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Clinical Sonography & Telecytology
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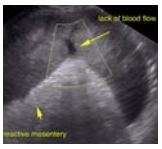
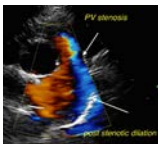
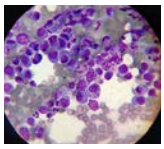
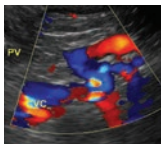

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1-800-838-4268 info@sonopath.com

PATIENT

Brady Thomas

SPECIES

Canine

BREED

Bull Terrier

SEX

Neutered Male

AGE

11 Years

WEIGHT

74 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Rachel Runnells, RVT

HOSPITAL NAME

SVS Imaging KC

REFERRING VET

Dr. Erin Miller

INVOICE

25278

DATE

9/9/21

PRESENTING CLINICAL SIGNS

9/8: Not eating well. Distended abdomen, clear fluid ascites aspirated from abdomen.
Abnormal PE/Chem/CBC/UA Results: 9/8: Chem- ALKP 324 (5-131), Potassium 5.6 (3.6-5.5), Precision PSL 143 (24-140). CBC- WBC 17.5 (4.0-15.5), PLT 463 (170-400), NEUT 13300 (2060-10600), MONO 1400 (0-840), T4 WNL. UA - Protein 2+, Microalbuminuria 9.8 (<2.5)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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

No overt pathology in the area of the residual prostate.

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 loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 5.9 cm. The right kidney measured 7.4 cm.

The area of the aortic trifurcation was free of pathology.

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 3.2 cm length x 1.2 cm at the caudal pole. The right adrenal gland measured 3.0 cm length x 0.96 cm at the caudal pole. No evidence of adrenal 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.

Liver

The liver presented 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 vasculature appeared to exhibit normal volume without evidence of congestion. In correlation, the cranial abdominal caudal vena cava did not appear to be distended in size, measuring 1.3 cm in diameter. The gallbladder was non distended in size with mild, echogenic, nonmineralized biliary sludge. The cystic duct and common bile ducts were normal without evidence of dilation.

Gastrointestinal

The stomach presented wall thickening secondary to echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. The stomach contained luminal gas along with mild retained anechoic fluid, subjectively within the pylorus. Pylorus wall measured 0.64 cm. Gastric body wall measured 0.54 cm.

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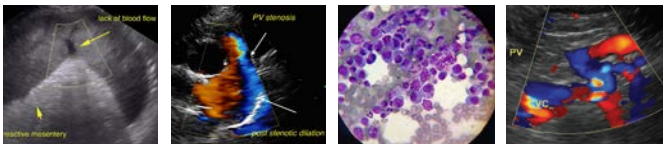

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The visualized small intestine presented intact wall layering with primarily maintained 1:3 muscularis/mucosa ratio. Intermittent subjectively mild mucosal speckling was noted. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material. No overt evidence of intestinal masses. Jejunum wall measured 0.52 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 noted along with moderate subjectively acellular to mildly cellular peritoneal free fluid. No overt lymphadenopathy.

Rapid view of the heart revealed no overt evidence of pericardial effusion, pericardial masses, or obvious right heart enlargement.

ULTRASONOGRAPHIC FINDINGS

- Mild subjectively non-congested hepatomegaly
- Mild gallbladder debris (non-mucocele)
- Mildly thickened gastric walls with minor retained pyloric fluid – non-specific, gastritis, edema, or potential early infiltrative mural process possible.
- Intact small bowel wall layering with intermittent mucosal speckling – non-specific, possibility for enteritis, minor inflammatory enteropathy.
- Moderate peritoneal free fluid with generalized reactive mesentery
- Moderate chronic renal changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Assuming normal albumin levels, and without evidence of passive hepatic or caudal vena congestion, lack of diffuse end stage hepatic disease, as well as no overt evidence of intestinal perforation or other pathology, an obvious cause of the effusion in this patient was not definitively evident. Effusion analysis cytology +/- culture and sensitivity if evidence of inflammatory cells as well as 3-view chest radiographs to asses cardiopulmonary status and rule out concurrent thoracic pathology recommended. Urine protein/creatinine ratio recommended to quantify degree of proteinuria. If subnormal albumin levels are present, and pending UPC, potential for intestinal protein loss may be a consideration in this patient.

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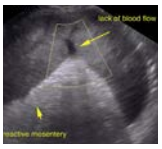
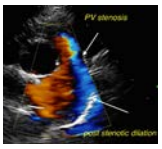
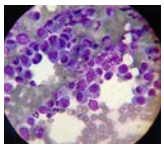
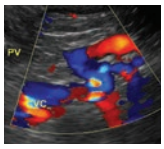

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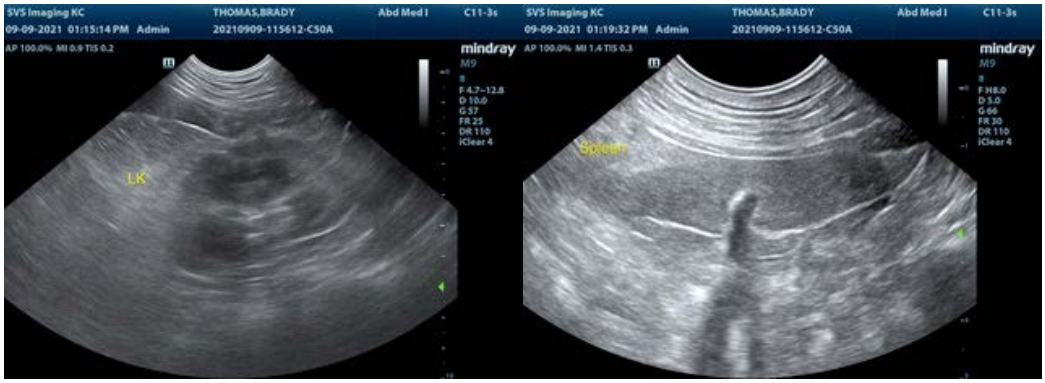

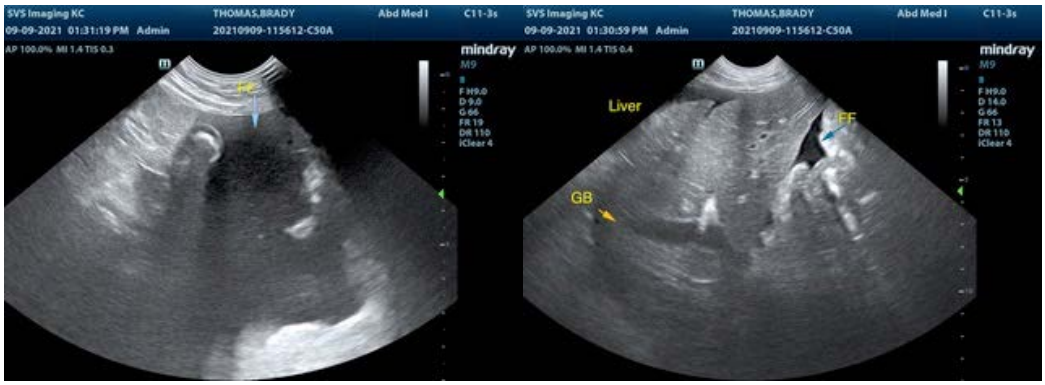

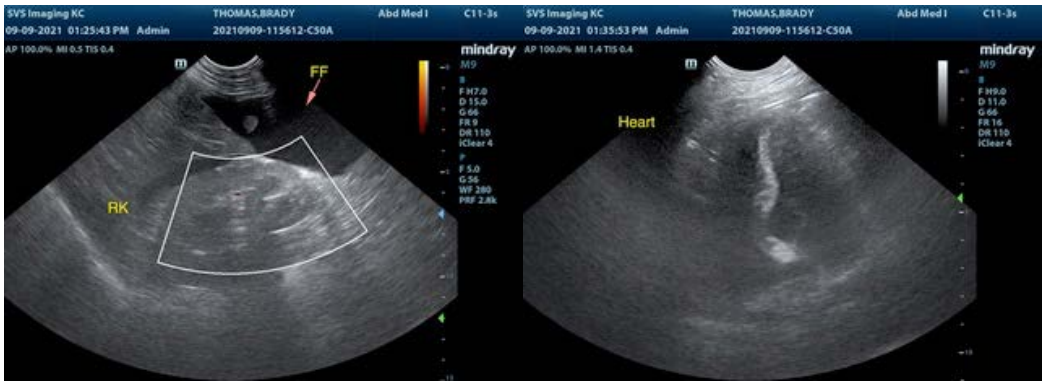

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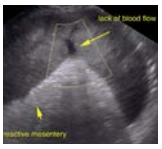
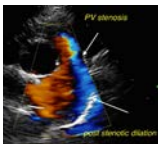
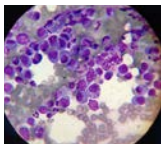
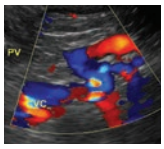

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@SonoPath.com