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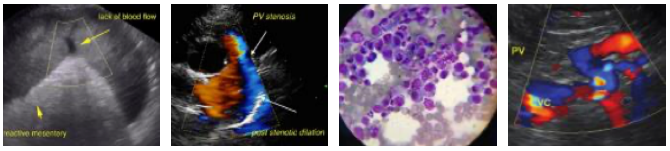
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Alondra Valdes

SPECIES
Canine

BREED
Miniature Dachshund

SEX
Female, spayed

AGE
13 Yrs.

WEIGHT
15.5 lbs.

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

IMAGING PERFORMED BY
Dr. Ferrer

HOSPITAL NAME
Paseos VC

REFERRING VET
Dr. Torres

INVOICE
14101

DATE
10/18/22

PRESENTING CLINICAL SIGNS

History: Presented as a referral for an abdominal ultrasound to evaluate increased liver enzymes. Pt has had progressive increase liver enzyme, especially ALP. The findings were noticed during screening for a dental cleaning and it was Incidental finding. Currently on Denamarin advanced, weekly sq fluids, Dasuquin.
Abnormal PE/Chem/CBC/UA Results: On July 28, 2022 Chemistry profile was done prior dental cleaning ALP (494 U/L) , High BUN (45mg/dL) , High Creatinine (1.5 mg/dL) On 10-14-21 ALP was 375.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is moderately distended. The wall is normal in thickness. The mucosal surface in the region of the apex is slightly irregular. A scant amount of gravity-dependent mineralized sand is observed within the lumen. The region of the trigone and the visible portion of the proximal urethra are normal.

The left kidney is normal size (4.79 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. Hyperechoic shadowing diverticular foci are visualized. A small cortical cyst is seen. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney is normal in size (5.24 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is mild to moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. Trace pyelectasia is present. There is no evidence of infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is borderline enlarged (0.56 cm at cranial pole) (0.56 cm at caudal pole); 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.

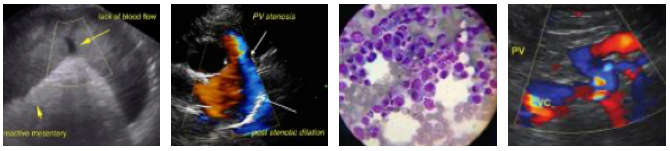
The right adrenal gland is mildly enlarged (0.96 cm at cranial pole) (0.64 cm at caudal pole)(2.33 cm in length) with a normal shape and smooth peripheral contours. The parenchyma is subtly heterogeneous with some loss of glandular detail. No focal lesions are observed. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (1.05 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. Myelolipomas are observed adjacent to the vessels. Splenic vasculature is normal.

Liver

The liver is subjectively prominent in size with normal curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and subtly heterogeneous in appearance. A 0.78 cm ill-defined hyperechoic nodule is observed on the left side. Vascular and biliary tracts are of normal volume with no evidence of congestion. The portal vein: caudal vena cava ratio is approximately 1:1. The gall bladder lumen is moderately distended. The wall is thin and smooth. A moderate to large amount of



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aggregated echogenic partially dependent sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. 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 colonic wall is normal. No obstructive disease is noted.

Pancreas

The right limb 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

There is no evidence of free fluid. The abdominal lymph nodes are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The gallbladder sludge may be secondary to an emerging mucocele, cholestasis or less likely, fasting.
- Suspected benign diffuse hepatopathy. Top differentials include vacuolar hepatopathy and/or regenerative nodular hyperplasia. Inflammatory disease is considered less likely in light of the normal ALT. Infiltrative neoplasia is possible but also considered less likely given the sonographic appearance of the liver.

Secondary Findings:

- Mild bilateral adrenomegaly.
- Bilateral, chronic renal changes with dystrophic mineralization.
- Scant urinary bladder sand.
- Age-related pancreatic remodeling with suspected fibrosis.
- Chronic low-grade pancreatitis may also be present, particularly if this diagnosis fits with the patient's clinical history.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Serial monitoring (i.e., every 3-4 months) of the patient's liver values is recommended. If liver values continue to increase, a repeat abdominal ultrasound +/- hepatic tissue sampling may be warranted.

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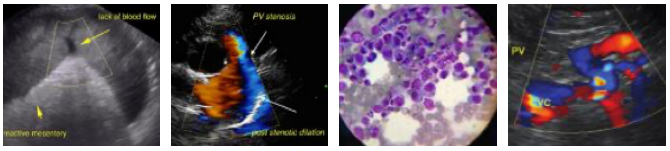

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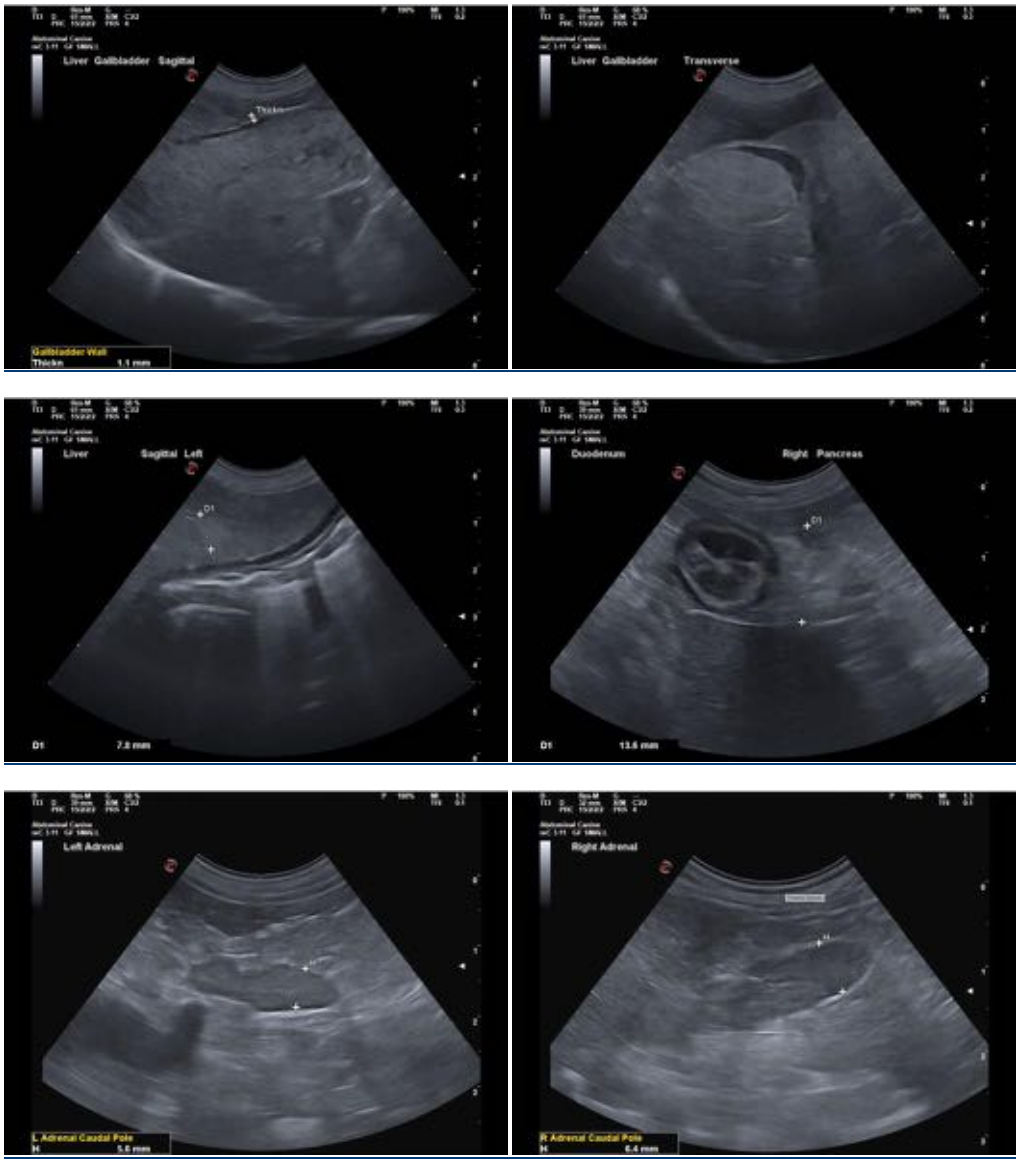
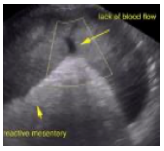
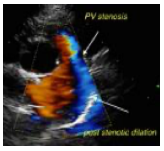
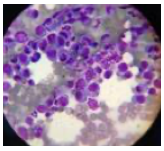
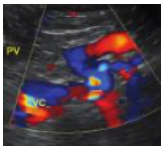
- Given the gall bladder changes, Ursodeoxycholic acid (Ursodiol) at 10-15 mg/kg once a day should be considered. Serial sonographic monitoring (e.g., every 4-6 weeks) of the gall bladder is recommended to assess for progression to a fully-formed mucocele.
- If the patient is exhibiting clinical signs of Cushing's disease (i.e., PU/PD), consider further testing (i.e., a low-dose Dexamethasone suppression test).
- A urinalysis is also recommended (if not already performed) to assess for isothenuria, proteinuria, etc.



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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