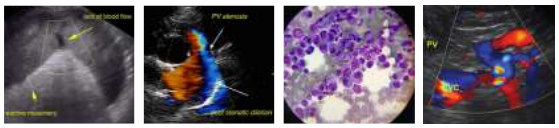

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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