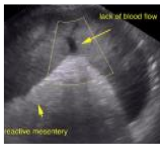
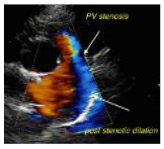
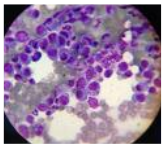
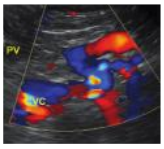
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

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

PATIENT
Abigail Sikes

SPECIES
Canine

BREED
Chihuahua Mix

SEX
Spayed Female

AGE
13 years

WEIGHT
9.7 lbs

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

IMAGING PERFORMED BY
Christina Sitton

HOSPITAL NAME
Sherwood Family Pet Clinic

REFERRING VET
Dr. Christina Sitton

INVOICE
10577

DATE
3/17/22

PRESENTING CLINICAL SIGNS

History: ADR - vomited a few times, somewhat lethargic, and decreased appetite, mild weight loss most recently PU/PD with accidents in house

Abnormal PE/Chem/CBC/UA Results: Chemistry BUN 34 (9-31) Potassium 5.8 (4-5.4) Na/K 25 (28-37) ALT 484 (18-121) ALP 926 (5-160); was 237 GGT 22 (0-13) CBC/T4/cpl: wnl UA USG 1.017 pH 6 2+ protein glucose, bilirubin, blood, ketones, bacteria, crystal negative UPC and BP pending pot belly appearance, soft palpation, non-painful -historically noted on PE records

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are 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. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal size (3.97 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. The cortex is hyperechoic. A few cortical cysts are visualized. Mild pyelectasia is present (0.20 cm in the transverse plane). There is no evidence of nephroliths, infarcts or hydroureter.

The right kidney is normal size (3.43 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. The cortex is hyperechoic. A few hyperechoic diverticular foci, +/- 1-2 small nephroliths are visualized. Several cortical cysts are seen. Trace pyelectasia is present (0.15 cm in the longitudinal plane). There is no evidence of infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.46 cm at cranial pole) (0.66 cm at caudal pole) (1.85 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.

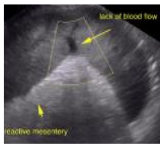
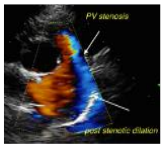
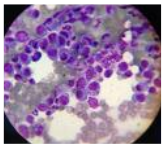
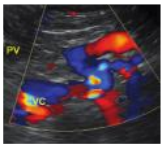
The right adrenal gland is enlarged (0.79 cm at cranial pole) (0.64 cm at caudal pole) (1.72 cm in length); with a slightly irregular shape. The parenchyma is subtly heterogenous with some loss of glandular detail. Surrounding vasculature are normal.

Spleen

The spleen is subjectively prominent in size, with a slight rounding of the peripheral margins at the cranial and caudal poles. The parenchyma is homogenous. No distinct focal lesions are observed. Splenic vasculature appears normal with no evidence of thrombosis.

Liver

The liver is subjectively enlarged with slightly swollen peripheral contours. The parenchyma is hyperechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions

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are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion. The gall bladder lumen is moderately distended. The wall is thin and smooth. A small amount of aggregated echogenic partially dependent debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

The gall bladder lumen is moderately distended. The wall is thin and smooth. A scant amount of echogenic debris is adhered to the luminal surface. 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 mildly distended with ingesta. 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 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 region of the pancreas is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional 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

- Nonspecific diffuse hepatopathy. Differentials include inflammatory disease (i.e., chronic active hepatitis, bacterial cholangiohepatitis), Leptospirosis, infiltrative neoplasia (i.e., lymphoma), hepatotoxicosis (i.e., copper), other hepatopathy +/- concurrent, age-related change (i.e., vacuolar hepatopathy, regenerative nodular hyperplasia).
- Bilateral adrenomegaly, most consistent with hyperplasia

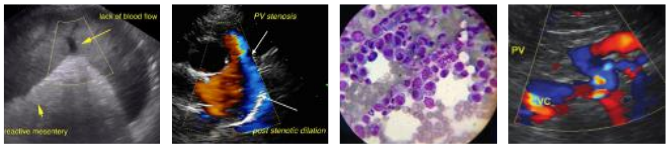
Secondary Findings

- Bilateral chronic degenerative renal changes with pyelectasia, cortical cysts and right dystrophic mineralization.
- The mild splenomegaly may be a normal variant for this patient, or may be secondary to antigenic stimulation, lymphoid hyperplasia, extramedullary hematopoiesis, or less likely, infiltrative neoplasia.

  ** A primary hepatopathy is of top concern regarding the patient's clinical history, although concurrent Cushing's Disease cannot be completely excluded.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Pre-and postprandial serum bile acids, as well as Leptospirosis testing (i.e., blood and urine PCR, serology), are recommended. Depending on the results, hepatic tissue sampling (i.e., fine-needle



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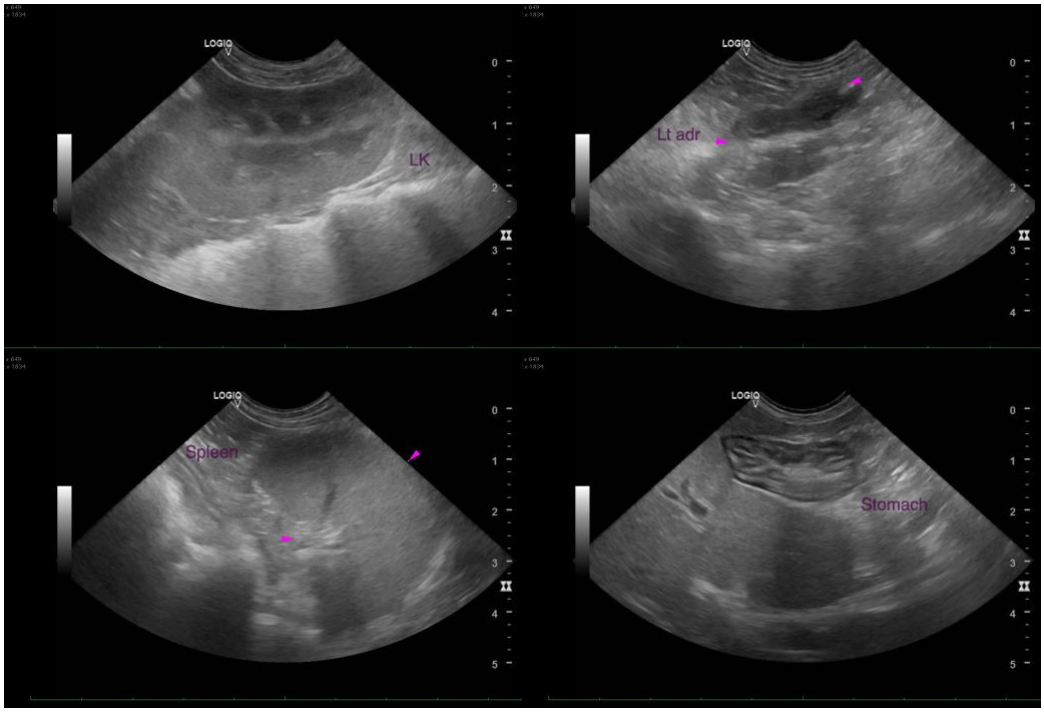
aspirate or biopsy), may be necessary to get a definitive diagnosis. Surgical biopsies would be ideal, in that they are more representative of global organ pathology. If surgery is pursued, aerobic and anaerobic bile cultures and acquisition of additional hepatic tissue samples for potential copper quantitation should be obtained. Three-view thoracic radiographs should be performed prior to anesthesia to assess cardiopulmonary status.

- Given the elevated BUN and sonographic renal changes, consider the following

1. Urine culture and sensitivity
2. UPC
3. Baseline blood pressure measurement



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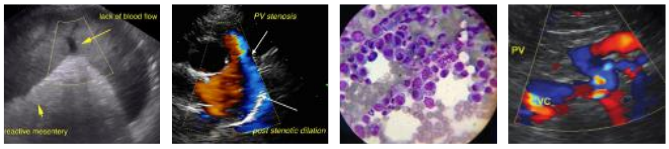

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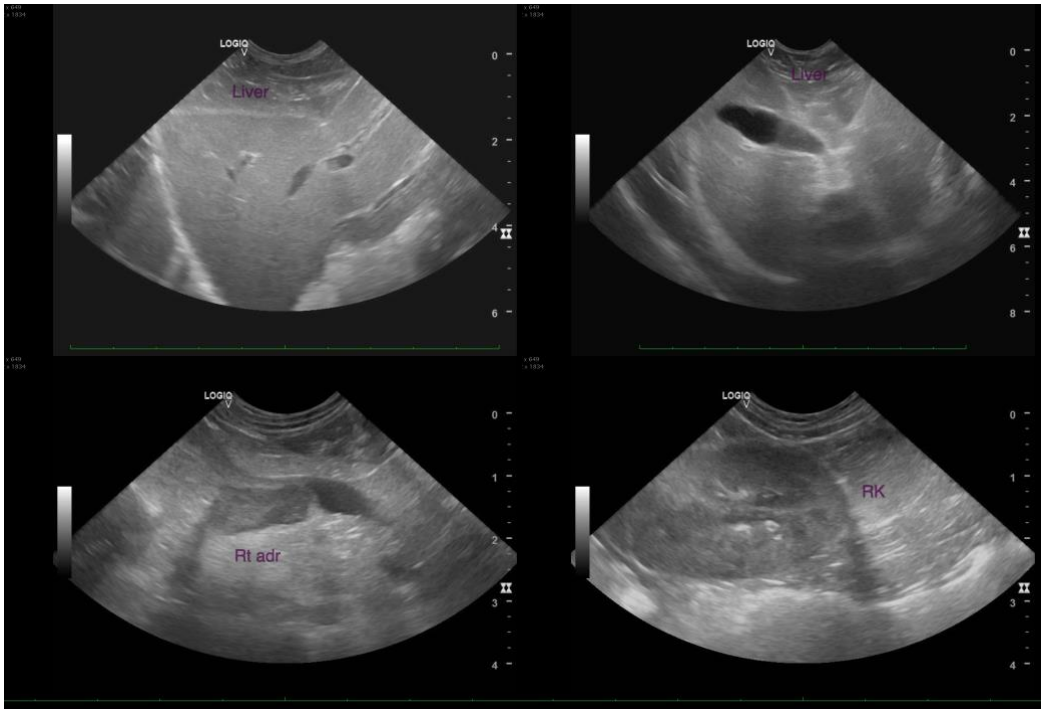

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
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