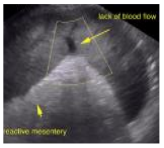
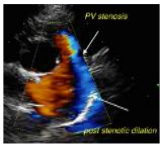
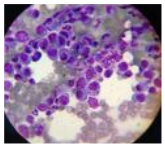
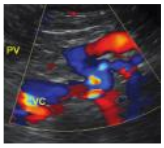
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™





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

PATIENT

Tinker Sloan

SPECIES

Canine

BREED

Basset Mix

SEX

Spayed Female

AGE

12 years

WEIGHT

50 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Kelly Vazquez

HOSPITAL NAME

Glen Rock VH

REFERRING VET

Dr. Scott Stekler

INVOICE

10744

DATE

4/14/22

PRESENTING CLINICAL SIGNS

History: Weight loss, vomiting, and pollakiuria. Current meds: Cerenia 60 mgs SID, Enroflaxacin 136 mgs SID.
Abnormal PE/Chem/CBC/UA Results: ALT 312.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are normal in thickness and the mucosal surface is slightly irregular. 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.

One still image of the left kidney is available for interpretation. The left kidney is normal size (5.67 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.

The right kidney is normal size (6.15 cm in length); with a slightly irregular shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.90 cm at cranial pole) (0.80 cm at caudal pole) (2.13 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 (1.37 cm at cranial pole) (0.74 cm at caudal pole) (2.26 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 (1.47 cm in width at the level of the hilus) 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 enlarged with slightly swollen 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 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 subtly thickened (up to 0.20 cm and hyperechoic). A small amount of gravity dependent, echogenic-to-mineralized debris/sand is observed within the lumen. 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 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

- An obvious cause for the elevated liver enzymes is not identified in the study. However, a microscopic hepatopathy (i.e., bacterial cholangiohepatitis, Leptospirosis, chronic active hepatitis, copper-associated hepatotoxicity, reactive hepatopathy, infiltrative neoplasia (less likely)) cannot be excluded.

- The minor gall bladder wall thickened may be secondary to age-related hyperplasia and/or mild cholecystitis.

Secondary Findings

- Minor bilateral age-related renal changes
- Borderline bilateral adrenomegaly
- 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).

- Minor, age-related pancreatic remodeling

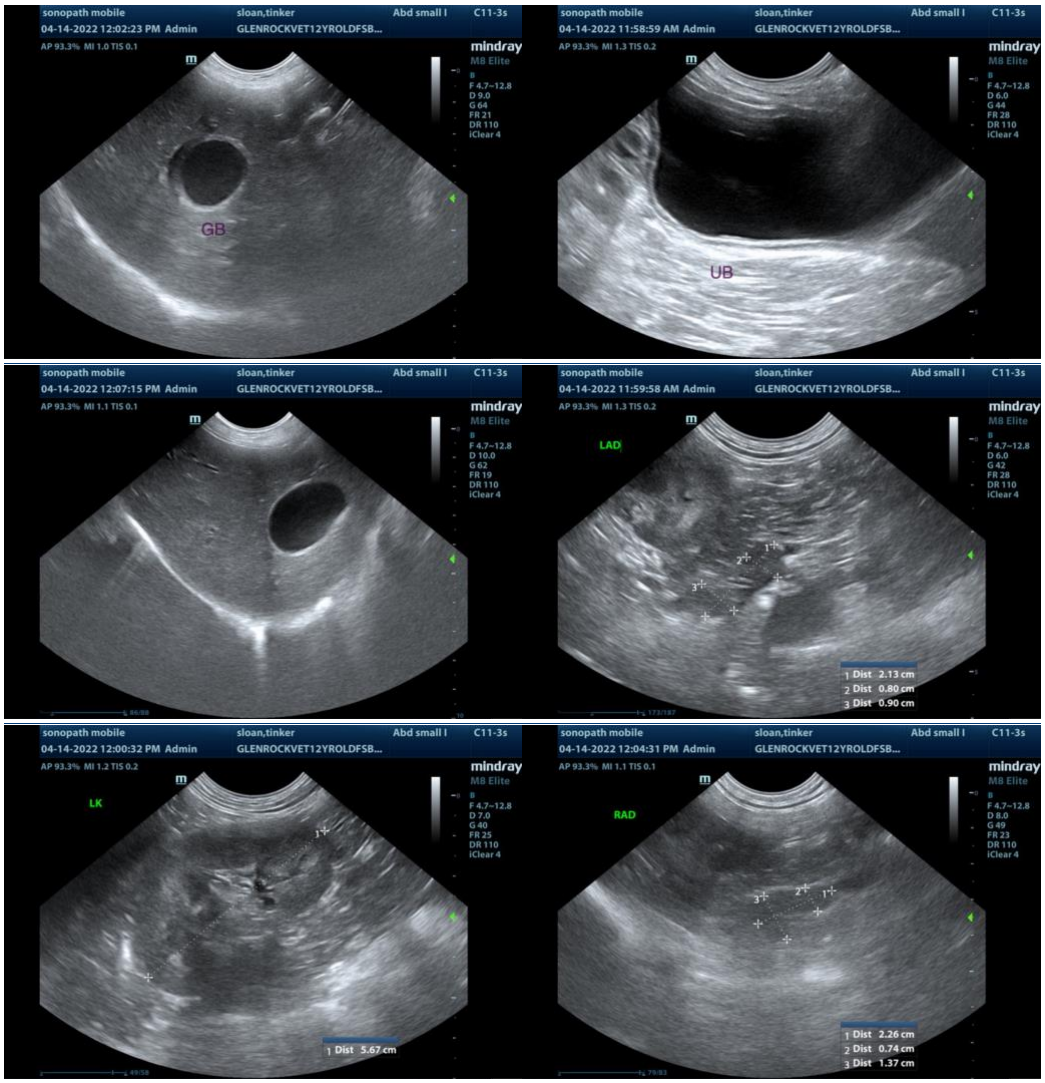
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

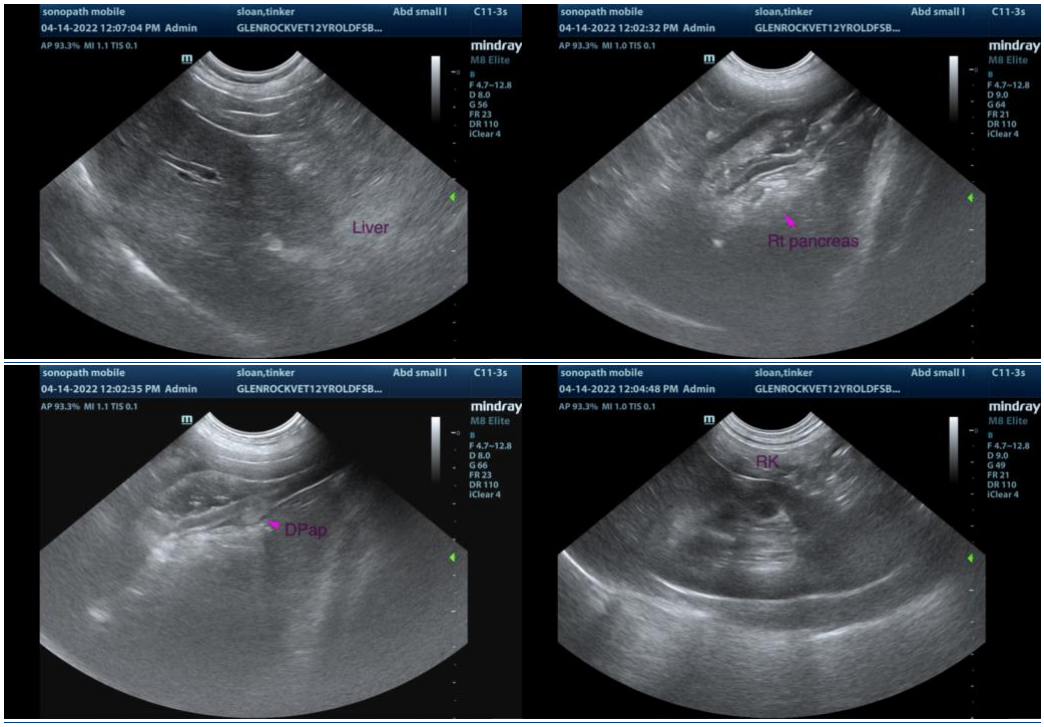
- Regarding the pollakiuria, a urinalysis and urine culture and sensitivity are recommended, preferably on a pre-antibiotic sample. Evaluation of the external genitalia should also be performed to assess for causes of pollakiuria (i.e., vulvar masses, etc.)

- Regarding the elevated ALT, weight loss and vomiting, consider the following:

1. Pre-and postprandial serum bile acids
2. Leptospirosis testing (i.e., blood and urine PCR, serology)
3. +/- hepatic tissue sampling (i.e., fine-needle aspirate or surgical biopsy). Surgical biopsies would be ideal in that they are more likely to represent global organ pathology. If biopsies are pursued, aerobic and anaerobic bile cultures and acquisition of additional hepatic tissue samples for potential copper quantitation are also recommended.

- Given the vomiting and weight loss, consider a malabsorption panel, including serum cobalamin and folate, TLI and PLI as well as thoracic radiographs (three-view).





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)
info@SonoPath.com