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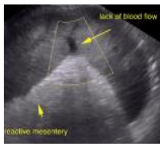
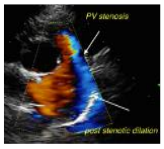
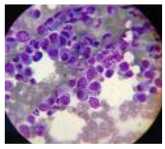
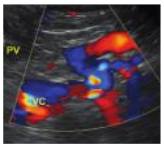

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Cooper Stayrook

SPECIES

Canine

BREED

Shih Tzu

SEX

Neutered Male

AGE

13 Years 1 Month

WEIGHT

13.6 Lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Potomac Mobile Veterinary Ultrasound

HOSPITAL NAME

Banfield Leesburg Village

REFERRING VET

Dr. Jarrett

INVOICE

13491

DATE

PRESENTING CLINICAL SIGNS

History: Weight loss, elevated ALKP, decreased appetite, and chronic kidney disease.
Abnormal PE/Chem/CBC/UA Results: CHEM: ALKP 956, CREA 1.9, TBIL <0.1 (01/12/2022).

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly to moderately distended. The wall in the region of the apex is mildly thickened (up to 0.34 cm) and irregular. Hyperechoic to mineralized foci are observed within the thickened portion of the wall. The wall tapers to a normal thickness as it extends toward the urinary bladder neck. A scant amount of echogenic debris is observed within the lumen. No cystic calculi are observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The prostate is normal in size (1.75 cm in length x 0.68 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is small in size (2.90 cm in length); with a relatively irregular shape. The cortex is variably thickened and there is poor corticomedullary distinction. A few complex cortical cysts are present. Several non-obstructive nephroliths are visualized. Trace pyelectasia is present. There is no evidence of hydroureter. Renal vasculature is normal.

The right kidney is small in size (2.94 cm in length); with a relatively irregular shape. The cortex is variably thickened and there is poor corticomedullary distinction. A cortical cyst is observed at the lateral aspect. Several non-obstructive nephroliths are visualized. There is no evidence of pyelectasia or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.65 cm at cranial pole) (0.66 cm at caudal pole) (2.15 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 normal size (0.56 cm at cranial pole) (0.46 cm at caudal pole) (1.79 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 (0.89 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

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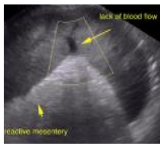
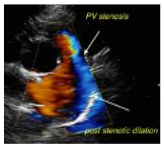
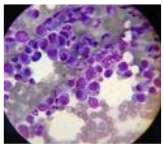
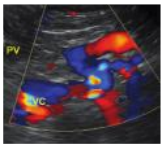

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The liver is subjectively prominent to enlarged with rounded peripheral contours. The parenchyma is isoechoic relative to the spleen and subtly heterogeneous in appearance with a few small ill-defined hypoechoic nodules/areas. A few lobar biliary stones are present. Hepatic vasculature is of normal volume with no evidence of congestion.

The gall bladder lumen is moderately distended. The wall is thin and smooth. A small to moderate amount of aggregated echogenic to mineralized partially dependent debris/sludge is observed within the lumen. The cystic and common bile ducts are normal.

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. 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. A 0.83 cm medial iliac lymph node is visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Bilateral chronic renal changes with nonobstructive nephrolithiasis and cortical cysts
- 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 unlikely. Intrahepatic biliary stones- incidental.
- Gallbladder debris, non-mucocele

Secondary Findings

- Age-related pancreatic remodeling +/- fibrosis. Concurrent low-grade pancreatitis may be present, particularly if the patient exhibits discomfort on cranial abdominal palpation.
- The urinary bladder wall thickening with mineralization could be consistent with cystitis. However, emerging neoplasia (i.e., transitional cell carcinoma) cannot be completely excluded. Correlation with clinical findings is recommended.
- Mild left adrenomegaly

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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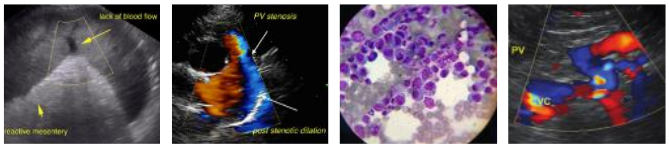

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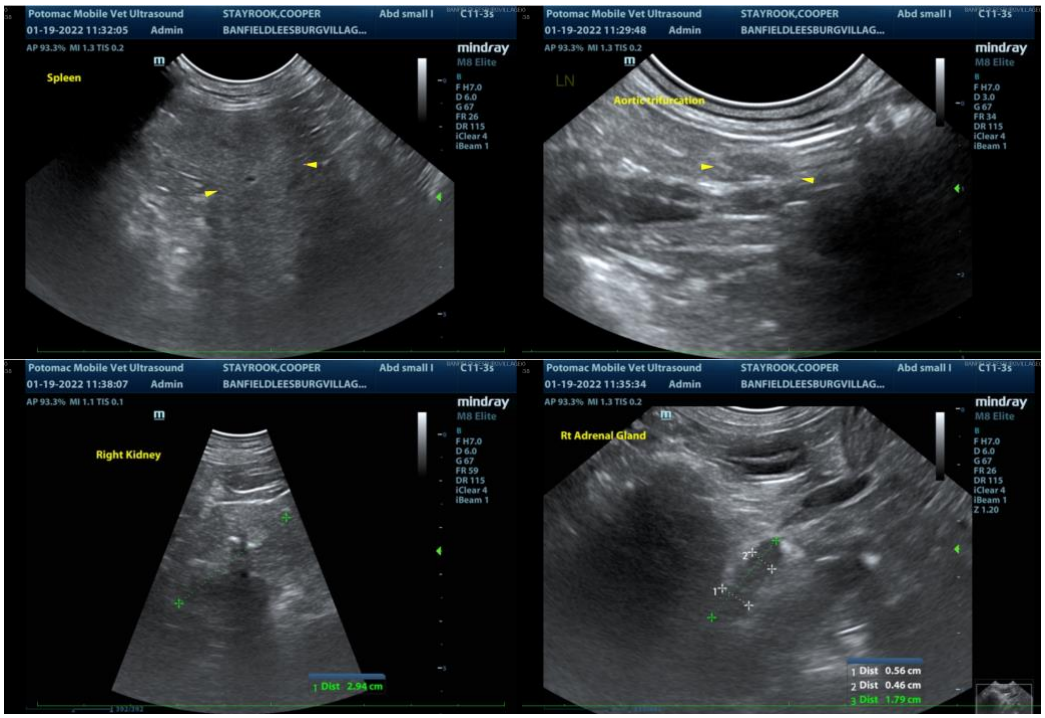
- Regarding the renal disease, consider the following:
    1. Urine culture and sensitivity to assess for occult pyelonephritis
    2. UPC (if proteinuria is present)
    3. Baseline blood pressure measurement
- Regarding the urinary bladder wall changes, consider a urine BRAF test to further evaluate for lower urinary tract neoplasia.
- Regarding the weight loss, consider the following:
    1. Three-view thoracic radiographs to assess for occult neoplasia in the chest
    2. Malabsorption panel, including serum cobalamin, folate, TLI and PLI
    3. Fecal evaluation for ova and Giardia



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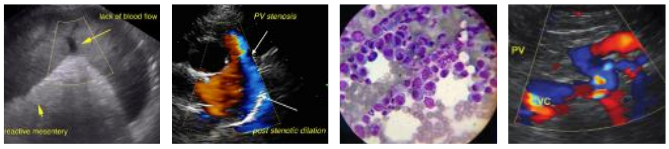

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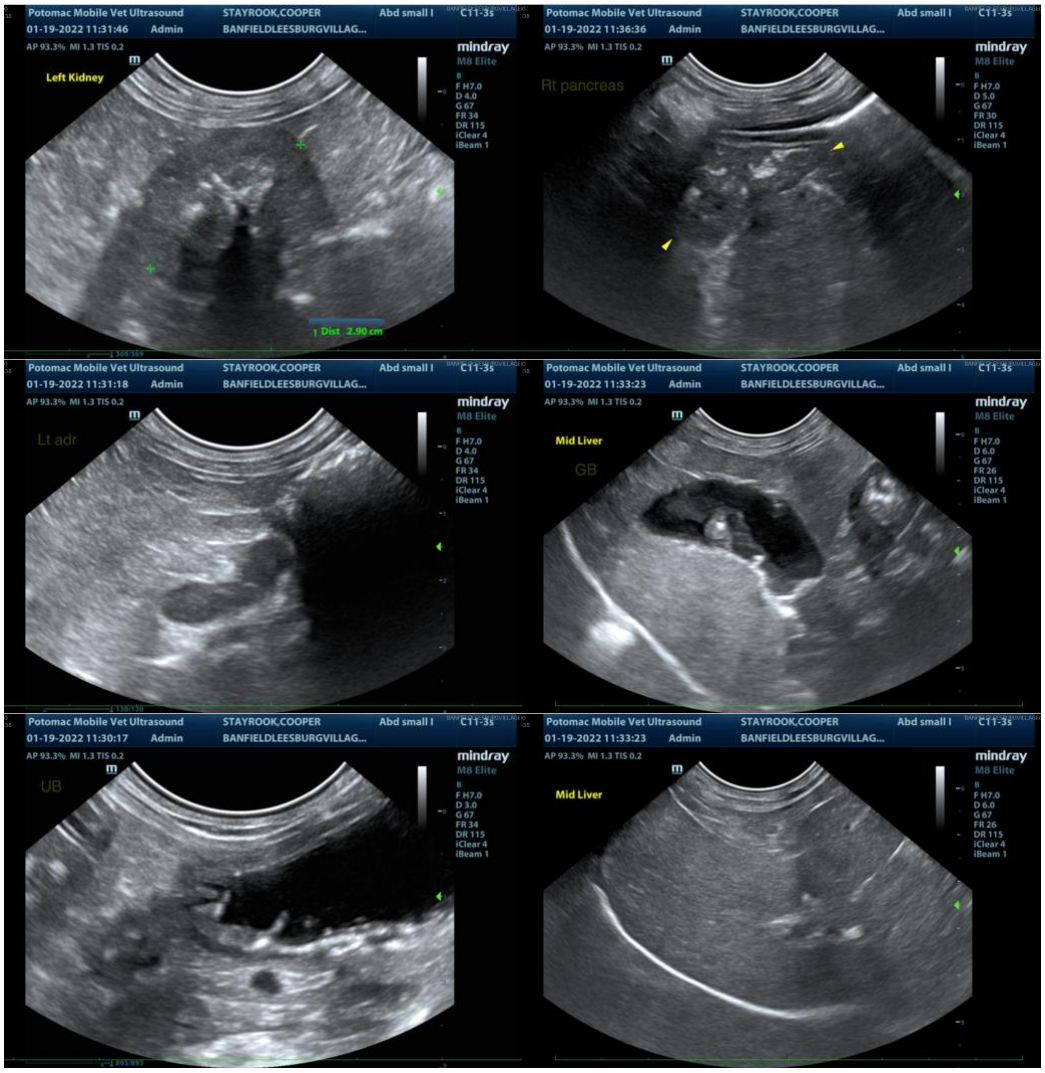

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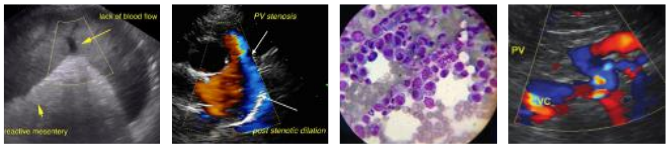

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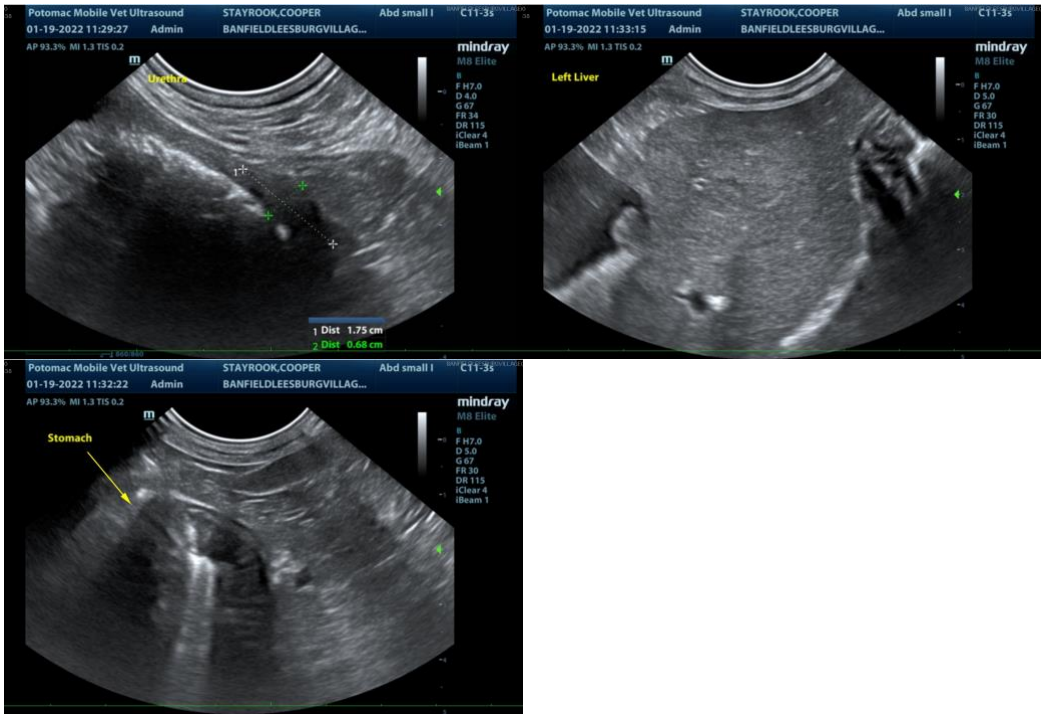

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

andrea_nicastro2@hotmail.com