CASE NUMBER: 04F-40-A3.2-30
DATE: May 21, 2004

HISTOPATHOLOGY:
Slide 13, A3.2-30-1:
1). Spleen, capsule: Peritonitis, moderate, multifocal, granulomatous with intralesional vacuoles and melanin granules
2). Liver, sinusoids: Congestion, mild, multifocal, random, acute

There are no overt lesions within the anterior kidney or heart.

Slide 14, A3.2-30-2:
1). Liver: Necrosis and hemorrhage, moderate, focal, acute

There are no overt lesions within the spleen, kidney or heart.

Slide 15, A3.2-30-3:
1). Spleen, as in slide 1, but less extensive

There are no significant lesions within the heart, liver or anterior kidney.

Slide 16, A3.2-30-4:
1). Spleen: As in slide 1.
2). Heart, compact ventricle: Myocarditis, moderate, focal, transmural, granulomatous, chronic

There are no overt lesions within the liver or kidney.

Slide 17, A3.2-30-5:
1). Pyloric caecae: Peritonitis, moderate, diffuse, granulomatous, chronic, with intralesional vacuoles

There are no significant lesions within the liver, spleen, kidney or heart.

Slide 18, A3.2-30-6:
There are no significant lesions within the spleen, kidney, liver, or heart.

Slide 19, A3.2-30-7:
There are no significant lesions within the liver, spleen, kidney or heart.

Slide 20, A3.2-30-8:
1). Liver: Hepatitis, marked, focally disseminate, granulomatous, chronic
2). Heart: Myocarditis, moderate, diffuse, granulomatous, chronic with reactive endocardia
3). Kidney: Nephritis, interstitial, marked, multifocal to coalescing, chronic with lymphomyeloid hyperplasia

4). Spleen: Lymphoid depletion, moderate, diffuse with ellipsoid histiocytosis

COMMENTS:
In 1of 8 sections, there is multisystemic granulomatous inflammatory infiltrate which would have contributed significantly to antemortem morbidity; based on the nature of the infiltrate and lack of discernible etiologic agents, *Renibacterium salmoninarum* would be a prime consideration and follow up culture, IFA, ELISA, or PCR may be considered. The splenic lymphoid depletion is attributed to peripheral mobilization of lymphocytes to nidi of inflammation and the reactive ellipsoids is likely due to persistent antigenemia. Although there is granulomatous infiltrate noted within the peritoneum of additional sections, the latter changes are considered post vaccination peritonitis.

FINAL REPORT