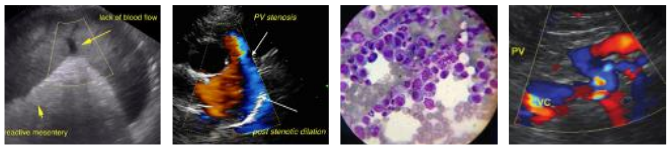
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Roxy Aoude

SPECIES

Canine

BREED

Pomeranian

SEX

Spayed Female

AGE

11 Years

WEIGHT

17.9 Lbs.

INTERPRETED BY

Andrea Nicastro, DMV, Diplomate DACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Amy Mayhew, LVT

HOSPITAL NAME

SVS Imaging, Michigan

REFERRING VET

Wixom Family Pet Practice

INVOICE

12866

DATE

12/8/21

PRESENTING CLINICAL SIGNS

History: Acute episode of weakness and ataxia last week. Decrease in appetite. These symptoms have improved. Elevated liver enzymes that have progressively worsened. Bile acids submitted to lab.

Abnormal PE/Chem/CBC/UA Results: Mild neutrophilia. T4 low at 0.73 (1.20-4.30 ug/dL) BUN 8.8 (9.0-29.0 mg/dl) ALT 547. (0-120) ALP >993 (0-140) AST 151 (0-60) Lipase 293 (0-225) Trig 188 (30-130)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder and visible portion of the pelvic urethra are normal for the degree of luminal distension. The urine is anechoic with no evidence of debris. Cystic calculi and discrete masses are not observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The left kidney is normal in size (4.79 cm in length); with a normal shape and smooth peripheral contours. The cortex is diffusely thickened and hyperechoic and there is mild to moderate loss of corticomedullary distinction. Hyperechoic shadowing diverticular foci are visualized. A 0.80 cm cortical cyst is present at the cranial pole. Mild pyelectasia is observed (0.28 cm) in the transverse plane. A cortical infarct is suspected. There is no evidence of hydroureter.

The right kidney is normal in size (4.91 cm in length); with a normal shape and smooth peripheral contours. The cortex is mildly thickened and hyperechoic and there is moderate loss of corticomedullary distinction. Hyperechoic shadowing diverticular foci are visualized. A 0.48 cm cortical cyst is present. A cortical infarct is suspected. There is no obvious evidence of pyelectasia or hydroureter.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.60 cm at cranial pole) (0.72 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.

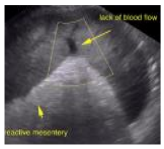
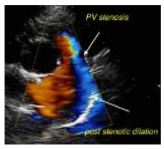
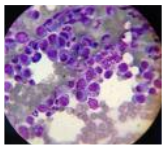
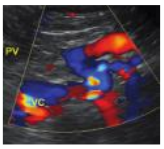
The right adrenal gland is mildly enlarged (0.75 cm at cranial pole) (0.71 cm at caudal pole) (2.70 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is subjectively enlarged (1.32 cm in width at the level of the hilus) with swollen slightly undulating peripheral contours. The parenchyma is of appropriate echogenicity and echotexture. A few ill-defined hyperechoic areas are observed throughout the organ. Splenic vasculature is normal with no evidence of thrombosis.

Liver

The liver is subjectively enlarged with irregular peripheral contours. The parenchyma is isoechoic relative to the spleen and diffusely mottled and heterogeneous, bordering on a nodular appearance. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

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The gall bladder lumen is moderately distended. The wall is thin and smooth. A small to moderate amount of partially dependent to suspended debris, in a partially stellate pattern is observed within the lumen. The cystic and common bile ducts are normal.

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 small intestinal lumen is not dilated. The small intestinal wall thickness is normal (xxx cm) with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. No obstructive or overt infiltrative disease is noted.

Pancreas

The left 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

Trace free fluid is observed. The abdominal lymph nodes are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

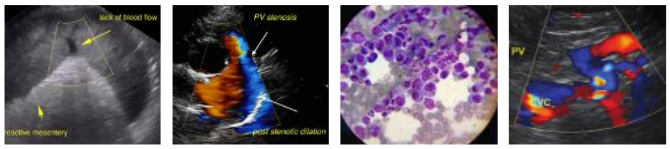
- The diffuse hepatic parenchymal changes are most concerning for infiltrative neoplasia (i.e., round cell tumor). However, a non-neoplastic process (i.e., severe inflammation, fibrosis) cannot be completely excluded.
- The gallbladder changes are suspicious for an early/developing mucocele.
- The trace ascites is likely secondary to hepatic pathology.

Secondary Findings

- Mild bilateral adrenomegaly
- The bilateral renal changes are consistent with chronic interstitial nephrosis/nephritis with cortical infarcts.
- Age-pancreatic remodeling +/- fibrosis
- The diffuse splenic changes are non-specific and could be consistent with lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
- Fine needle aspirates of the liver and spleen can be considered if clotting status is appropriate. A 25-gauge needle should be used. If cytology results are inconclusive, an



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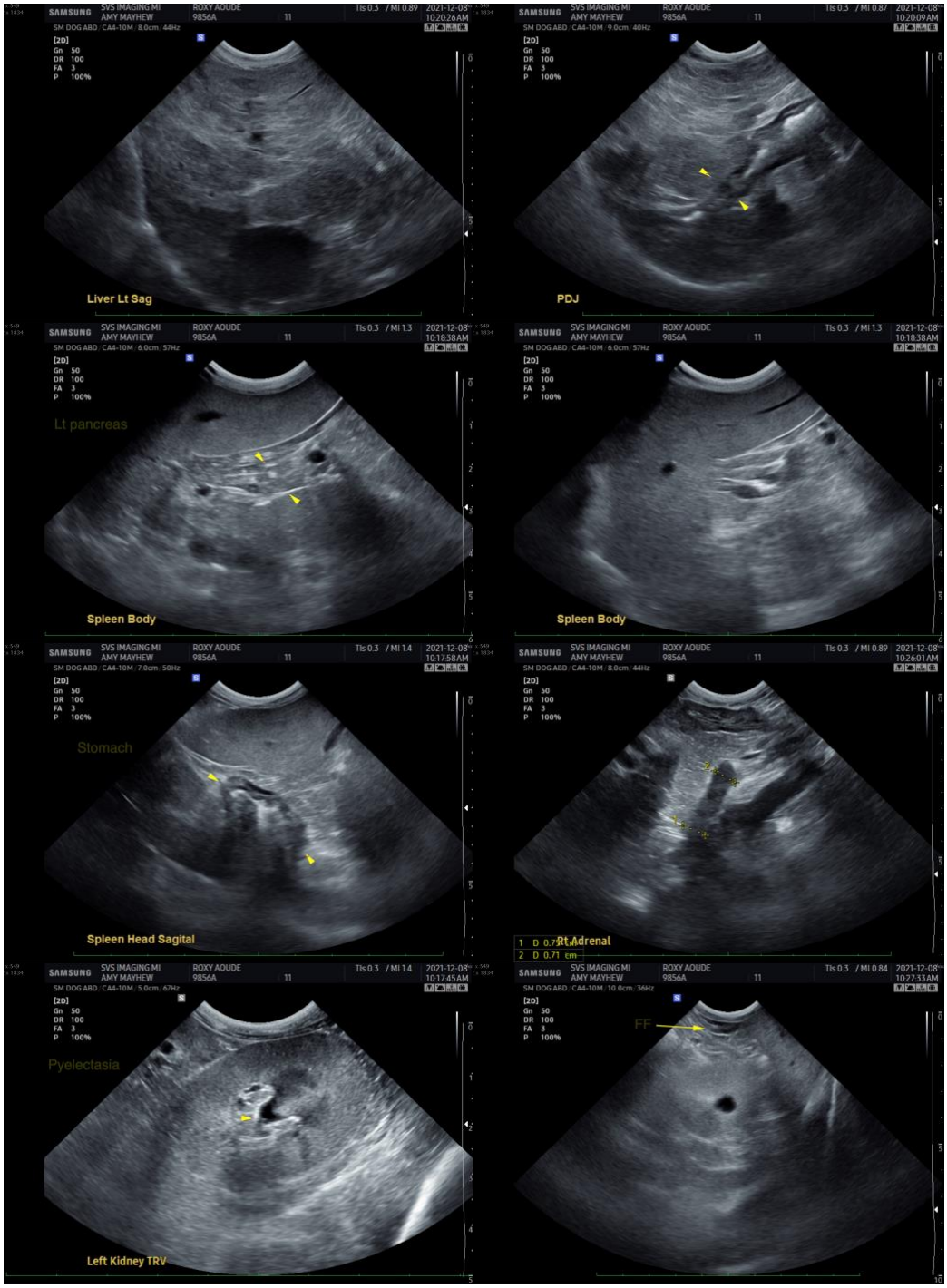
abdominal exploratory with a surgical liver biopsy and assessment of the gallbladder (+/- cholecystectomy) may be necessary to get a definitive diagnosis.



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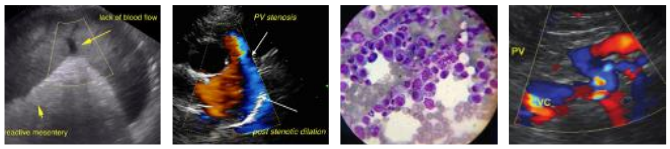

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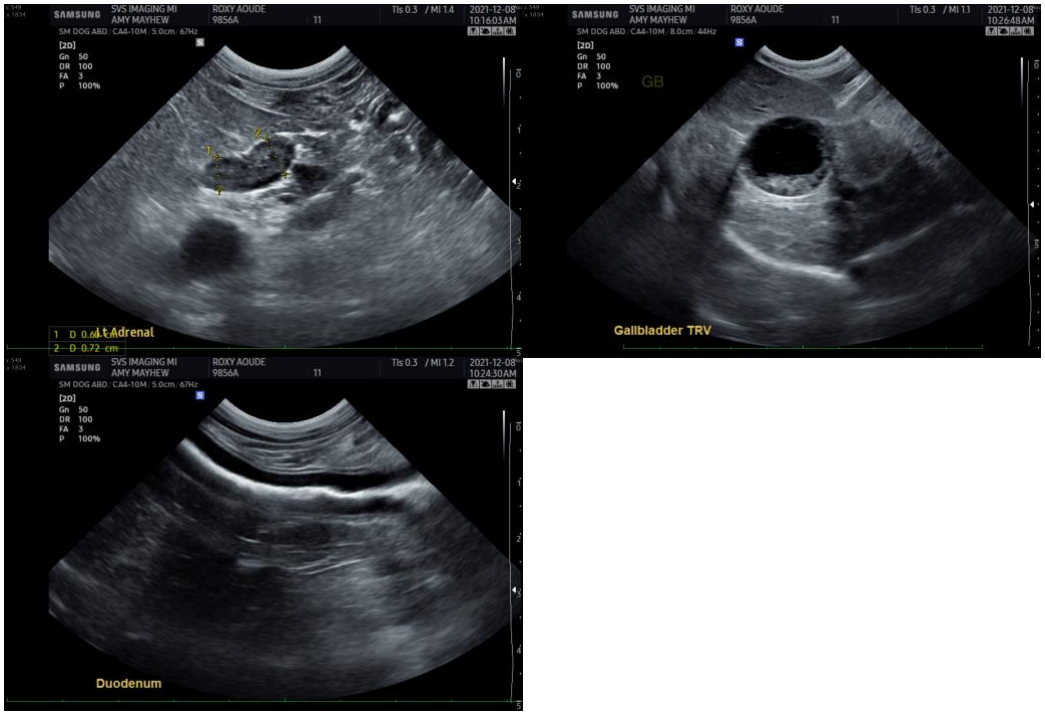

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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 DACVIM (Small Animal Internal Medicine)
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