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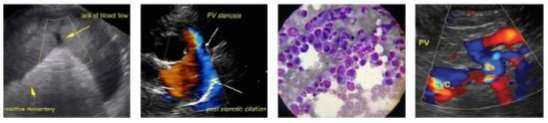


IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Bailey Toothacre

SPECIES

Canine

BREED

Border Collie

SEX

Spayed Female

AGE

12 years

WEIGHT

28 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT LVT

HOSPITAL NAME

MountianView AH

REFERRING VET

Dr. Sarah Kalivada

INVOICE

11280

DATE

7.29.22

PRESENTING CLINICAL SIGNS

History: Suspected Cushing's, vomiting, diarrhea, UTI, elevated BUN and SDMA, mild hypoalbuminemia, and electrolyte imbalance- lethargic Bailey presented for vomiting, diarrhea and hyporexia. The vomiting resolved but she is still having liquid diarrhea and has a decreased appetite. She is suspected to have Cushing's disease and has recurrent bacteria in urine but is not always showing signs of a UTI. She does have a history of bradycardia and a heart murmur, unknown cause but heart rate was normal on examination the other day. Hospitalized on IVF at the clinic all day- MEDS: Four Marvels Multivitamin 1/2 packet Bone broth with meals, apple cider vinegar Digestive enzyme- Denamarin Vitamin C Probiotics Amantadine D-Mannose Welactin Ursodiol 1/2 mL BID Amlodipine Rx Clay Lignans Melatonin

Abnormal PE/Chem/CBC/UA Results: Blood work was performed which showed neutrophilia, eosinopenia, thrombocytosis, elevated BUN (126), elevated SDMA (31), hyperphosphatemia, hypochloremia, hypokalemia, hyponatremia, hypoalbuminemia with total protein decreased. Urinalysis shows USG 1.015 with pyuria, hematuria, and bacteria (rods). Waiting urine culture.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** wall is normal in thickness and the mucosal surface is smooth. The bladder is distended. A moderate amount of echogenic debris is observed within the lumen. 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 **left kidney** is normal size (7.17 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. A few small cortical cysts are seen. Mild pyelectasia is present (0.39 cm in the longitudinal plane). There is no evidence of nephroliths, infarcts or hydroureter.

The **right kidney** is normal size (5.95 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. A small cortical cyst is observed at the caudal pole. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The **left adrenal gland** is enlarged (1.51 cm at cranial pole) (1.21 cm at caudal pole) (3.43 cm in length); with a slightly irregular shape. The parenchyma subtly heterogenous with mild loss of glandular detail. The phrenicoabdominal vein and surrounding vasculature appear normal.

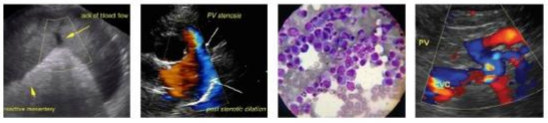
The **right adrenal gland** is mildly enlarged (0.86 cm at cranial pole) (0.88 cm at caudal pole) (2.77 cm in length); with a slightly irregular shape at the caudal pole. The parenchyma is hypoechoic with some loss of glandular detail. The phrenicoabdominal vein and surrounding vasculature are normal. The mesentery surrounding the gland is mildly hyperechoic.

Spleen

The **spleen** is normal in size (1.98 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 with normal curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and mildly heterogenous in appearance. A 2.70 cm ill-defined,



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hyperechoic to heterogenous cavitated mass is observed at the caudal aspect. A 0.72 cm hypoechoic to anechoic nodule is observed in the left lateral lobe. In addition, a 1.87 cm isoechoic to mildly heterogenous cavitated nodule is observed in the region of the right medial lobe. Hepatic vasculature and intrahepatic 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 large amount of aggregated, echogenic, partially dependent to suspended sludge is observed within the lumen. Some sludge is also adhered to the luminal surface. 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 outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall is normal in thickness with a normal layering pattern. There is evidence of mucosal speckling in some segments. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas

The base and limbs of the **pancreas** are visible with normal curvilinear peripheral contours. The parenchyma is largely hyperechoic 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

There is no evidence of free fluid. The abdominal **lymph nodes** are normal/not visible.

Other

A brief echocardiogram reveals no evidence of pericardial effusion or obvious right atrial/auricular mass.

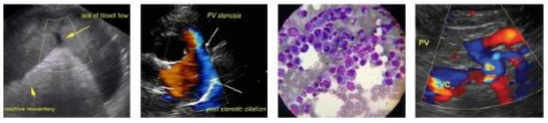
ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The pancreatic changes are consistent with chronic age-related change/fibrosis. Concurrent pancreatitis may also be present, particularly if the patient exhibits a positive Murphy's sign.
- The hepatic nodules and mass could be consistent with emerging neoplasia. Alternatively, a benign process (i.e., cystadenoma) may be present. The diffuse hepatic parenchymal changes are nonspecific and are likely benign in origin (i.e., regenerative nodular hyperplasia and/or vacuolar hepatopathy).
- Bilateral chronic, age-related renal changes with left pyelectasia.
- The urinary bladder debris could be consistent with cells, crystals and/or exfoliated material.
- The small intestinal mucosal speckling is suggestive of inflammatory disease.

Secondary Findings

- The gall bladder changes could be consistent with a developing mucocele, cholestasis, or less likely secondary to fasting.



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- Bilateral adrenomegaly. The irregularity at the caudal pole of the right adrenal gland may be secondary to hyperplastic change or an emerging tumor. There is suggestion of retroperitonitis in this region.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Regarding the GI signs, consider the following:

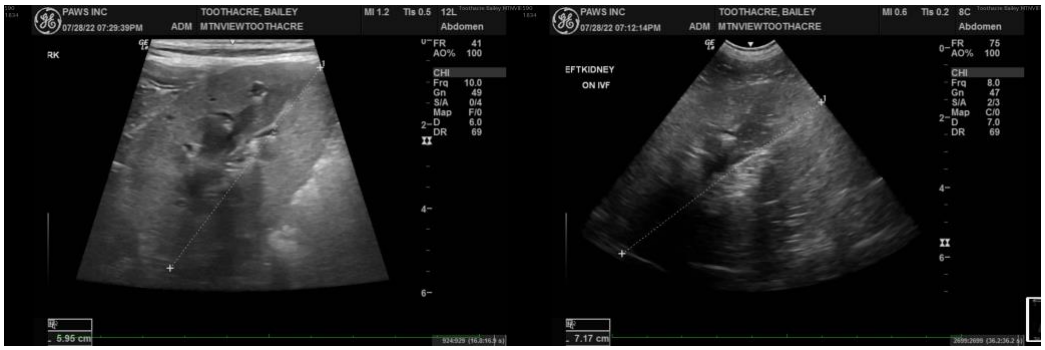
- cPLI +/- a full GI panel to further evaluate for pancreatitis and maldigestion/malabsorption.
- A fecal evaluation for ova and Giardia is also recommended.
- Initiation of a probiotic with a high colony count (i.e., Proviable Forte or Visbiome)

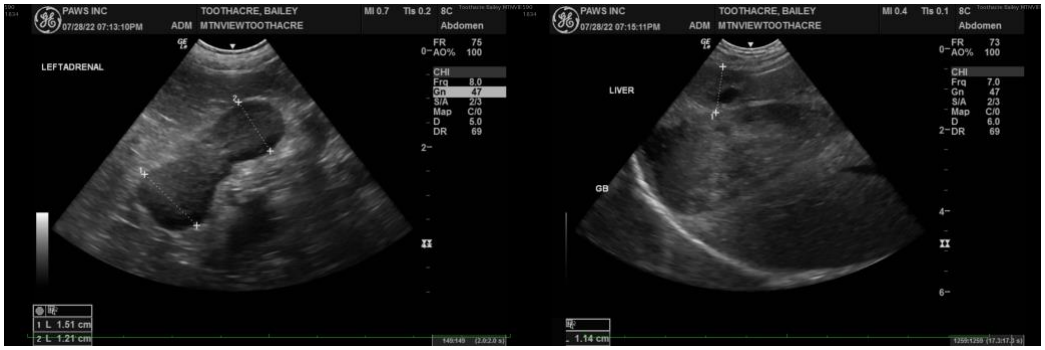
Regarding the azotemia and sonographic renal changes, consider initiation of empirical treatment for pyelectasia (i.e., fluoroquinolone) along with continued IV fluid therapy and symptomatic care. Also consider a baseline blood pressure measurement.

Regarding the hypoalbuminemia, consider the following:

1. UPC (when the urine culture has resolved)
2. Pre-and postprandial serum bile acids to assess for occult hepatic dysfunction
3. GI Panel (as mentioned above)

Given the patient's age, three-view thoracic radiographs are recommended to assess cardiopulmonary status.





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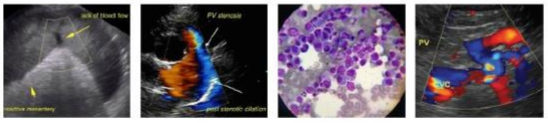

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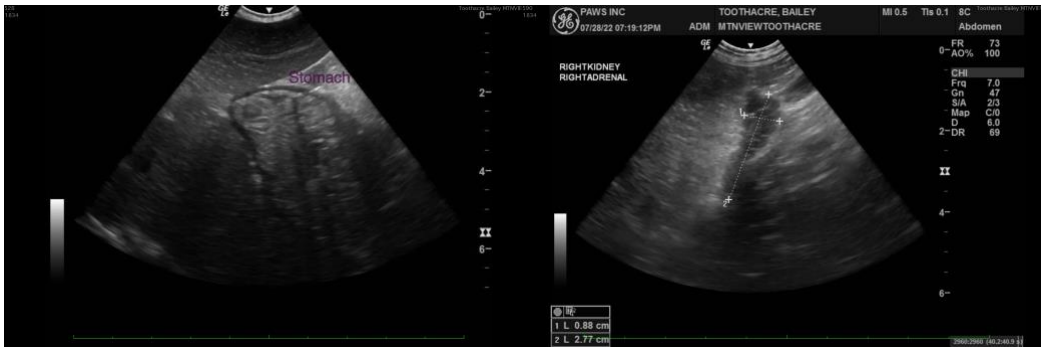

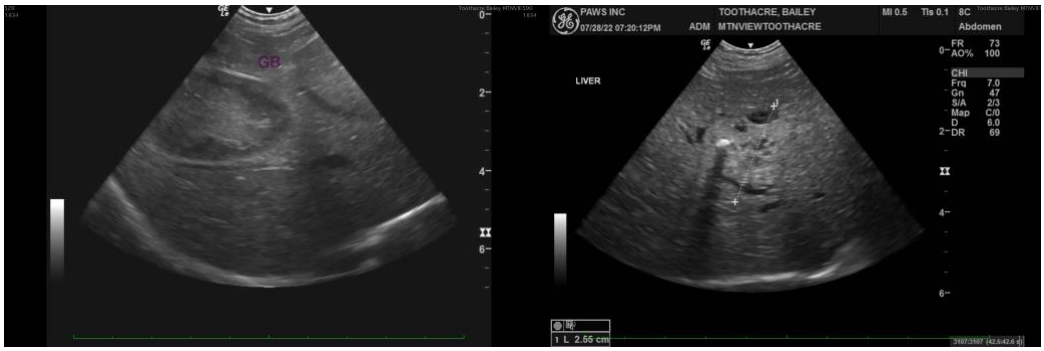

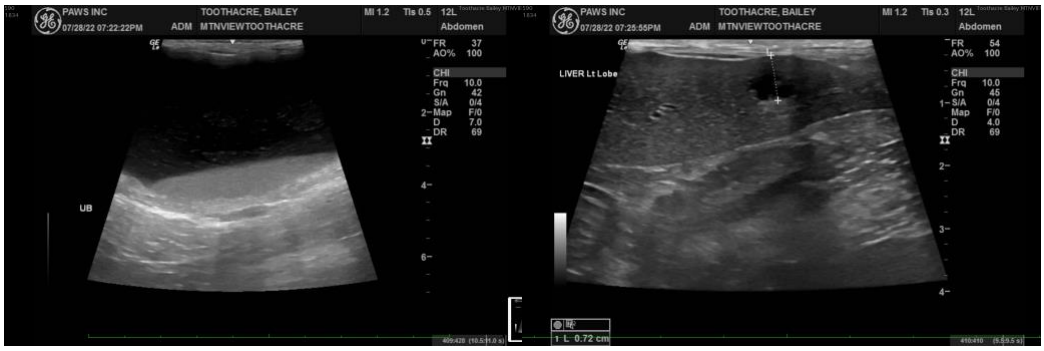

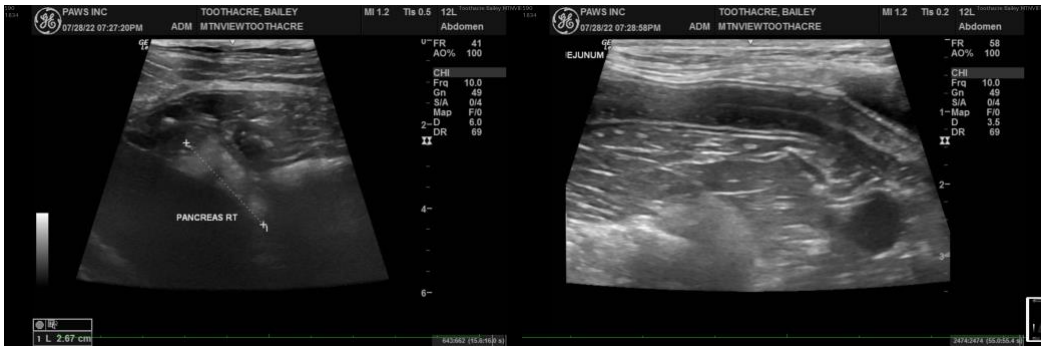

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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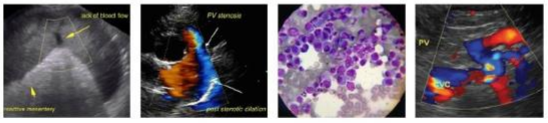

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Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance, please contact me.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com