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Clinical Sonography & Telecytology
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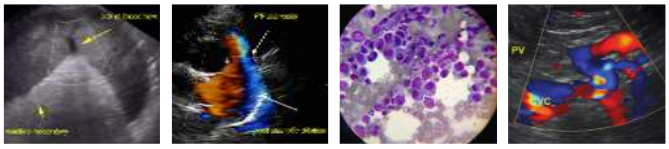

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1-800-838-4268 info@sonopath.com

PATIENT
Elliot Fry

SPECIES
Canine

BREED
Saint Bernard Mix

SEX
Neutered Male

AGE
10 years

WEIGHT
41 kg

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

IMAGING PERFORMED BY
Erin Wicks

HOSPITAL NAME
Shored Veterinary Emergency Center

REFERRING VET
Dr. Lupole

INVOICE
12318

DATE
9/28/21

PRESENTING CLINICAL SIGNS

Presented at our hospital for: D+ for almost a week. ADR, weight loss, muscle loss. PCV 80%???? at rDVM today. Vet Med reports for chest and abdomen rads attached. CBC showed non-regenerative anemia. PCV upon arrival to SHORES was 40%. Previous Health Concerns: No
Abnormal PE/Chem/CBC/UA Results: Abdominal: tender on cranial palpation Musculoskeletal: generalized weight loss Reg vet; Chem- ALT 187 (H) ALP 298(H) CBC: RBC 5.05(L) HCT 32%(L) HGB 12.5(L) plat 105(L) Rads- reg vet- decreased detail right quadrant; hip dysplasia, possible multiple punctate opacities in lungs, mild cardiomegaly, patch bronchointerstitial pattern

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and cystourethral junction exhibited normal thickness and tone. Minor particulate sediment was present, likely indicative of minor cellular or crystalline debris or potential minor mucus. 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 7.5 cm in length. The right kidney measured 7.5 cm in length.

Adrenal Glands

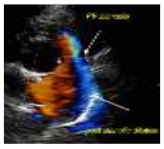
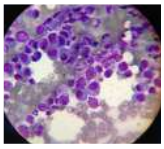
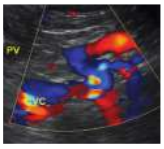
The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 3.2 cm length x 0.62 cm width at the caudal pole. No overt pathology was noted in the area of the right adrneal gland, although not definitively visualized.

Spleen

The spleen exhibited subjective mild generalized enlargement, generalized heterogeneous parenchyma, with intermittent non-expansive nonhomogeneous to subtly hypoechoic parenchymal nodules. An example of a splenic nodule measured 1.3 cm in diameter. Mild asymmetrical lateral and medial splenic capsule contour was present. Normal splenic vascularity was noted.

Liver/ Gallbladder

The liver presented enlarged in size with symmetrical yet swollen contour. The parenchyma exhibited conserved uniform parenchyma with normal echogenicity isoechoic to the spleen and falciform fat. The hepatic vasculature was dilated in appearance, most notable at the level of the hepatic vein / caudal vena cava junction, without evidence of thrombosis. The gallbladder was non-distended in size. Minor, nondependent, nonorganized, echogenic luminal debris was present. The gallbladder wall was thickened in appearance consisting of an echogenic double rim corresponding to the inner and outer portions of the wall. This is consistent with gallbladder wall edema. Possible causes may include acute

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inflammation, edema and anaphylaxis. The gallbladder wall width measured 0.43 cm. The common bile duct was normal.

Gastrointestinal

The stomach presented wall thickening secondary to echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. The gastric body wall measured 0.57 cm width. Mild gastric distension was noted. Minor retained echogenic ingesta was present in the gastric lumen.

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 width measured 0.50 cm.

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

Pancreas

The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

Free Abdomen

Generalized reactive mesentery along with mild to moderate subjective acellular to potentially mild cellular peritoneal free fluid.

Transdiaphragmatic view of the caudal thorax and heart revealed pericardial effusion.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Pericardial effusion on transdiaphragmatic view of the heart
- Congestive hepatopathy pattern with concurrent gallbladder wall edema
- Mild peritoneal free fluid and generalized reactive mesentery
- Generalized heterogeneous spleen with intermittent, nonspecific, heterogeneous nodules - hyperplasia, hematopoiesis, splenitis, infarction, or neoplasia possible
- Gastroenteritis pattern - potential edematous gastrointestinal tract

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the pericardial effusion noted on transdiaphragmatic view of the heart, the presentation of the liver, gallbladder, as well as concurrent peritoneal effusion most consistent with congestive hepatopathy and cardiogenic ascites, potentially secondary to cardiac tamponade, an overt cause of the pericardial effusion was not definitively evident. Concurrent possible primary hepatic parenchymal disease i.e., vacuolar hepatopathy, inflammatory hepatic parenchymal disease, hepatobiliary process, or less likely occult hepatic neoplasia cannot be definitively excluded. Correlation with peritoneal effusion analysis cytology +/- C/S is suggested.

Assuming normal clotting status, ultrasound guided FNA of the spleen using a 25-gauge needle Is warranted for screening cytology given the presence of pericardial effusion.

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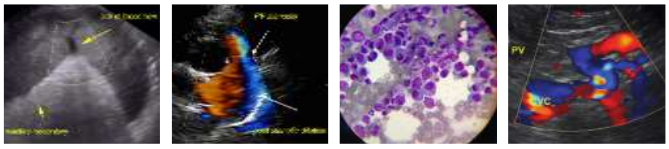

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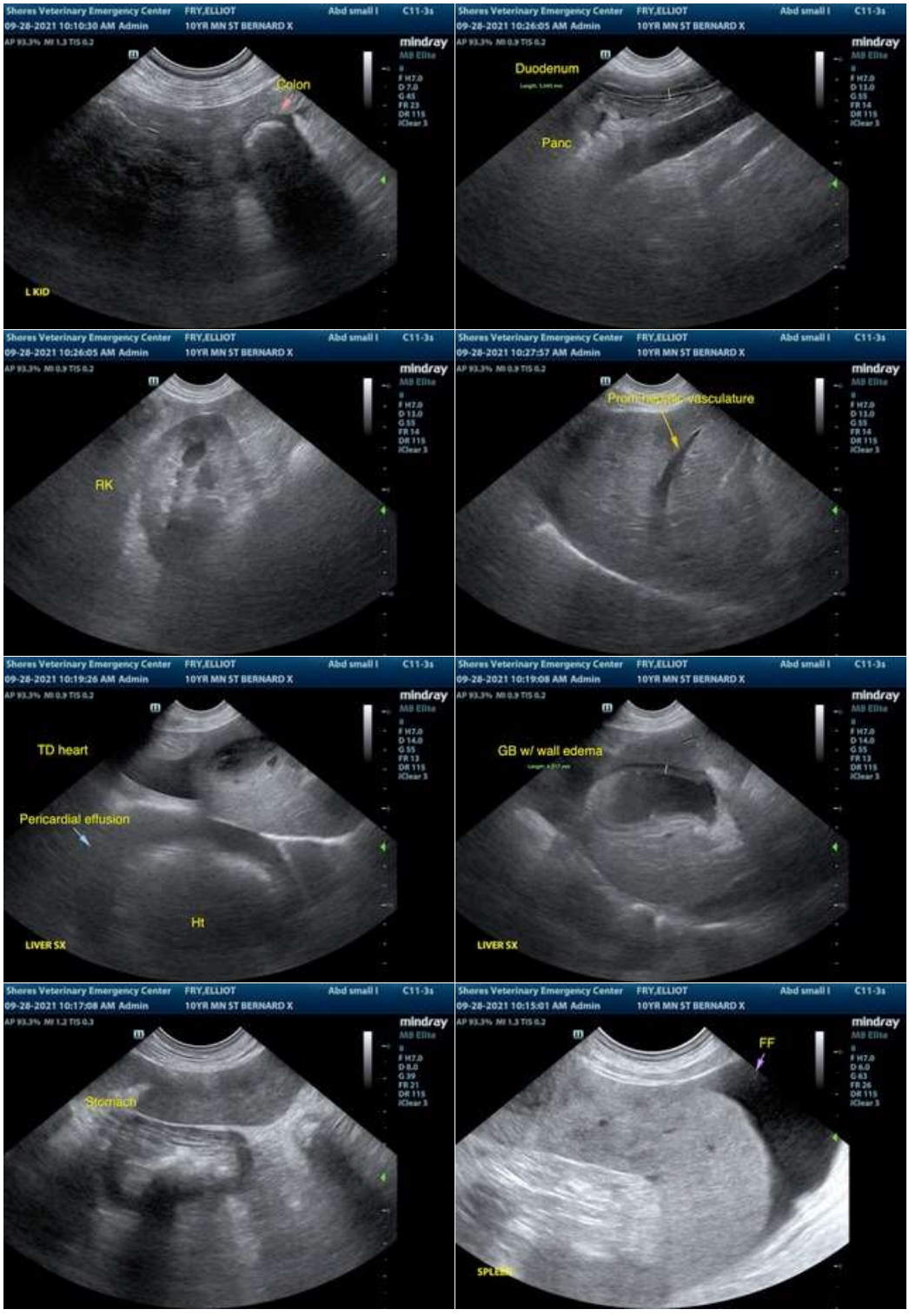
Further assessment would include full echocardiogram +/- pericardiocentesis. Assessment of albumin levels, if not done Is recommended. Continued GI support +/- a GI panel to include PLI/TLI/Cobalamin/Folate may be considered.



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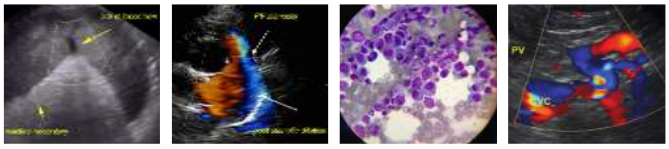

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@SonoPath.com