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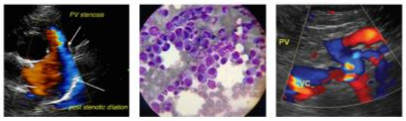
svsimagingqc.net 309-737-3070

SVS IMAGING



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

PATIENT

Max Stone 27475A

SPECIES

Canine

BREED

Chihuahua Mix

SEX

Neutered Male

AGE

15 years, 4 mo

WEIGHT

7.6 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VET

Madison Vet. Spec. - Dr. Maller

INVOICE

10625

DATE

3/29/22

PRESENTING CLINICAL SIGNS

History: Presenting for possible compost ingestion within last few days. Lethargy and vomiting started yesterday with no interest in thing normally done. Ate some ground beef this afternoon without vomiting. No ataxia

Abnormal PE/Chem/CBC/UA Results: Elevated ALKP, SDMA, LYM, and MPV values. AFAST suspect liver or splenic mass

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 prostate is normal in size (1.12 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney presented normal size (3.54 cm in length); with a slightly irregular shape. The cortex is diffusely and variably thickened and heterogenous in appearance. There is moderate loss of corticomedullary distinction. A 2.40 x 1.63 irregular cortical cyst, containing echogenic material is observed at the caudal pole. Several smaller cortical cysts are also seen. Hyperechoic shadowing diverticular foci are visualized. Trace pyelectasia is present (0.16 cm in the longitudinal plane). There is no evidence of hydroureter.

The right kidney is normal size (4.43 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. A few small cortical cysts are present. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.48 cm at cranial pole) (0.61 cm at caudal pole) (1.98 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.

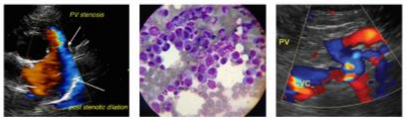
The right adrenal gland is upper limits of normal size (0.57 cm at cranial pole) (0.59 cm at caudal pole) (1.89 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size with a normal capsular contour. The parenchyma is slightly mottled in appearance. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively prominent in size with rounded peripheral contours. The parenchyma is isoechoic relative to the spleen and heterogenous in appearance with ill-defined hyperechoic areas. 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 moderate amount of aggregated echogenic debris/sludge is observed within the lumen, some of which is partially dependent, and some of which 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 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 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 limbs and base 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

No free fluid is observed. The abdominal lymph nodes are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory and infiltrative disease are considered less likely.
- Gall bladder debris/sludge. The gall bladder/sludge could be consistent with cholestasis, fasting, or less likely, early mucocele formation.

Secondary Findings

- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The splenic parenchyma changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis or splenitis with a low possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).
- Borderline bilateral adrenomegaly
- Bilateral age-related renal changes with cortical cysts, more pronounced on the left side

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Continued supportive care for dietary indiscretion (compost ingestion) is recommended

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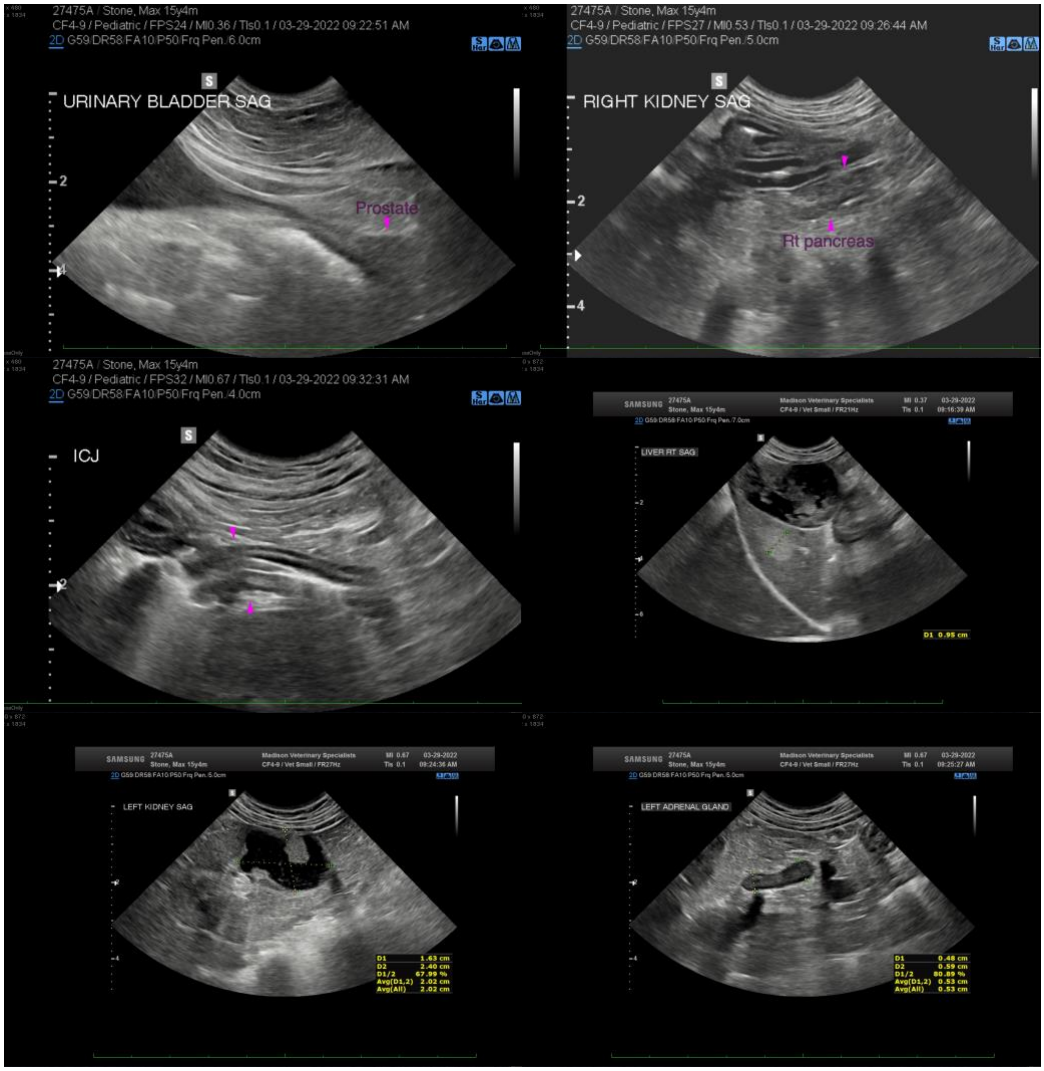
- Continued monitoring for neurologic signs is also recommended. Symptomatic care should be provided as needed.
- Consider testing for hyperadrenocorticism with a low-dose dexamethasone suppression test or ACTH stimulation test if clinical signs (i.e., PU/PD) develop in the future.



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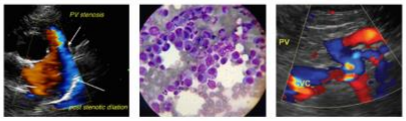

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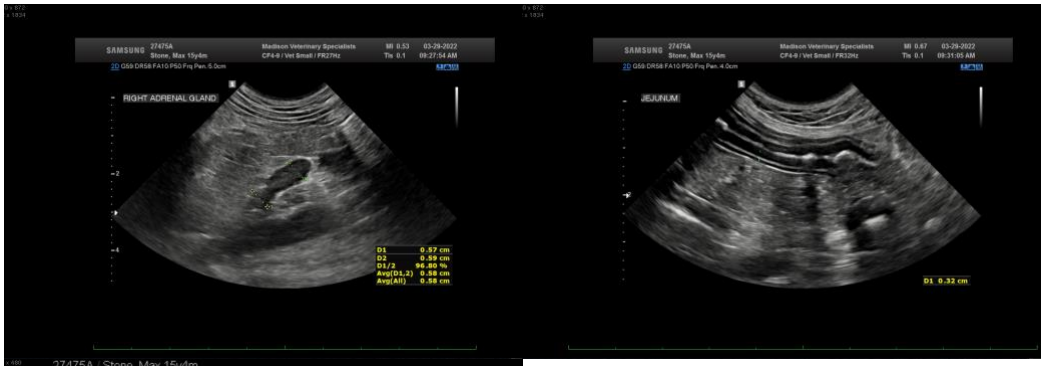

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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