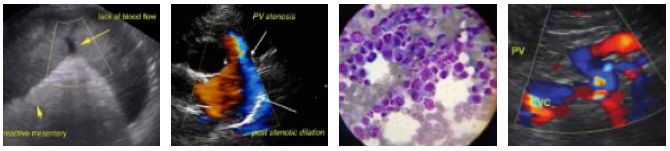
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Jasmine Gates

SPECIES
Canine

BREED
Mini Pinscher

SEX
Female, spayed

AGE
14 Yrs. 9 Months

WEIGHT
22.5 lbs.

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

IMAGING PERFORMED BY
Heather

HOSPITAL NAME
Animal Care Clinic of Flanders

REFERRING VET
Dr. Casulli

INVOICE
14908

DATE
5/9/23

PRESENTING CLINICAL SIGNS

History: pre-surgical, met check showed large rounded liver rimadyl 25mg 1/2 BID enalapril 5mg SID Abnormal PE/Chem/CBC/UA Results: alt - 165, alk phos - 201, bun - 44, chronic liver value elevations for years (had abd u/s 7/2020) u/a +2 protein, UPC - 0.9 SG - 1.020

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly to moderately distended. The wall is of appropriate thickness for the level of repletion. The mucosal surface in the region of the apex is slightly irregular. A scant amount of echogenic debris is observed within the lumen. The region of the trigone is normal.

The left kidney is normal size (4.22 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is isoechoic relative to the spleen. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. Trace pyelectasia is present. A few small cortical cysts are seen. Hyperechoic shadowing diverticular foci are visualized. There is no evidence of infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (4.95 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is isoechoic relative to the spleen. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. Trace pyelectasia is present. At least one small cortical cyst is seen. Hyperechoic shadowing diverticular foci are visualized .There is no evidence of infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is borderline enlarged (0.54 cm at cranial pole) (0.68 cm at caudal pole); 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 borderline enlarged (0.92 cm at cranial pole) (0.64 cm at caudal pole); 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.

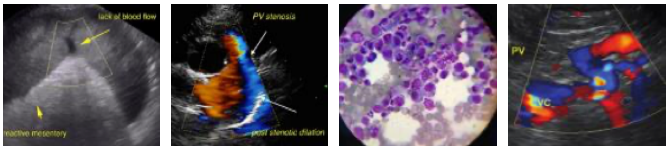
Spleen

The spleen is normal in size (1.41 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 enlarged with slight rounding of the curvilinear 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 moderate amount of aggregated echogenic partially dependent sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal



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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 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 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 (0.32 cm in diameter). 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.

Other

A brief echocardiogram reveals no obvious evidence of pericardial effusion.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

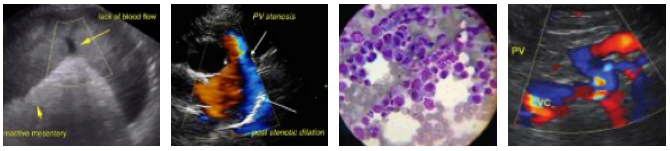
- Non-specific diffuse hepatopathy. Vacuolar hepatopathy (i.e., endocrine, idiopathic) is the top differential. However, inflammatory disease or infiltrative neoplasia cannot be completely excluded.
- The gallbladder sludge could be consistent with cholestasis, fasting or developing mucocele.

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.
- Borderline bilateral adrenomegaly.
- Bilateral chronic nephropathy with dystrophic mineralization, pyelectasia and cortical cysts.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to complete the metastatic check.
- Serial monitoring (i.e., every 3-4 months) of the patient's liver values is recommended. If liver values continue to increase, a repeat abdominal ultrasound +/- hepatic tissue sampling may be warranted.
- 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.
- Given the proteinuria, consider the following:



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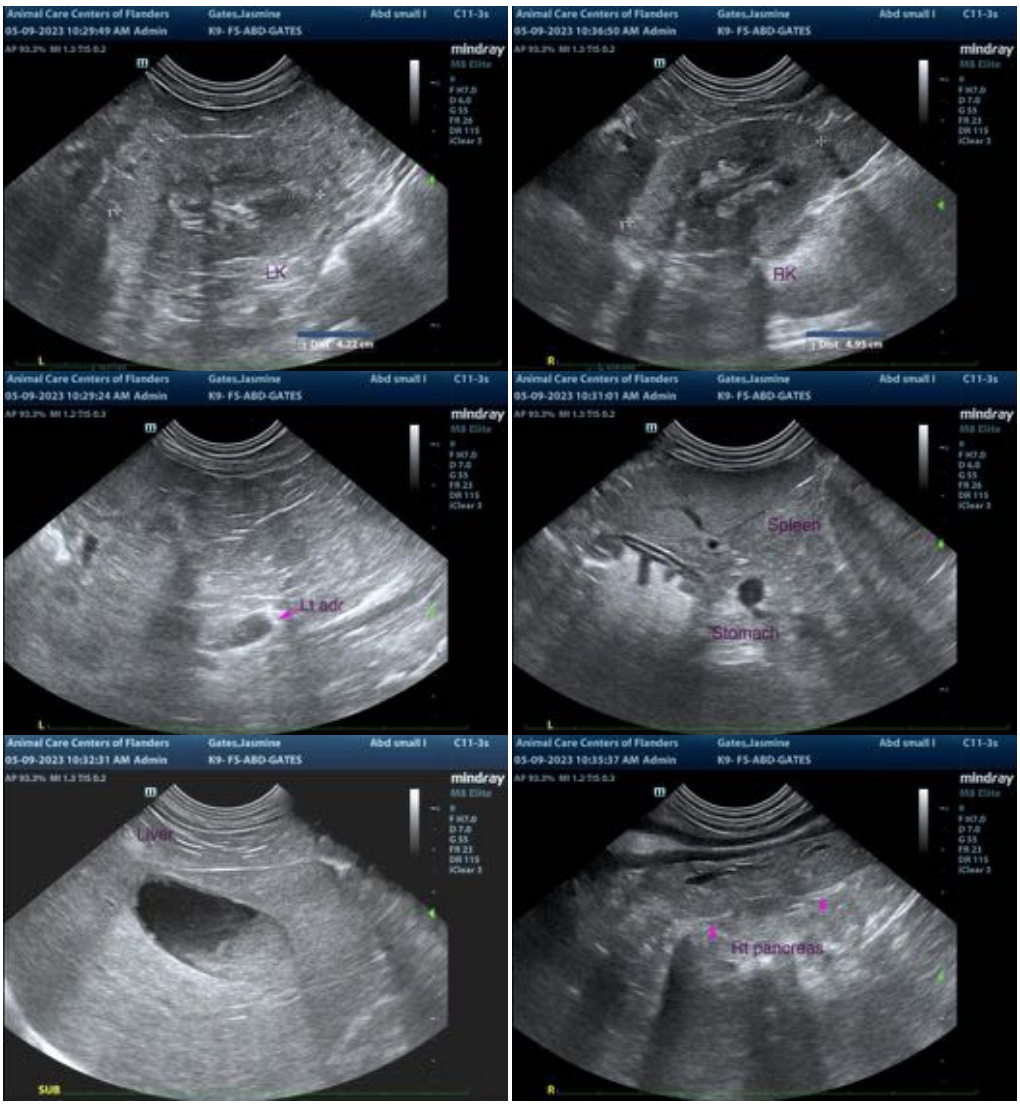
1. Addition of an angiotensin receptor blocker (i.e., Telmisartan)
2. Baseline blood pressure measurement
3. Urine culture and sensitivity to assess for occult infection
4. Omega-3 fatty acids
5. Prescription renal diet, if the patient is not already receiving one
6. Serial monitoring of the patient's renal values to assess for progressive azotemia



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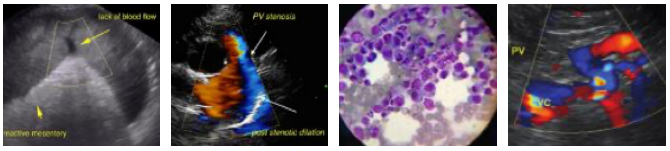

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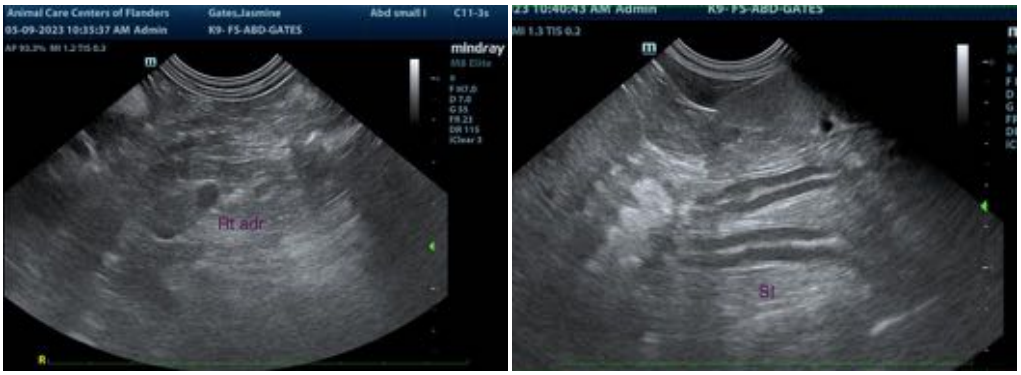

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
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