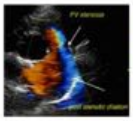
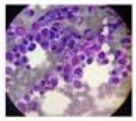
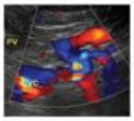

PATIENT

Diamond Williams

SPECIES

Canine

BREED

Mini Schnauzer

SEX

Female Spayed

AGE

12 years

WEIGHT

20.8 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Amy Mayhew LVT

HOSPITAL NAME

SVS Imaging MI

REFERRING VET

Dr. Shelby

INVOICE

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PRESENTING CLINICAL SIGNS

History: Bloating. Thrombocytosis.

Abnormal PE/Chem/CBC/UA Results: Problem list: 1. Potbellied - r/o cushinoid, organomegaly, neoplasia 2. Difficulty walking - spinal pain, arthritis, other 3. Dehydration 5%. ALP 2308. Hypertriglyceridemia. USG 1.019. 3+ proteinuria, inactive sediment. T4 normal.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly distended with anechoic urine. The wall is of appropriate thickness for the level of repletion. The mucosal surface is slightly irregular. No cystic calculi are observed. The region of the trigone and visible portion of the proximal urethra are normal.

The left kidney is normal in size (5.71 cm in length) with a normal shape and smooth peripheral contours. The cortex is hyperechoic relative to the spleen and mildly thickened, with moderate loss of corticomedullary distinction. Hyperechoic shadowing diverticular foci are visualized. A 1.50 x 1.06 cm hypoechoic nodule is observed at the medial aspect, at the corticomedullary junction. Trace pyelectasia is present. There is no evidence of infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (5.55 cm in length) with a normal shape and smooth peripheral contours. The cortex is hyperechoic and thickened. There is moderate loss of corticomedullary distinction. Hyperechoic shadowing diverticular foci are visualized. There is no evidence of pyelectasia, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is normal in size (0.50 cm at cranial pole) (0.51 cm at caudal pole) with a normal shape and 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 in normal size (0.76 cm at cranial pole) (0.49 cm at caudal pole) with a normal shape and 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 (1.43 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.

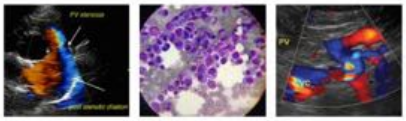
Liver

The liver is subjectively prominent in size with normal curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and mottled in appearance, with at least two ill-defined hypoechoic nodules (the largest measuring 1.70 cm in diameter). Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

The gall bladder is moderately distended. The wall is normal in thickness. A moderate to large amount of aggregated echogenic to suspended sludge, in a stellate pattern is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

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 is normal in thickness with a normal layering pattern. There is slight mucosal



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speckling in some segments. Discreet masses are not identified. The colonic wall is normal. There is no evidence of an obstructive pattern.

Pancreas

The right limb is visible with normal curvilinear peripheral contours. The parenchyma is largely isoechoic relative to surrounding omental fat and slightly mottled in appearance. No distinct focal lesions are observed. The pancreatic duct is visible but not overtly dilated (0.23 cm in diameter).

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

- Left renal nodule. This could be consistent with an emerging tumor, granuloma, inflammatory focus, other.
- The gall bladder changes are consistent with a mucocele.
- The hepatic parenchymal changes are nonspecific, and in light of the liver enzyme pattern, are most consistent with vacuolar hepatopathy and/or regenerative nodular hyperplasia. The hypoechoic nodules trend toward the benign (i.e., regenerative nodules) with a lower possibility of emerging neoplasia.

Secondary Findings

- Bilateral age-related renal changes with nonobstructive nephrolithiasis
- Minor age-related pancreatic remodeling in the right limb
- The small intestinal mucosal speckling may be a normal variant for this patient or could be associated with an inflammatory process (i.e., enteritis). Correlation with the patient's clinical history is recommended.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Regarding the left renal nodule, consider the following:

  1. Three-view thoracic radiographs to assess for pulmonary metastatic disease
  2. An abdominal CT scan to further characterize the lesion

- Regarding the gall bladder mucocele, a prophylactic cholecystectomy can be considered. If surgery is pursued, a liver biopsy should also be obtained. The left renal nodule should also be biopsied the time of surgery, if visible. If a cholecystectomy is not pursed at this time, serial sonographic monitoring (i.e., 4-8 weeks) of the gall bladder and left renal lesion is recommended to assess for progression. The client should be warned for the potential of gall bladder rupture with subsequent bile/peritonitis if the mucocele progresses.
- Fine-needle aspirates of the hepatic nodules can be considered, if clotting status is appropriate. Alternatively, serial sonographic monitoring (i.e., every 3-6 months) can be considered to assess for growth.
- Given the proteinuria, a UPC is recommended.

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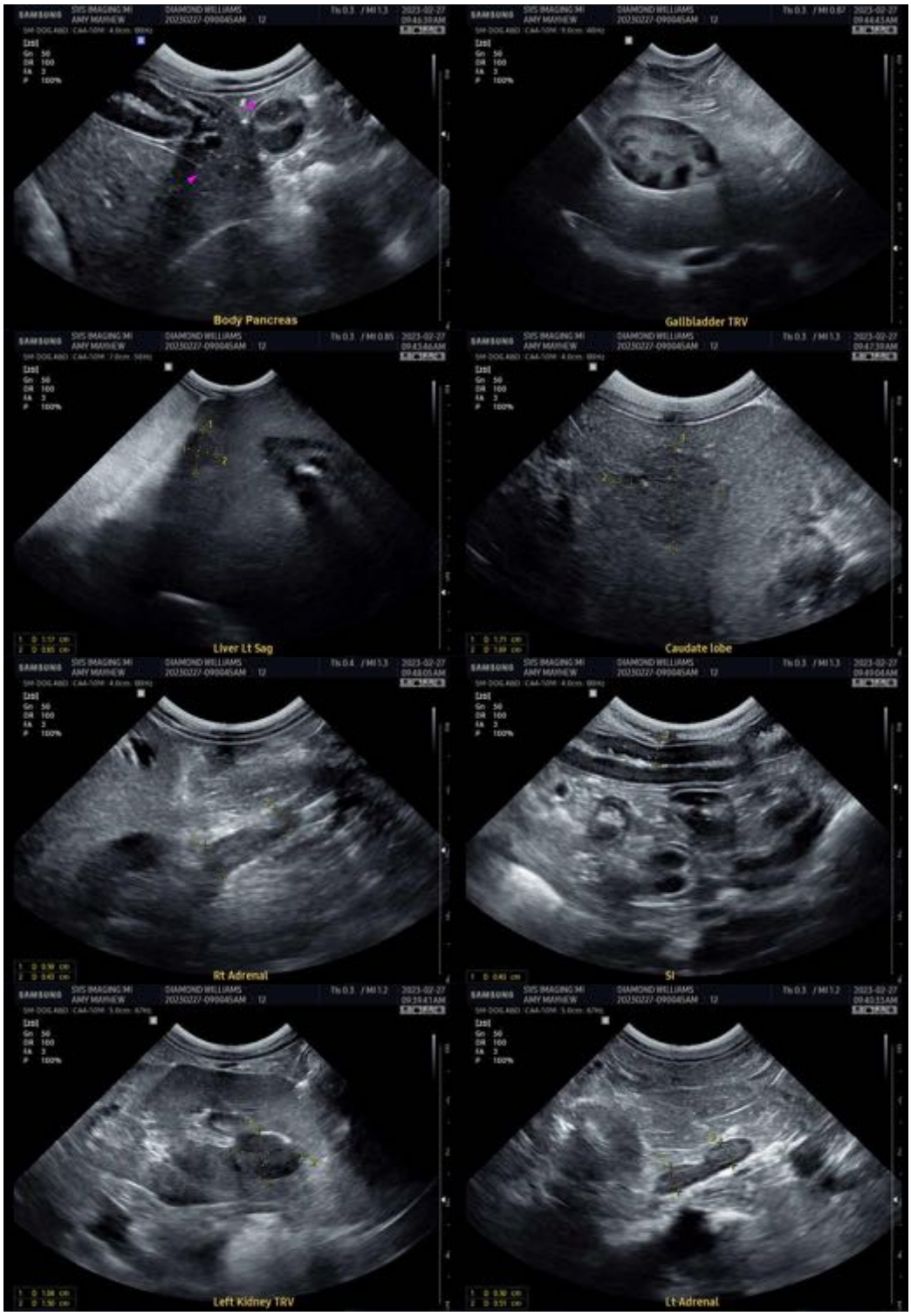
- Consider testing for hyperadrenocorticism with a low-dose dexamethasone suppression test or ACTH stimulation test if clinical signs (i.e., PU/PD) develop in the future.



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Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

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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