SonoPath
Clinical Sonography & Telecytology
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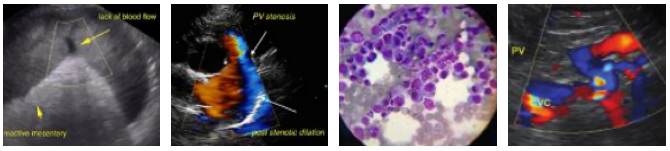

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Winston Davis

SPECIES
Canine

BREED
Cocker spaniel

SEX
Male, neutered

AGE
14 years

WEIGHT
25 lbs

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

IMAGING PERFORMED BY
Potomac Mobile Veterinary Ultrasound

HOSPITAL NAME
Hoof and Paw VH

REFERRING VET
Dr. Jarrett

INVOICE
12407

DATE
10/25/21

PRESENTING CLINICAL SIGNS

History: Abdominal distension concern for possible ascites. Received gabapentin and trazadone prior to ultrasound.
Abnormal PE/Chem/CBC/UA Results: ALP 321, PSL 440, platelet 622 , lymphocytes 8 USG 1.012

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. A scant amount of echogenic debris is suspended within the lumen. 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 prostate is normal in size (2.00 cm in length; 1.01 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal in size (5.43 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal in size (5.67 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is enlarged (1.20 cm at cranial pole) (0.84 cm at caudal pole) (4.09 cm in length) with an irregular shape. A 2.10 x 1.01 cm irregular hyperechoic nodule is observed at the cranial aspect. The nodule causes capsular expansion. Glandular echogenicity and detail at the caudal pole are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is mildly enlarged (0.63 cm at cranial pole) (0.77 cm at caudal pole) (2.20 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 (1.29 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A 0.47 x 0.44 cm hypoechoic nodule is observed approximately mid-spleen. Splenic vasculature is normal.

Liver

The liver is subjectively prominent in size with swollen curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and exhibits mild heterogeneity. A few ill-defined hypoechoic nodules/areas are observed. Hepatic vasculature and biliary tracts are of normal volume with no evidence of congestion. The gall bladder lumen is moderately distended. The wall is normal in thickness. A moderate amount of aggregated echogenic sludge, some of which is partially dependent and some of which is adherent is observed within the lumen. The common bile duct is mildly dilated (up to 0.52 cm in diameter) but can be seen entering the duodenal papilla, which is thickened (0.63 cm in width).

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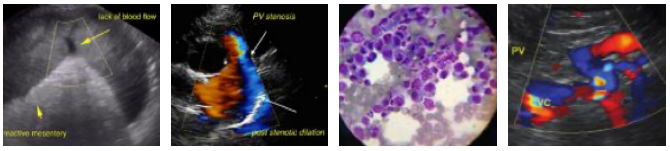

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Gastrointestinal

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 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. 2-3 jejunal lymph nodes are visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- 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 gallbladder sludge could be consistent with cholestasis, early mucocele formation or fasting.
- Mild common bile duct dilation without evidence of intraluminal obstruction.
- Mild bilateral adrenomegaly. The left adrenal nodule is most consistent with a benign process (i.e., nodular hyperplasia) with a lower possibility of an early neoplastic process.

Secondary Findings:

- Bilateral age-related degenerative renal changes with dystrophic mineralization.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The splenic nodule trends toward the benign (i.e., focus of lymphoid hyperplasia or extramedullary hematopoiesis) with a lower possibility of emerging neoplasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Consider testing for hyperadrenocorticism with a low-dose dexamethasone suppression test or ACTH stimulation test if clinical signs (i.e., PU/PD) develop.
- Given the gallbladder changes, consider Ursodiol, broad spectrum antibiotic therapy (as empirical treatment for cholecystitis) +/- hepatic antioxidants with a recheck ultrasound in 4 weeks.

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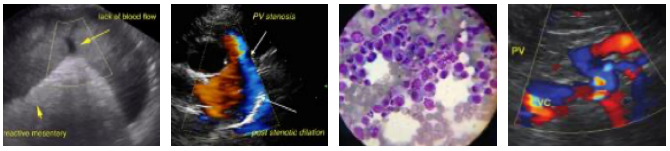

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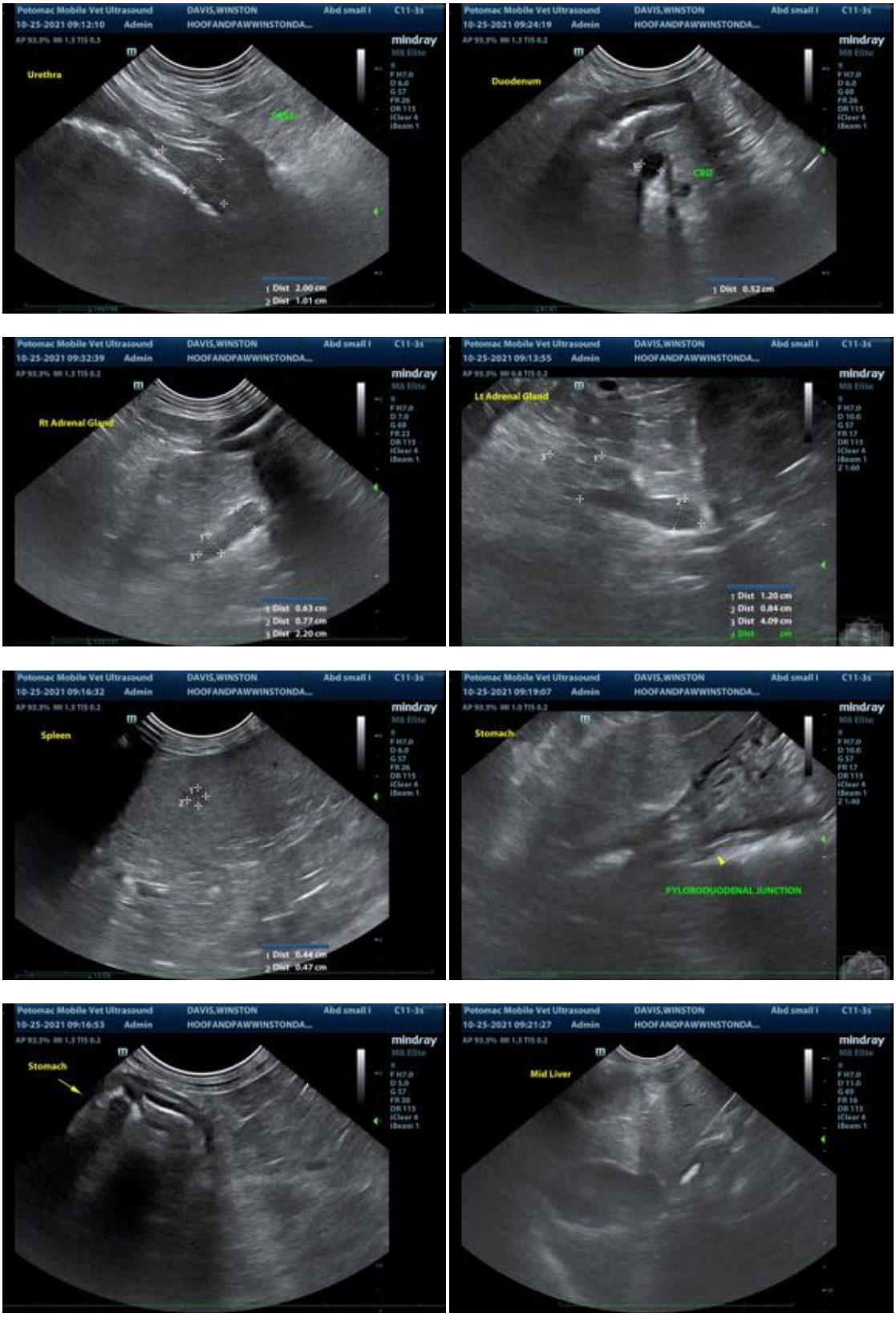

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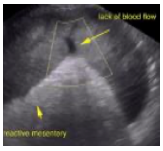
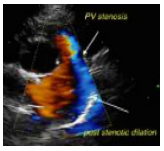
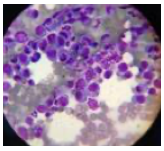
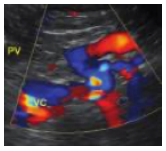

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.nicastro@sonopath.com