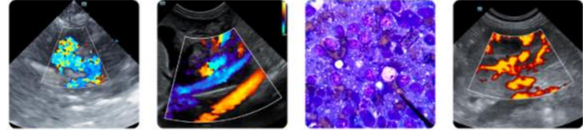
Charleston Mobile Veterinary Services
IN PARTNERSHIP WITH SONOPATH VETERINARY ULTRASOUND



Clinical Sonography & Telecytology
Educational Teleconsultation Services™

SonoPath FOSTERING THE ART OF VETERINARY MEDICINE™
www.charlestonmobile.net
info@charlestonmobile.net 800.403.5408

PATIENT
Tootie Emerson

SPECIES
Canine

BREED
Bichon Frise

SEX
Female Spayed

AGE
11

WEIGHT
Not Provided

INTERPRETED BY
Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

IMAGING PERFORMED BY
Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

HOSPITAL NAME
Dunes VC

REFERRING VET
Dr Soileau

INVOICE
22297

DATE
11-21-25

PRESENTING CLINICAL SIGNS

Patient has a long-term history of diabetes mellitus. Was originally on Novolin insulin. About 6 months ago, was switched to Degludec, which is a long-acting insulin. Has had some dose adjustments. Is currently on 8 units. Last dose was 36 hours ago. About a week ago, started shaking and having weakness. Insulin was continued. Presented yesterday. Blood glucose was 42. Was given Karo syrup and insulin was discontinued. Blood glucose has remained low until this morning. A blood glucose off insulin for 36 hours was 200. Creatinine 2.7. BUN 75. Calcium 11.9. ALP 197. T4 1.5. CBC unremarkable. USG 1.014. 2+proteinuria. Inactive sediment. 4dx negative. SDMA 17.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System
The urinary bladder is mildly to moderately distended. The wall is diffusely thickened (up to 0.43 cm) with a slightly irregular mucosal surface. A small amount of echogenic debris is observed within the lumen. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal in size (5.27 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. Pinpoint hyperechoic foci are observed within the cortex. Moderate pyelectasia is present (0.46 cm in the longitudinal plane). There is no evidence of infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (4.31 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. Mild to moderate pyelectasia is present (0.32 cm in the longitudinal plane). There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands
The left adrenal gland is normal in size (0.46 cm at cranial pole) (0.46 cm at caudal pole) with a normal shape. Pinpoint hyperechoic foci are observed within the parenchyma. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal in size (0.65 cm at cranial pole) (0.63 cm at caudal pole) with a normal shape. Pinpoint hyperechoic foci are observed within the parenchyma. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen
The spleen is normal in size (1.11 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 normal to prominent-in-size, with normal peripheral contours. The parenchyma is isoechoic relative to the spleen and exhibits mild heterogeneity. No distinct focal lesions are observed. Hepatic vasculature and biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1: 1.

The gallbladder is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. Several polypoid-like lesions are arising from the mucosal surface. No choleliths are observed. The cystic and common bile ducts are normal. The duodenal papilla is normal-in-size (0.32 cm in width).

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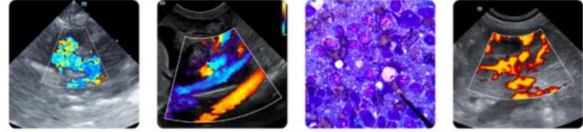

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Gastrointestinal
The gastric lumen is mildly distended with ingesta. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall is normal in thickness 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.

Lymph Nodes
The abdominal lymph nodes are normal/not visible.

Free Abdomen
There is no evidence of free fluid.

Other
A brief echocardiogram reveals no obvious evidence of right atrial or auricular mass. There is no obvious evidence of pericardial effusion.

ULTRASONOGRAPHIC FINDINGS

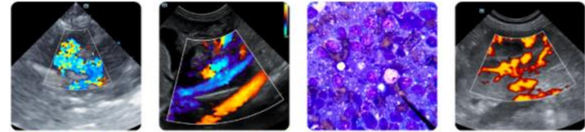
Primary Findings

- The urinary bladder wall changes are suggestive of cystitis. Correlation with the patient's clinical history is recommended.
- Mild bilateral nonspecific age-related renal changes. The bilateral pyelectasia may be secondary to parenchymal remodeling, pyelonephritis, PU/PD (if applicable), or some combination thereof.

Secondary Findings

- The pinpoint hyperechoic-to-mineralized foci within the adrenal glands likely represents a benign age-related incidental finding.
- The diffuse hepatic changes are nonspecific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory disease, infiltrative neoplasia and other hepatopathies are considered less likely.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

*An obvious cause for the patient's hypoglycemia is not definitively identified in this study. The top consideration is insulin excess, with a lower possibility of a small insulinoma, hepatic dysfunction, hypoadrenocorticism, sepsis, other.



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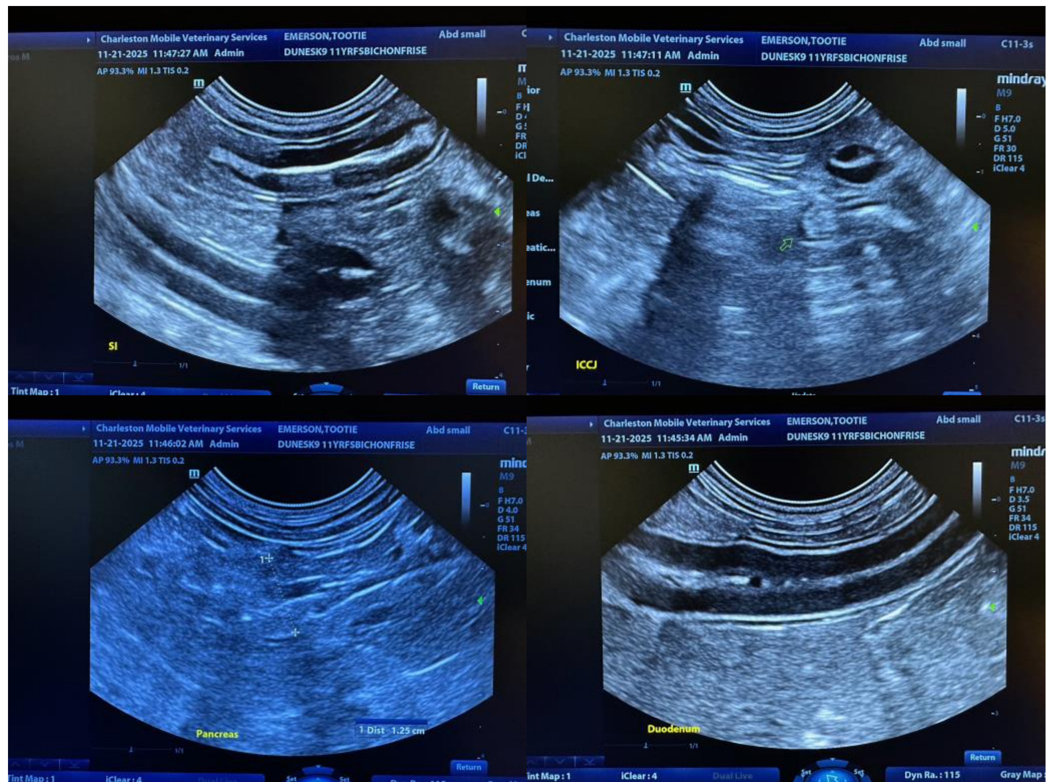
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Consider a reduction in the patient's insulin dose, with a recheck glucose curve in 5-7 days (or sooner if the patient is still experiencing clinical signs of hypoglycemia). If it is ultimately determined the patient does not tolerate this particular insulin, a different insulin type may be indicated.



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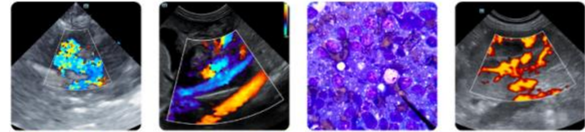

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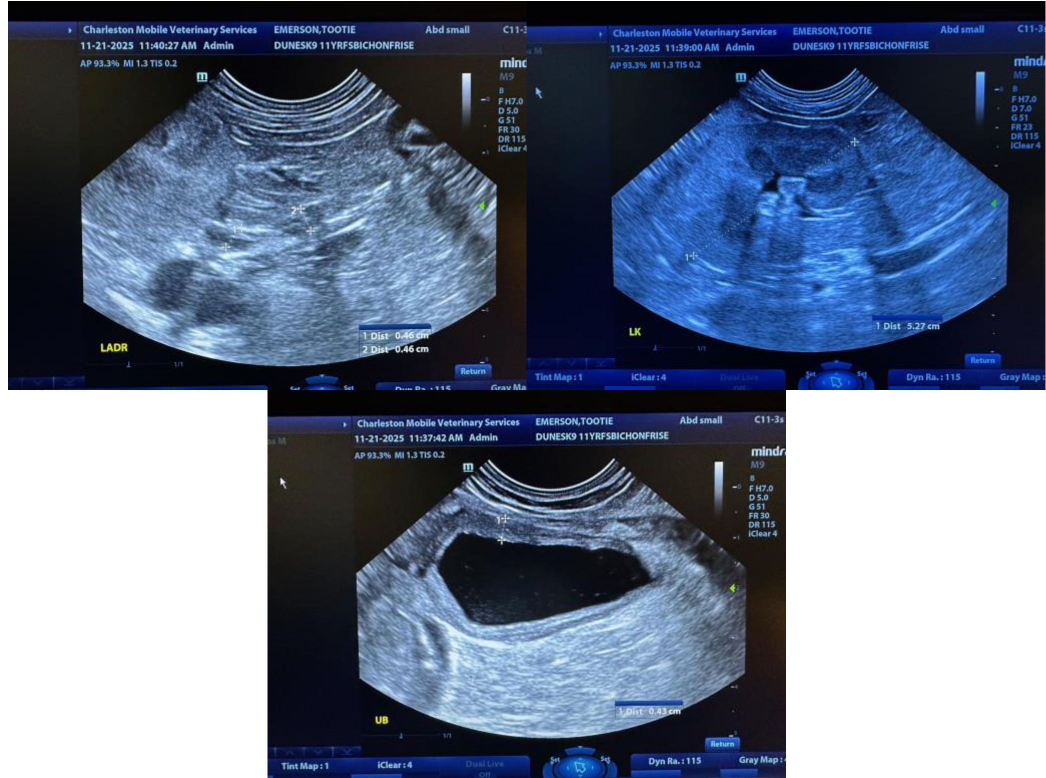

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance, please contact me.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com