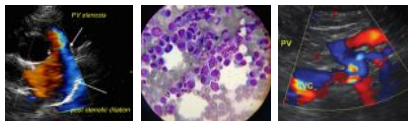
IMAGING PERFORMED BY

IntraPet.com



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DATE

1/20/2022

PATIENT

Yogi Schrekinger

SPECIES

Canine

BREED

Cocker Spaniel

SEX

Female Spayed

AGE

10-28-2008

WEIGHT

31.6 Lbs.

INTERPRETED BY

Andrea Nicastro, DMV, Diplomate DACVIM (Small Animal Internal Medicine)

HOSPITAL NAME

Belvedere Veterinary

REFERRING VET

Center Dr. Moulder

INVOICE

10170

PRESENTING CLINICAL SIGNS

History: Geriatric dog with long term heart murmur (managed at CVCA- mitral valve regurgitation- no current therapy), proteinuria, DJD, CCL Tear (surgically repaired), persistent blood work changes.

Current Medications: Omeprazole- 10mg SID, Enalapril- 10mg SID.
Lab Results: Previous blood works from- April, July, Nov, Dec: Alk Phos- 337, 189, 393, 374, ALT- 140, 65, 100, 326. The Alk Phos and cholesterol have remained consistent. Hypothyroid values in November have normalized and the pancreatic value (pPSL- 2000) has been greatly reduced. December labs attached separately.
Date of Previous IntraPet Ultrasound: No previous IntraPet scans.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

Imaging Performed By: Andi Parkinson, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are normal in thickness and the mucosal surface is smooth. The bladder lumen is moderately distended with anechoic urine. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal size (5.83 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. A 0.71 x 0.67 cm septated cortical cyst is observed. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney is normal size (5.53 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. A 0.71 x 0.67 cm septated cortical cyst is observed. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.84 cm at cranial pole) (0.92 cm at caudal pole) (2.08 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is mildly enlarged (0.85 cm at cranial pole) (0.91 cm at caudal pole) (2.23 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (1.40 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver
The liver is subjectively enlarged with swollen peripheral contours. The parenchyma is isoechoic relative to the spleen and exhibits a finely heterogenous pattern. No distinct focal lesions are observed. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

The gall bladder is distended. The wall normal in thickness. A large amount of aggregated echogenic suspended sludge is observed within the lumen, in a partially stellate pattern. The cystic and common bile ducts are normal/not seen.

Gastrointestinal
The gastric lumen is not distended. The gastric wall is normal in thickness with a normal layering pattern. The small intestinal lumen is segmentally dilated with gas and chyme. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas
The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely isoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Free Abdomen
The peritoneal cavity is normal. There is no evidence of inflammation or effusion. The abdominal lymph nodes are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Non-specific diffuse hepatopathy. Differentials could include inflammatory/immune-mediated disease, hepatotoxicosis (i.e., copper), Leptospirosis, infiltrative neoplasia (less likely) +/- concurrent age-related changes (i.e., vacuolar hepatopathy, regenerative hyperplasia).
- The gall bladder changes are consistent with a mucocele.
- Mild bilateral adrenomegaly

Secondary Findings

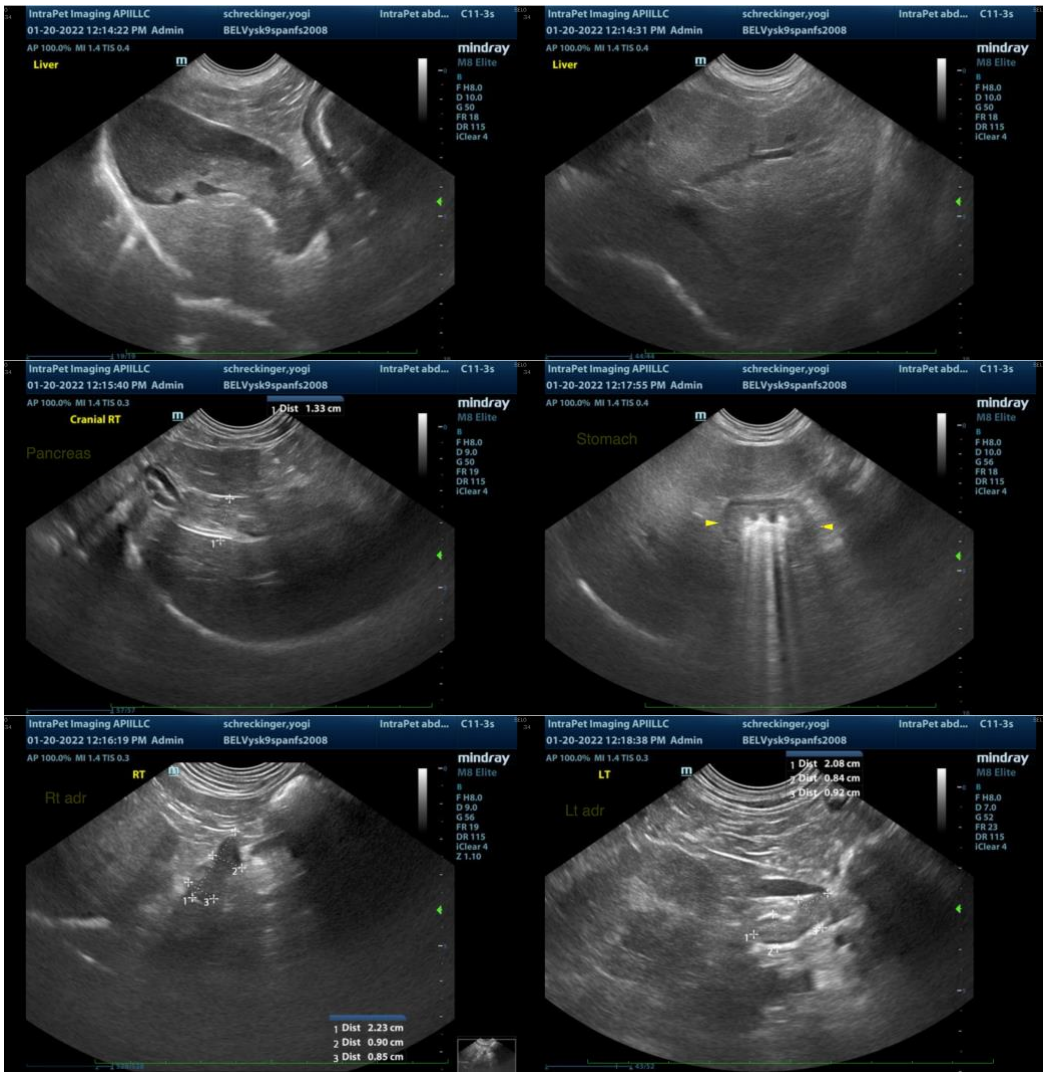
- Bilateral non-specific age-related renal changes
- Age-related pancreatic remodeling

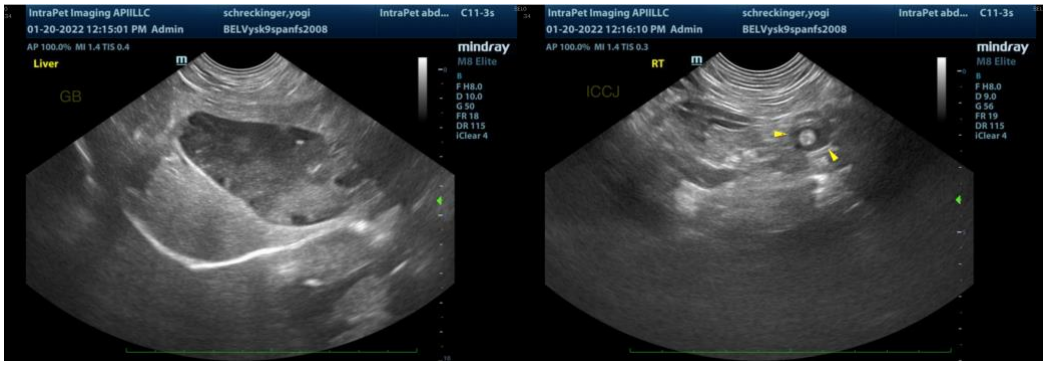
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Regarding the gall bladder, if an aggressive approach is desired, consider referral to a board-certified surgeon to discuss cholecystectomy and a liver biopsy.
- If a more conservative approach is desired, consider initiation of Ursodiol therapy along with broad-spectrum antibiotics and Denamarin with follow-up bloodwork in 7-10 days. If the ALT does not improve during that time period, antibiotics can be discontinued. Regardless, if surgery is not

pursued, a repeat ultrasound is recommended 4-6 weeks to assess for progression of the gall bladder changes.

- Also consider a fine-needle aspirate of the liver, if clotting status is appropriate, particularly if surgery is not pursued at this time.
- Consider testing for hyperadrenocorticism with a low-dose dexamethasone suppression test or ACTH stimulation test if clinical signs (i.e., PU/PD) develop in the future.
- Three-view thoracic radiographs should be performed prior to any anesthetic event.





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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