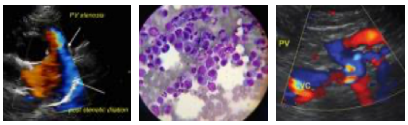
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
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DATE

4/26/22

PATIENT

Hefner Herman

SPECIES

Canine

BREED

Chihuahua

SEX

Male, neutered

AGE

8/1/2007

WEIGHT

9 lbs.

INTERPRETED BY

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

HOSPITAL NAME

Timonium AH

REFERRING VET

Dr. McIntyre

INVOICE

13277

PRESENTING CLINICAL SIGNS

Chronic progressive inappetence, weight loss, food sensitivity and vomiting.

Current Medications: Prednisolone 5mg SID for 7 days then 2.5mg SID- started 1 week ago- no improvement in signs. No improvement with Mirtazapine. PRN Metronidazole and Cerenia for vomiting/soft stool.
Lab Results: 4/20/22- Creat 1.3, BUN 59, Phos 6.4, ALT 186, ALP 222, T4 1.5, USG 1.026.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

Imaging Performed By: Andi Parkinson, RDMS.

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 mostly 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 (0.90 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal size (3.47 cm in length) with a slightly irregular shape. The cortex is variably thickened and there is moderate loss of corticomedullary distinction. Hyperechoic shadowing diverticular foci are visualized. At least one small cortical cyst is observed. There is no evidence of pyelectasia or hydroureter.

The right kidney is normal size (3.62 cm in length) with a slightly irregular shape. The cortex is variably thickened and there is moderate loss of corticomedullary distinction. Hyperechoic shadowing diverticular foci are visualized. 2-3 cortical cysts are observed. Moderate pyelectasia is present (0.36 cm in the longitudinal plane). There is no evidence of hydroureter.

Adrenal Glands

The left adrenal gland is normal size (0.44 cm at cranial pole) (0.52 cm at caudal pole) (1.38 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 normal size (0.35 cm at cranial pole) (0.47 cm at caudal pole) (1.48 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 (0.85 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 slightly rounded peripheral contours. The parenchyma is isoechoic relative to the spleen and mottled in appearance with several small ill-defined hypoechoic nodules/areas. 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 moderate to large amount of

suspended echogenic debris/sludge 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 in the region of the fundus is normal in thickness with a normal layering pattern. In the region of the pyloric antrum, the muscularis layer is prominent. The pyloric outflow tract is patent. 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 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:

- Excessive gallbladder debris/sludge. Possible causes include cholestasis, a developing mucocele or fasting (less likely).
- 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.
- Bilateral non-specific age-related renal changes with dystrophic mineralization and right pyelectasia.

Secondary Findings:

- The prominent pyloric antral muscularis layer may be secondary to hypertrophy, inflammation, emerging neoplasia (less likely) or a normal variant for this patient.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given the clinical history and sonographic renal changes, a urine culture and sensitivity, UPC (if proteinuria is present) and baseline blood pressure measurement are recommended.
- Given the gall bladder changes, Ursodeoxycholic acid (Ursodiol) at 10-15 mg/kg once a day is recommended. Serial sonographic monitoring (e.g., every 6-8 weeks) of the gall bladder is recommended to assess for progression to a fully-formed mucocele.
- Consider three-view thoracic radiographs to assess for occult neoplasia in the chest as a possible cause for inappetence and weight loss.
- Also consider a GI panel (send to Texas A&M) as well as a fecal evaluation for ova and Giardia.


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Liver
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IntraPet Imaging APIILLC
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Cranial
Pylorus
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Prostate
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The information and recommendations provided are based on the images presented by the referring veterinarian. 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 ACVIM (*Small Animal Internal Medicine*)
Andrea.nicastro@sonopath.com