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Clinical Sonography & Telecytology
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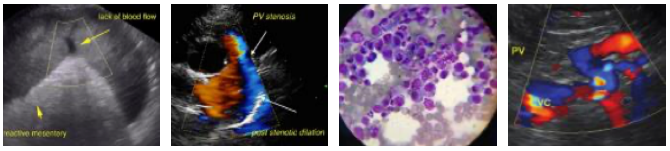

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1-800-838-4268 info@sonopath.com

PATIENT
Samantha Peters

SPECIES
Canine

BREED
Beagle mix

SEX
Female, spayed

AGE
9 Yrs.

WEIGHT
22.2 kg.

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

IMAGING PERFORMED BY
Erin Wicks

HOSPITAL NAME
Shores Veterinary Emergency Center

REFERRING VET
Dr. Luphole

INVOICE
14632

DATE
2/22/23

PRESENTING CLINICAL SIGNS

History: Presented at our hospital for: started yesterday with wobbly, stiff, head bobbing episodes. This has happened 3 times. Noted trembling of hind limbs over last several days. Previous Health Concerns: None Current Medications/Supplements/OTC: None
Abnormal PE/Chem/CBC/UA Results: Respiratory: mild harsh BV sounds all quadrants Abdominal: possible cranial organomegaly, no obvious mass or fluid wave noted BG upon arrival: 36 Chemistry: Glucose 29 L, ALP 177 H CBC: Eos 0.02 L, EPOC: pH 7.334 L, Lactate 3.92 H, Glucose 30 L Cortisol: 3.2 N Insulin:glucose ratio: pending, sent to Antech

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder lumen is moderately distended with anechoic urine. No masses, inflammatory changes or calculi are observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The left kidney is normal size (6.23 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (6.57 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is enlarged (1.06 cm at cranial pole) (1.06 cm at caudal pole) (2.70 cm in length) with a slightly irregular shape. 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 enlarged (1.14 cm at cranial pole) (1.03 cm at caudal pole) (3.02 cm in length) with a slightly irregular shape. A 1.26 x 0.89 cm hyperechoic nodule is observed at the cranial pole. A small hyperechoic focus is also observed at the caudal pole. Remaining glandular echogenicity and detail are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (1.94 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 curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion. The gallbladder is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No cholelithes are observed. The cystic and common bile ducts are normal.

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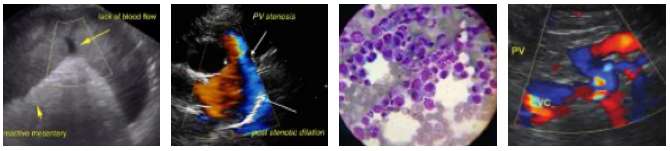

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Gastrointestinal

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. The lumen of the descending colon contains shadowing fecal material. 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. The abdominal lymph nodes are normal/not visible.

Other

The uterine stump is visible (0.46 cm in width). No obvious pathology is seen.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

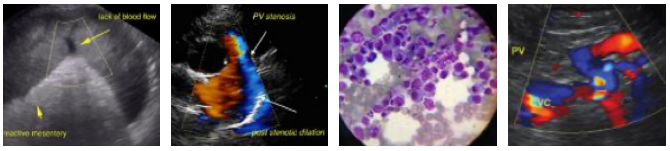
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis. A pancreatic tumor is not definitively visualized. However, a small insulinoma cannot be completely excluded.

Secondary Findings:

- Bilateral adrenomegaly. The right adrenal nodule may represent benign nodular hyperplasia or an emerging tumor.
- Mild bilateral, age-related renal changes.
- Suspected benign diffuse hepatopathy. Vacuolar hepatopathy (i.e., idiopathic, endocrine) is the top differential. However, correlation with the patient's liver values is recommended.
- Visible uterine stump- incidental.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- If the insulin:glucose ratio supports an insulinoma, consider the following:
  1. Three-view thoracic radiographs to assess for pulmonary metastatic disease.
  2. A contrast abdominal CT scan to further assess an insulinoma.



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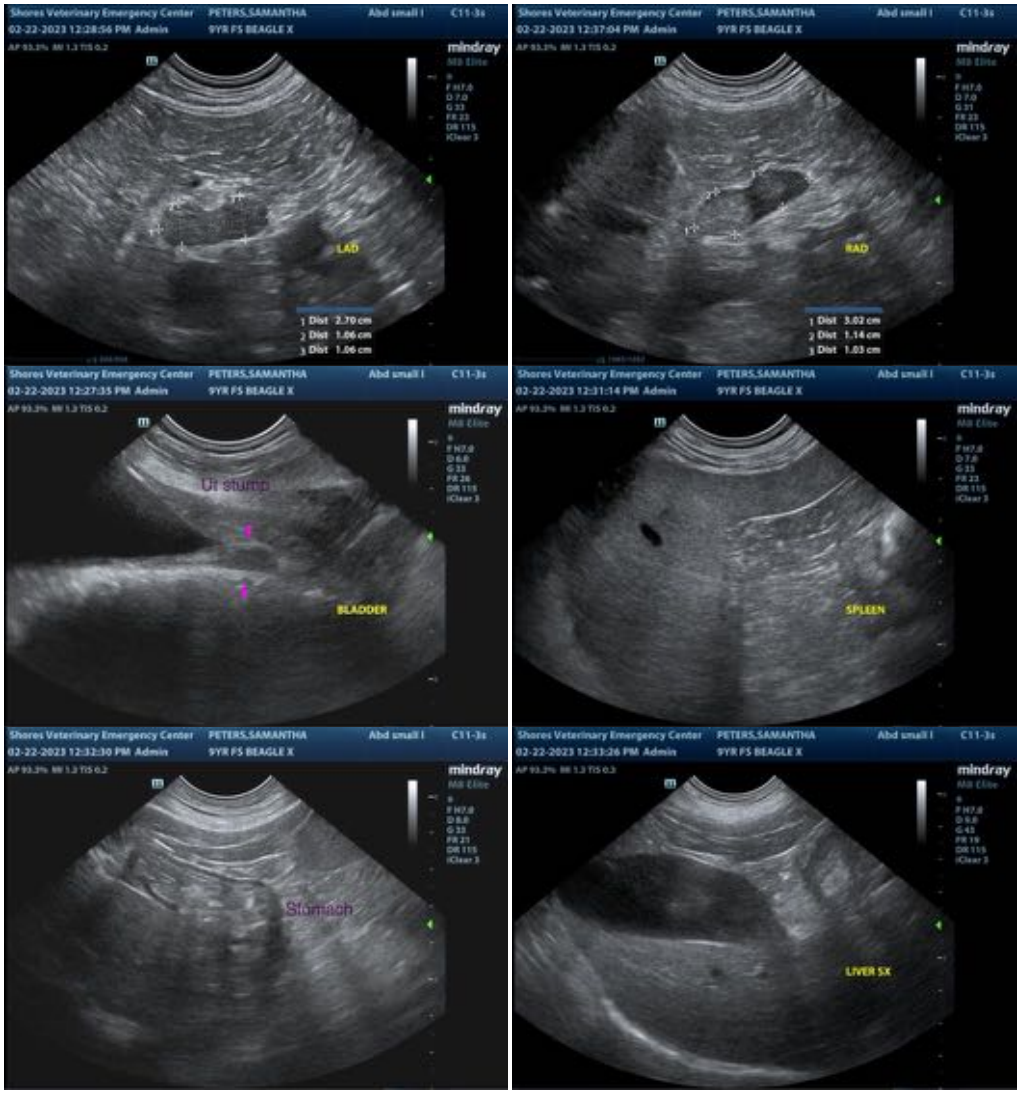
3. Ultimately if a pancreatic tumor is identified, consider consultation with a board-certified surgeon to discuss removal.

- If the insulin:glucose ratio does NOT support an insulinoma, consider pre- and post-serum bile acids and an ACTH stimulation test to further evaluate for causes of hypoglycemia.
- Consider testing for hyperadrenocorticism with a low-dose dexamethasone suppression test or ACTH stimulation test if clinical signs (i.e., PU/PD) develop in the future. Also consider a baseline blood pressure measurement to evaluate for systemic hypertension.



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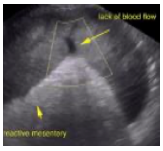
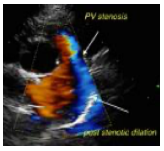
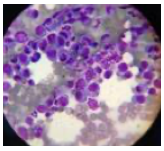
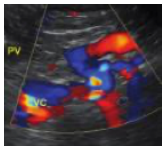

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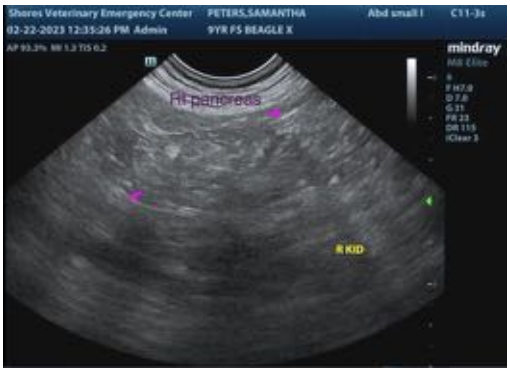

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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