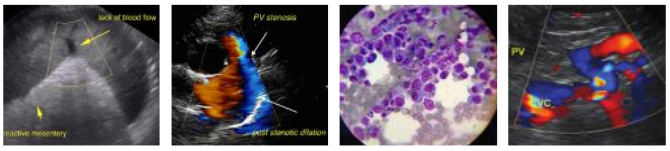
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Mercedes Cabral

SPECIES

Canine

BREED

Bichon Frise

SEX

Female Spayed

AGE

15 years

WEIGHT

7.5 kg

INTERPRETED BY

Andrea Nicastro, DVM, Diplomate ACVIM (*Small Animal Internal Medicine*)

IMAGING PERFORMED BY

Dr Belan

HOSPITAL NAME

Legacy Vet. Clinic

REFERRING VET

Dr Woo

INVOICE

10214

DATE

1/27/22

PRESENTING CLINICAL SIGNS

History: Anorexic lethargic and intermittent vomiting for 3 days. Hospitalized and on fluids plus cerenia ampicillin metronidazole and mertazapine and zentonil. Torn for scan
Abnormal PE/Chem/CBC/UA Results: Severe elevation of ALPK and moderate elevation of liver enzymes and leukocytosis

45 still images and 7 videoclips are available for interpretation.

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 (4.38 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. Trace pyelectasia is mild (0.29 cm in the transverse plane). A 0.70 cm cortical cyst is observed at the medial aspect. There is no evidence of nephroliths, infarcts or hydroureter.

The right kidney is normal size (4.69 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. Trace pyelectasia is present (0.20 cm in the transverse plane). There is no evidence of nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland mildly enlarged (0.72 cm at cranial pole) (0.64 cm at caudal pole) (2.15 cm in length); with a slightly irregular shape. A 1.14 x 0.72 cm irregular hyperechoic nodule is observed in the mid-aspect. In addition, a 0.65 x 0.65 cm hyperechoic nodule is observed at the caudal pole Surrounding vasculature appears normal.

The right adrenal gland is mildly enlarged (0.50 cm at cranial pole) (0.69 cm at caudal pole) (1.98 cm in length); with anormal shape and smooth peripheral contours. A 0.83 x 0.53 cm hypoechoic nodule/area is observed at the caudal pole. Glandular echogenicity and detail at the cranial pole are normal. Surrounding vasculature appears normal.

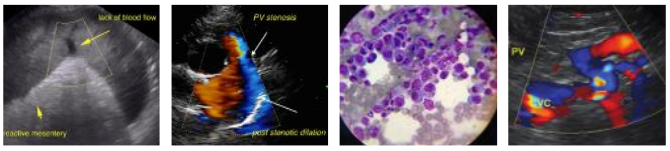
Spleen

The spleen is normal in size (1.28 cm in width at the level of the hilus) with a normal capsular contour. The parenchyma is slightly mottled in appearance. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively prominent in size with slightly swollen contours. The parenchyma is hypoechoic relative to the spleen and subtly heterogenous in appearance with a few ill-defined hyperechoic areas. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion. The portal vena to cava ratio is approximately normal 1:1.

The gall bladder lumen is distended. The wall is thickened (up to 0.40 cm), hyperechoic and irregular. A moderate to large amount of aggregated echogenic suspended sludge is observed within the lumen.



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The mesentery effacing the serosal surface is hyperechoic. Trace free fluid is observed in this region. 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 not dilated. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. There is no obvious evidence of an obstructive pattern.

Pancreas

The base and limbs of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely hyperechoic 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

Trace free fluid is observed. The mesentery in the cranial abdomen is hyperechoic. A 0.65 cm cranial abdominal lymph node is visualized. In addition, 2 to 3 prominent mesenteric nodes are seen, the largest measuring 0.65 cm in length.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

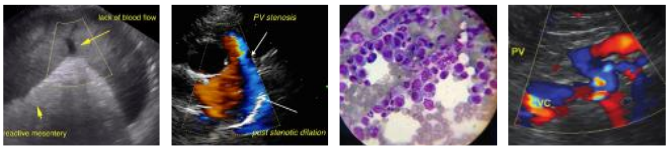
- The gall bladder changes are most consistent with severe cholecystitis with intraluminal sludge and regional peritonitis.
- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory and infiltrative disease are considered less likely.
- The bilateral adrenal changes could be consistent with benign nodular hyperplasia. Alternatively emerging neoplasia is possible.

Secondary Findings

- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The lymph node changes are most consistent with reactive lymphadenitis or lymphoid hyperplasia.
- Bilateral chronic regenerative renal changes with trace pyelectasia.
- The splenic parenchymal changes are most consistent with lymphoid hyperplasia or extramedullary hematopoiesis with a lower possibility of emerging neoplasia (i.e., round cell tumor)

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess cardiopulmonary status, particularly given the patient's age.



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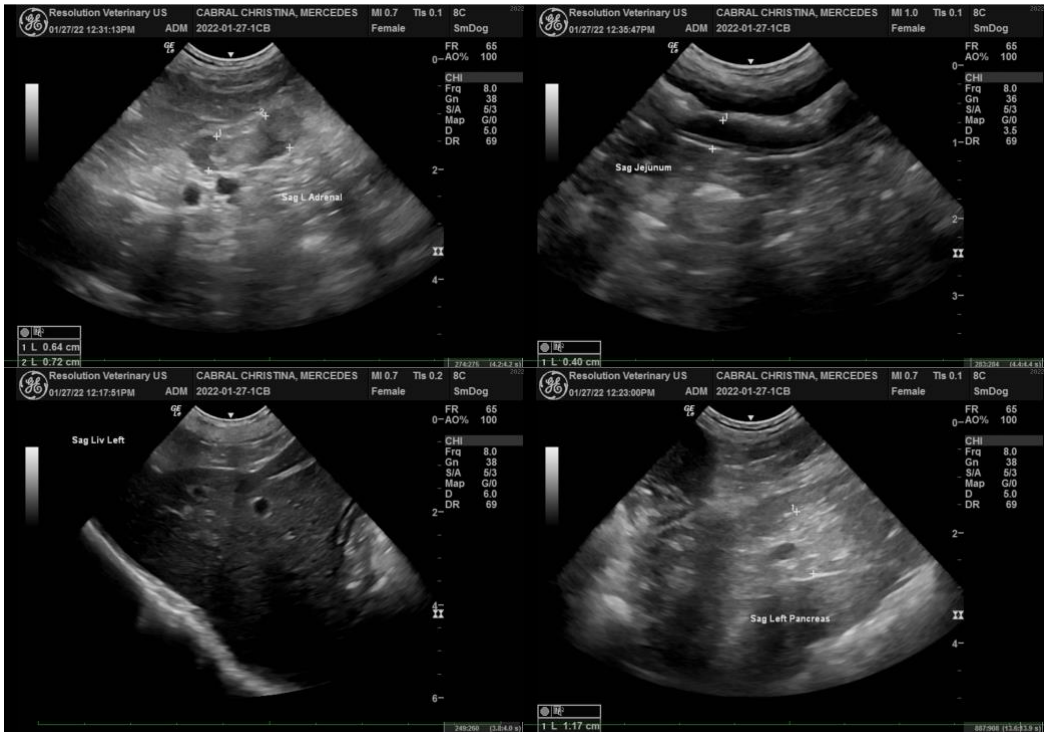
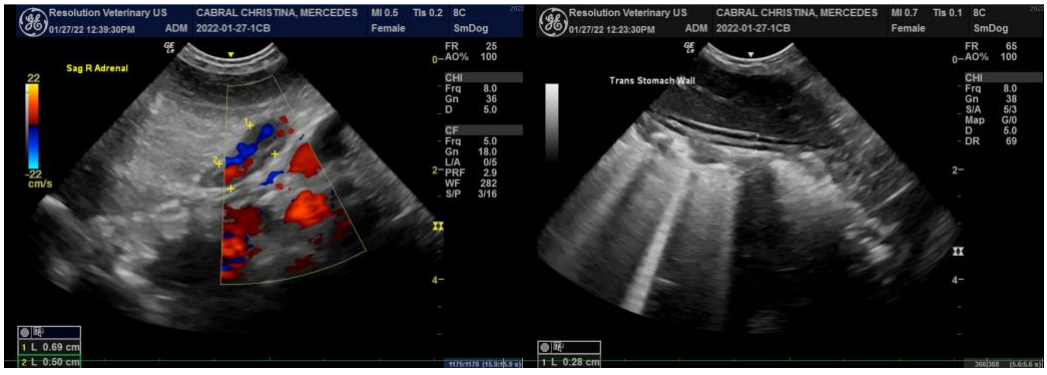
- Aggressive supportive care for acute cholecystitis is recommended, including fluid therapy, broad-spectrum antibiotics, antiemetics, gastric protectants and pain medication as needed.
- Serial sonographic monitoring (i.e., daily) of the gall bladder is recommended to assess for progression/rupture.
- Also consider a malabsorption panel including serum cobalamin and folate PLI and TLI to further assess for concurrent pancreatitis and small intestinal disease.
- 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.





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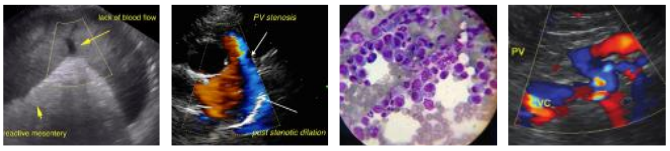

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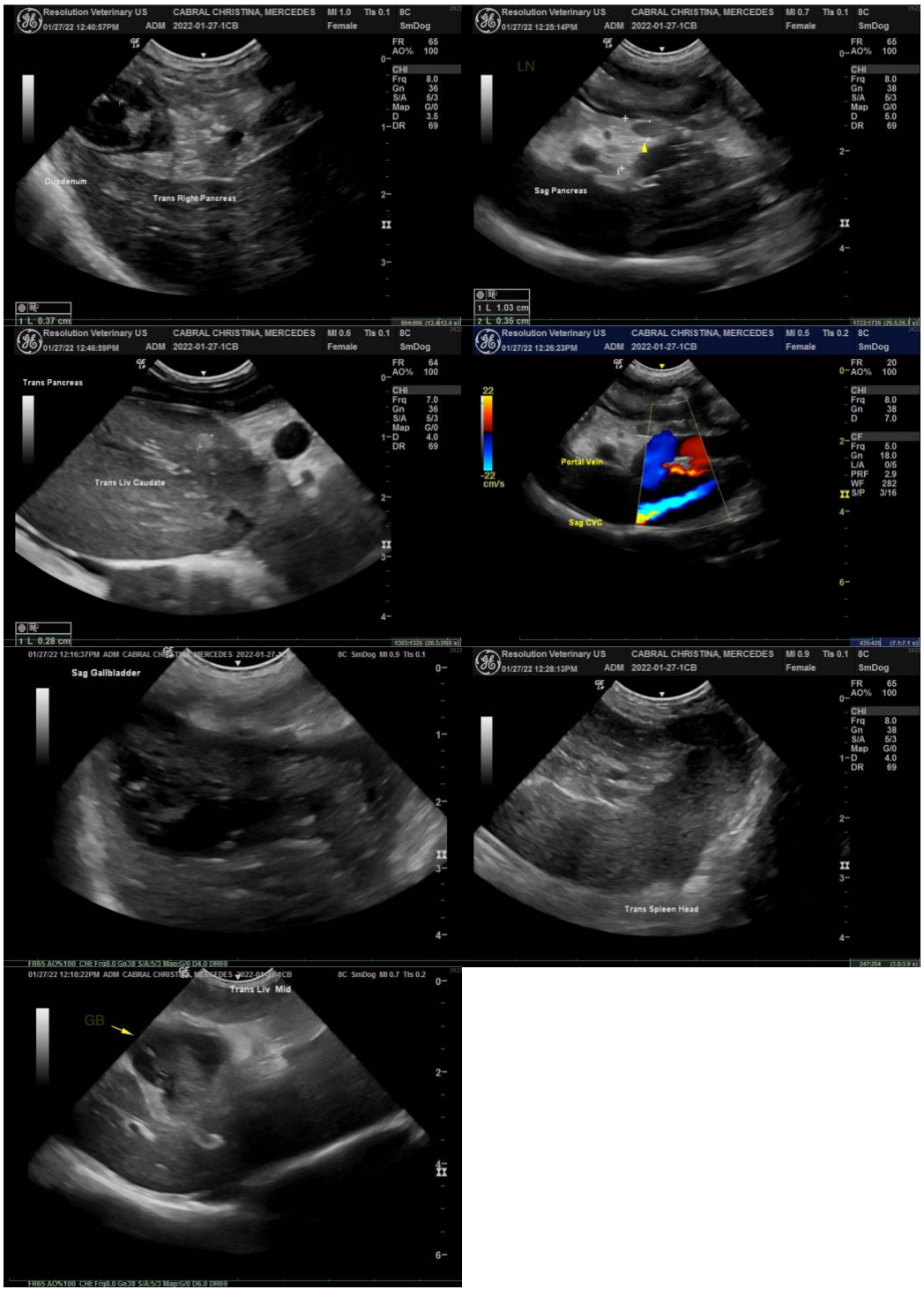
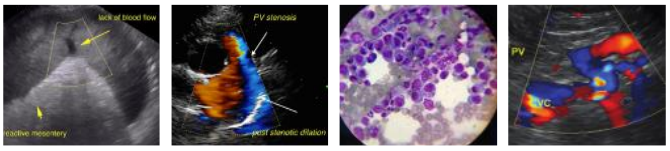


The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I



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can be of any further assistance, please contact me.

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