SonoPath Teleradiology

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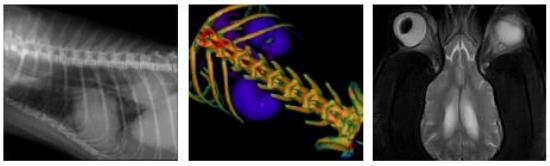


SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Harley Russell

SPECIES

Canine

BREED

Dachshund

SEX

Neutered Male

AGE

13 Years, 11 Months

INTERPRETED BY

Sebastian Schaub, DVM
Dr. med. vet. DipECVDI

HOSPITAL NAME

Neel Veterinary Hospital

REFERRING VET

Dr. Deepan Kishore

INVOICE

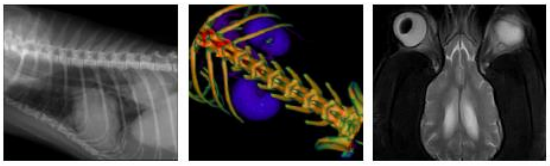
54475

DATE

10-5-22

PRESENTING CLINICAL SIGNS

Presented to NVH on 9/25/22 for lethargy and vomiting. Harley is being given DOCP injections for Addison's dz. Gave DOCP injection on 9/25/22 and sent home oral Metronidazole. Owner returned on 9/26/22 Returned this morning because still not feeling better. He only ate a few pieces of canned chicken on Sunday evening - had his metronidazole and prednisone pilled down him last night - no vomiting since injection. Today(9/26/22) still lethargic and not wanting to eat. Examination today stable - mm-pink / moist / tartar on teeth / temp-101.2 - We did an ultrasound, found a bladder stone , mild changes to both kidneys - everything else looked ok. Hospitalized on 9/26/22 started injectable Unasyn, Cerenia, metoclopramide, and gave dexamethasone sp. Stayed in hospital until 9/27/22 Went home returned on 9/28/22 for hospitalization and continuing not to eat or drink at home. Sent Harley back home on 9/29/22 due to his temperament and being stressed in the clinic. He returned on 9/30 for not improving at home with oral medications mirtazpine, metro, clavamox, carafate slurry. Patient has been in the ICU since 9/30/22. Blood glucose is not regulating. Currently on a 5% dextrose CRI with q 2hrs BG checks. He is being syringe fed. Having some green/brown diarrhea. Pet developed aspiration pneumonia and baytril was added. PER VOCN consult lowered dexsp dose, increase reglan, increase protonix to BID, added mirtazapine and discontinued buprenex. Continuing to monitor chest rads. Patient still currently hospitalized. Also continuing to consult with VOCN with any new updates. ABDOMINAL ULTRASOUND October 4, 2022: A total of 55 still images and 15 cine loops are available and compared to a prior study dated September 26, 2022. FINDINGS: An ovoid heterogeneous hypoechoic structure measuring 0.9 cm in height and 1.6 cm in length is present within the left abdomen. A heterogeneous hyperechoic nodule measuring 0.6 cm in height and 0.9 cm in length is present within the region of the pancreas and suspected to be within the pancreatic parenchyma. The remaining imaged portion of the pancreas is normal. Two hypoechoic nodules measuring approximately 0.9 cm in diameter and 0.4 cm in diameter are present cranial to the left adrenal gland and may represent the nodule seen in other still images or additional nodules. The gallbladder contains a similar volume of echogenic debris which is likely incidental. The gastrointestinal tract is normal. Similar decreased cortical medullary definition of the kidneys is unchanged. The kidneys are otherwise normal. The urinary bladder contains a moderate amount of free-floating echogenic debris. The previously identified calculus is not seen in a still image provided. The prostate is normal. The liver and spleen are normal. The adrenal glands measure normal in height (0.4 cm) in the current study. CONCLUSIONS: 1. The nodular structures within the left abdomen could be associated with the pancreas. Pancreatic nodules could represent a neoplastic process, and an insulinoma would be considered most likely if the patient is hypoglycemic. Benign nodular hyperplasia is also possible. Mesenteric lymphadenopathy or mesenteric nodules are also possible and could also represent a neoplastic process or reactive process. 2. Similar degenerative changes of the kidneys are present. 3. A moderate volume of urinary bladder debris is present and is of unknown clinical significance. 4. The adrenal glands are normal in size and the current study which is not considered to be clinically significant, and likely represents under-estimation of the adrenal gland size in the prior study. RECOMMENDATIONS: Fine-needle aspiration and cytology of the suspected nodules is recommended. Discontinuing the dextrose supplementation and monitoring for hypoglycemia with submission of insulin and glucose levels if the patient becomes hypoglycemic should be considered as this would be diagnostic for an insulinoma. A contrast CT with arterial and venous phases could also be considered to further corroborate an insulinoma as pancreatic nodules that are contrast enhancing in the arterial phase are highly suggestive of an insulinoma. 3 view thoracic radiographs could also be considered to evaluate for metastatic neoplasia. Consultation with an internal medicine specialist could be considered. A phone consultation with an IDEXX internal medicine specialist may be helpful.
Abnormal PE/Chem/CBC/UA Results: 9/25/22 CBC Reticulocyte Hemoglobin 31.9 pg PDW



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ALT 186 U/L ALP 1717 U/L 9/30/22 CBC MCH 26.2 pg lytes 3.3 mmol/L Chem ALP 622U/L CPL normal 10/04/22 CBC Reticulocytes 8.5 K/uL WBC 19/32 K/uL Neutrophils 16.74K/uL CHEM BUN 6mg/dL TP 3.4g/dL Globulin 1g/dL ALP 461 U/L Lytes chloride 123 mmol/L

COMPUTED TOMOGRAPHY OF THE NECK, THORAX AND ABDOMEN

A high resolution pre- and post-contrast CT study of the neck, thorax and abdomen are provided for review.

COMPUTED TOMOGRAPHIC FINDINGS

Thorax

Level with the intervertebral disc space C2/C3, mild heterogeneous hyperattenuating material is mildly bulging into the vertebral canal, distorting the ventral epidural space. Chronic remodeling of the vertebral endplates of C2/C3 is appreciated with a defect of the subchondral bone approximately in the midline.

The costal cartilages present moderate degenerative changes. Multiple lipomas are seen along the thoracic wall.

The sternal, cranial mediastinal and tracheobronchial lymph nodes are small elongated with a normal short-to-long-axis-ratio is < 0.5, the attenuation and contrast enhancement pattern is uniform and considered within normal limits.

The cardiovascular structures including the pulmonary vasculature are within normal limits.

The bronchial tree presents with regular branching and tapers uniformly towards the periphery as expected, the bronchial walls are thin and smooth. The bronchus-to-artery ratio is within normal limits.

The caudal part of the left cranial lung lobe and the right middle lung lobe present a mild decreased volume and multiple irregular regions of consolidation of the pulmonary parenchyma. The lung parenchyma presents the expected architecture and attenuation behavior.

Small incidental gas pockets are seen within the esophageal lumen, there is no evidence of abnormal dilation.

Abdomen

The serosal fat presents normal attenuation behavior. There is no evidence of peritoneal effusion or peritonitis.

Both kidneys present within normal limits for size, shape and organ architecture. After contrast administration a bilaterally symmetric and uniform nephro- and pyelogram is noted.

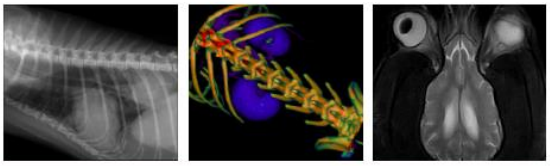
The adrenal glands are small and present moderate granulated mineralization of the parenchyma.

Both liver and spleen present with normal shape, even surface, uniformly attenuating parenchyma and homogeneous contrast enhancement, unremarkable.

The splenic lymph nodes are prominent and rounded.

The gallbladder contains a moderate amount of sedimented gallbladder sludge.

The pancreas is evenly contoured, the pancreatic parenchyma is homogeneous and presents



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uniform contrast enhancement.

The position, delineation, wall and content of the gastrointestinal tract are considered within normal limits throughout.

The vertebral endplates T13/L1 present moderate spondylosis formation. The intervertebral discs T11/T12 to L4/L5 are mildly to moderately protruding into the vertebral canal, distorting the ventral epidural space and mildly the dural tube at the same level.

COMPUTED TOMOGRAPHIC DIAGNOSIS

- History of Addison disease with advanced atrophy and dystrophic mineralization of the adrenal glands
- History os aspiration pneumonia
- Lymphadenopathy splenic lymph nodes
- Intervertebral disc protrusion T11/T12 to L4/L5 with compressive myelopathy
- Suspect history of ventral slot C2/C3
- Multiple lipomas along the thoracic wall

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The enlarged splenic lymph nodes can be a sequela to reactive hyperplasia or is due to neoplastic infiltration. Ultrasound guided FNA sampling would be ideal for further differentiation.

No abnormalities of the pancreas are appreciated, however this does not rule out insulinoma. If lab work is suggestive for insulinoma due to normal or high insulin levels despite low blood glucose values, diagnostic celiotomy with thorough palpation of the pancreas would be the next diagnostic step. Rule out low blood glucose levels being a sequela to Addison crisis as well.

The pulmonary changes are fitting the history of aspiration pneumonia.

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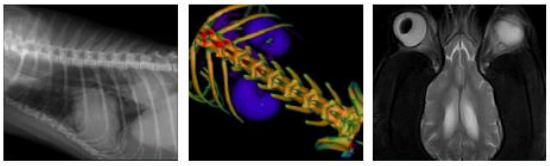

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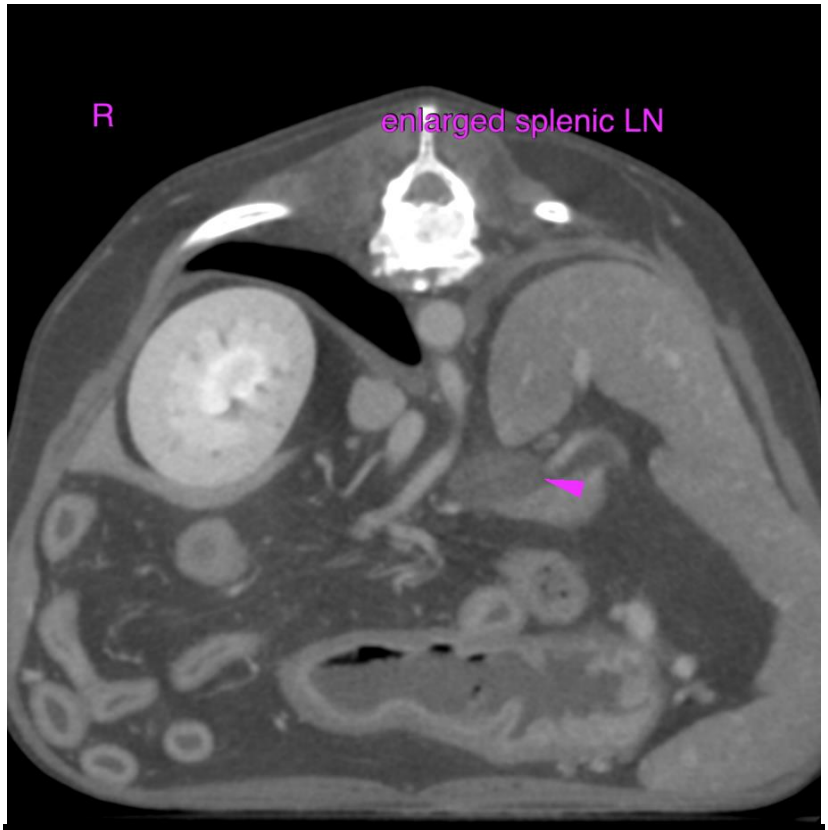

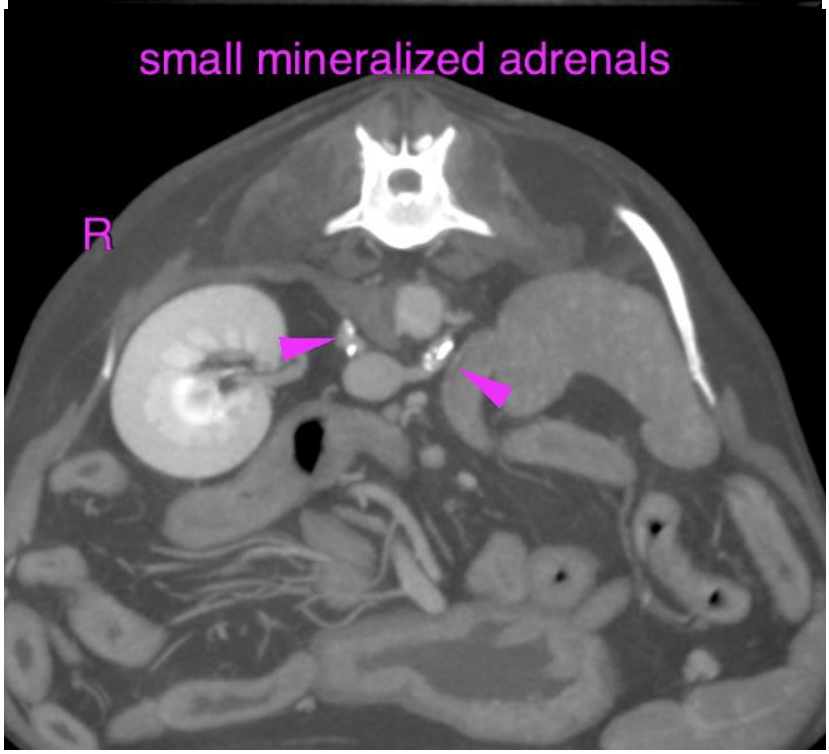

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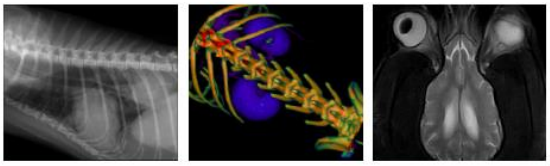

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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