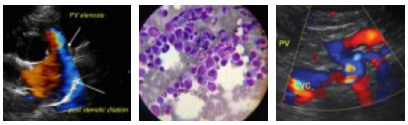
IMAGING PERFORMED BY

IntraPet.com



SonoPath
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DATE

2/27/23

PATIENT

Beau Campbell

SPECIES

Canine

BREED

Staffordshire Terrier

SEX

Male, neutered

AGE

8/21/2010

WEIGHT

59.6 lbs.

INTERPRETED BY

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

HOSPITAL NAME

Belvedere VC

REFERRING VET

Dr. Kauder

INVOICE

14645

PRESENTING CLINICAL SIGNS

Various health issues that are mostly stable (IBD, mitral valve disease, possible hepatopathy, anal sac adenocarcinoma 2020, osteoarthritis). New- occasional teeth chattering, mild head tremors (infrequent), lame left front-years (but now improved back on Deramaxx). PE: gr 3 systolic murmur, lenticular sclerosis, lungs clear. Abd wnl, rectal exam wnl. Neuro- slight head tremor/twitch noted during exam, no CP deficits, rest of neuro exam wnl

Current Medications: Gabapentin 300mg BID-years, Metronidazole 250mg BID-4 months, Denamarin 425mg SID-years, Dasuquin SID-years, Pimobendan 7.5m BID-6 months, Deramaxx 37.5mg SID-years, then off when IBD flared 10/2022, then resumed 2/14/2023.
Lab Results: ALT 189, ALP 180
Date of Previous IntraPet Ultrasound: 8/2022. See attached.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Andi Parkinson, BS, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is not visualized in its entirety. In the visualized portions, no obvious abnormalities are seen.

The prostate is normal in size (0.99 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal size (6.82 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.

The right kidney is normal in size (6.09 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 mildly enlarged (1.31 cm at cranial pole) (0.82 cm at caudal pole) (3.48 cm in length) with a slightly irregular shape. The parenchyma is mildly heterogeneous with some loss of glandular detail. Surrounding vasculature appears normal.

The right adrenal gland is mildly enlarged (1.47 cm at cranial pole) (0.73 cm at caudal pole) (3.42 cm in length) with a slightly irregular shape. The parenchyma at the cranial pole is mildly heterogeneous with some loss of glandular detail. The glandular echogenicity and detail at the caudal pole are unremarkable. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (1.32 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 slightly prominent in size with normal curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and mildly heterogeneous in appearance with a few small ill-defined

hypoechoic nodules, the largest measuring 0.59 cm in diameter. Vascular and biliary tracts are of normal volume with no evidence of congestion. The gall bladder lumen is distended. The wall is normal to mildly thickened (up to 0.27 cm). A moderate to large amount of aggregated, echogenic, partially dependent to suspended sludge is observed within the lumen. The sludge is in a partially stellate pattern. 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 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.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- Gallbladder changes consistent with a developing to fully formed mucocele. The gallbladder wall changes are most consistent with cholecystitis. Changes are similar to the previous sonogram.
- The hepatic parenchymal changes could be consistent with a benign hepatopathy (i.e., regenerative nodular hyperplasia). Alternatively, inflammatory disease, fibrosis or other hepatopathy may be present. Changes are similar to the previous sonogram.

Secondary Findings:

- Mild bilateral adrenomegaly. Changes are similar to the previous sonogram.
- Bilateral, chronic age-related renal changes with mild dystrophic mineralization and trace pyelectasia. Changes are similar to the previous sonogram.

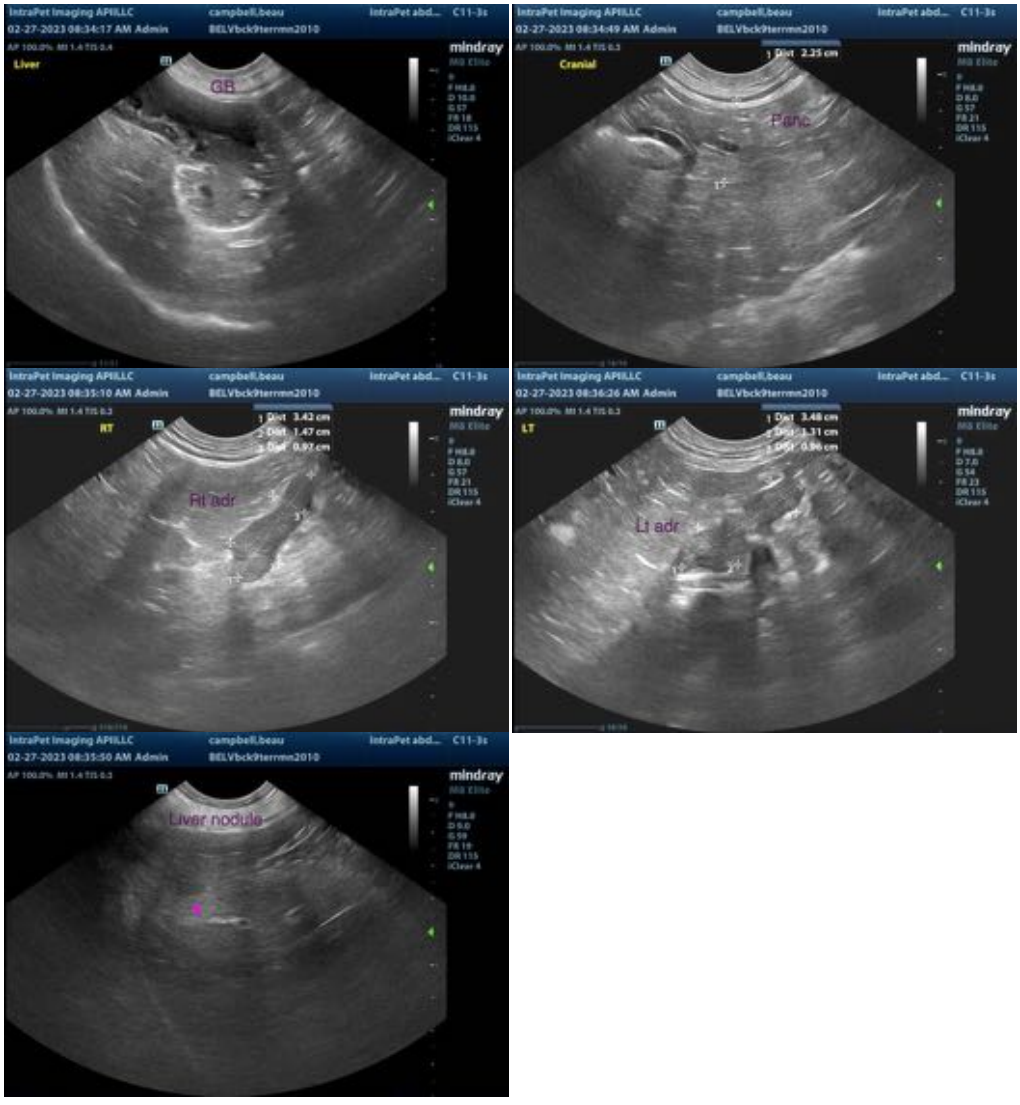
*There is no obvious evidence of metastatic disease in the abdomen.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for pulmonary metastatic disease, if not already performed.
- Regarding the gallbladder changes, a prophylactic cholecystectomy can be considered. If not pursued, Ursodiol therapy is recommended along with serial sonographic monitoring (i.e., every 6-8 weeks) to assess for progression. If pursued, a liver biopsy should also be obtained.

- 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.

- Consider testing for hyperadrenocorticism with a low-dose dexamethasone suppression test or ACTH stimulation test if clinical signs (i.e., PU/PD) develop.



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, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)

info@SonoPath.com