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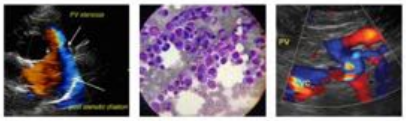
SVS IMAGING



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

PATIENT

Toby Longo

SPECIES

Canine

BREED

Bichon Frise

SEX

Neutered Male

AGE

13.5 years

WEIGHT

12.92 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

Judi Fleischaker DVM

INVOICE

12846

DATE

4.24.23

PRESENTING CLINICAL SIGNS

History: Gastroenteritis with increased alt and alk phos

Abnormal PE/Chem/CBC/UA Results: ALT287, ALP 538 ALT slightly increased, ALP stable

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The prostate is normal in size (0.59 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal in size (5.28 cm in length) with a normal shape, architecture and smooth peripheral margins. The cortex is isoechoic relative to the spleen. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney is normal in size (5.02 cm in length) with a normal shape, architecture and smooth peripheral margins. The cortex is isoechoic relative to the spleen. Several small cortical cysts are seen. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is normal in size (0.57 cm at cranial pole) (0.54 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 (0.56 cm at cranial pole) (0.59 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 (0.89 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.

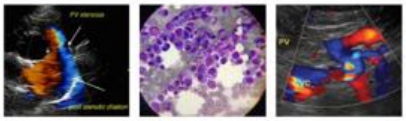
Liver

The liver is subjectively normal in size. The parenchyma is hypoechoic relative to the spleen and slightly mottled in appearance. A 2.45 cm isoechoic mass is visualized at the caudal aspect. It appears to cause slight capsular expansion. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

The gall bladder is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. 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



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outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. There is no evidence of an obstructive pattern.

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

There is no obvious evidence of free fluid. A 0.74 cm mesenteric lymph node is visualized.

ULTRASONOGRAPHIC FINDINGS

Findings

- The hepatic mass could be consistent with a benign process (i.e., large regenerative nodule, inflammatory focus) or an emerging tumor (i.e., adenoma, adenocarcinoma, other). The diffuse hepatic parenchymal changes are nonspecific and could be associated with a benign age-related process (i.e., remodeling, regenerative nodular hyperplasia). Alternatively, more insidious hepatic pathology (i.e., inflammatory disease, hepatotoxicosis (i.e., copper)), infiltrative neoplasia (less likely), other hepatopathy should also be considered (particularly in light if the rising ALT).
- The prominent mesenteric lymph nodes is likely reactive with a lower possibility of emerging neoplasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Regarding the elevated liver values, consider the following:

  1. Pre-and postprandial serum bile acids
  2. Leptospirosis testing (i.e., blood and urine PCR, serology), particularly if the clinical suspicion for disease is high.
  3. Hepatic tissue sampling (i.e., fine-needle aspirate or biopsies). Specific attention to the mass should be made. If biopsies are pursued, aerobic and anaerobic bile cultures should be obtained, and hepatic copper quantitation performed. If tissue sampling is not pursued at this time, a recheck ultrasound is recommended in 4 weeks to assess for growth of the mass.

- Regarding the patient's GI signs, the following diagnostics/therapeutics can be considered:

  1. Fecal evaluation for ova and Giardia (if not already performed)
  2. Prophylactic deworming with Fenbendazole
  3. Initiation of a probiotic with a high colony count (i.e., Proviable Forte or Visbiome)
  4. +/- fiber supplement
  5. GI panel including serum cobalamin and folate, TLI, PLI and resting cortisol level (send to Texas A&M).
  6. If the GI signs are chronic, a 2-4-week limited antigen or hydrolyzed protein diet trial is recommended.
  7. Depending on the results of the above diagnostics/therapeutics, endoscopic or surgical GI biopsies may be necessary to get a definitive diagnosis. If pursued, thoracic radiographs are recommended prior to anesthesia to assess cardiopulmonary status.

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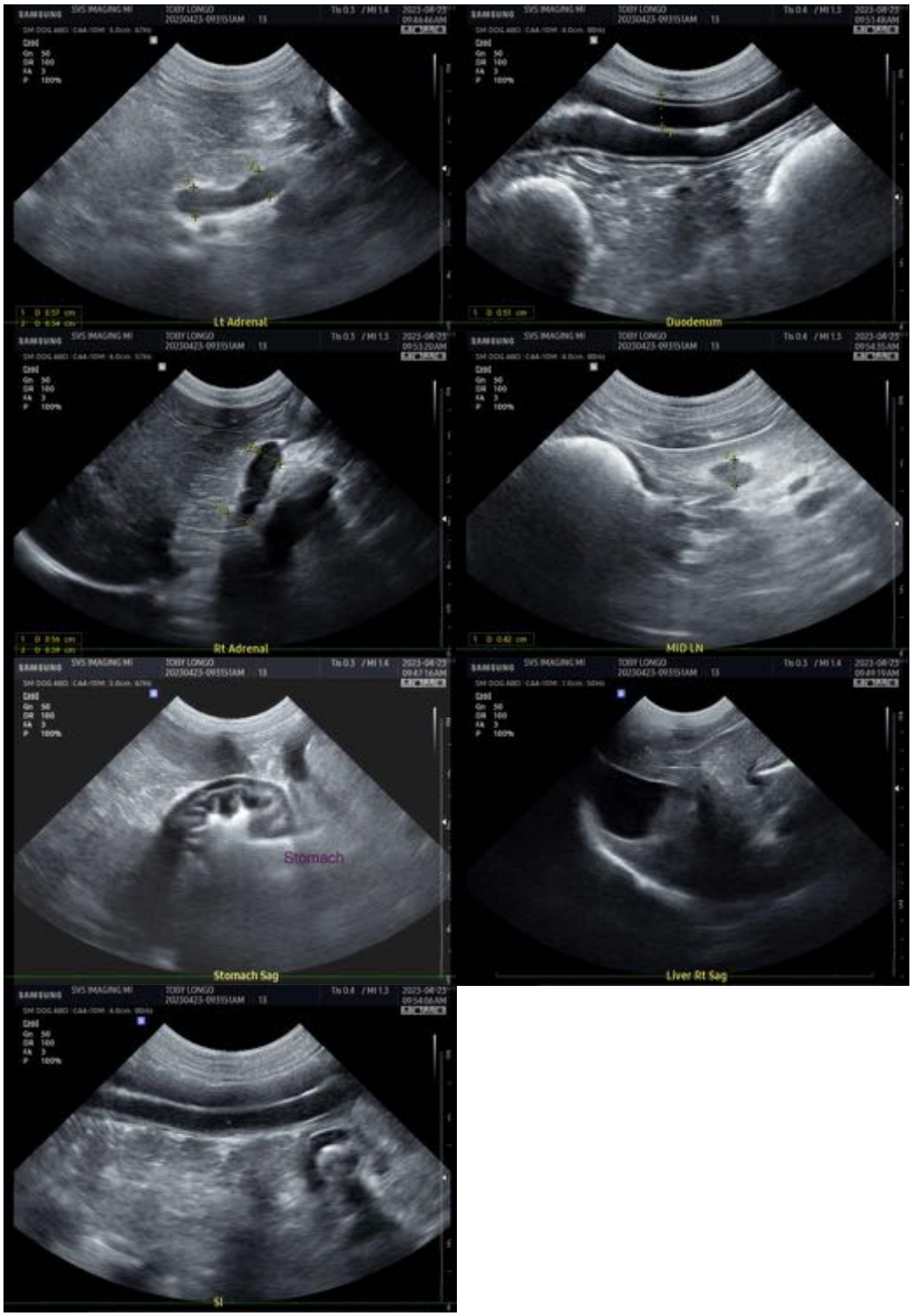

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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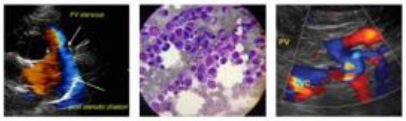

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Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance, please contact me.

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info@SonoPath.com