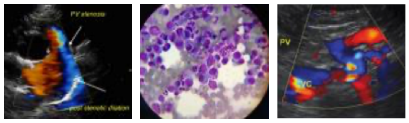
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
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DATE

8.12.2022

PATIENT

Beau Glenn Campbell

SPECIES

Canine

BREED

American Staffordshire

SEX

Neutered Male

AGE

8/21/2010

WEIGHT

65lbs

INTERPRETED BY

Andrea Nicastro, DMV, Diplomate DACVIM (Small Animal Internal Medicine)

HOSPITAL NAME

Timonium Animal Hospital

REFERRING VET

Dr. Kauder

INVOICE

11401

PRESENTING CLINICAL SIGNS

Annual met check- history of anal sac adenocarcinoma 9/2020; had pancreas pseudocyst removed 11/2021 (Blue Pearl) & biopsies of liver 11/2021-referral info attached as a file

Current Medications: Dasuquin-long term, Deramaxx 75mg- 1/2-3/4 tab daily- long term, Gabapentin 300mg BID long term, Denamarin 425mg- daily long term, Ursodiol 300mg sid- long term
Date of Previous IntraPet Ultrasound: 8/22/21. See attached.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

Imaging Performed By: Andi Parkinson, BS, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** wall is normal in thickness and the mucosal surface is smooth. 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.

The **prostate** is normal in size (1.34 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 (7.17 cm in length); with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild to moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis.

The **right kidney** is normal in size (6.26 cm in length); with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild to moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. A 0.98 cm cortical cyst is observed in the medial aspect. There is no evidence of pyelectasia, infarcts or hydronephrosis.

Adrenal Glands

The **left adrenal gland** is mildly enlarged (1.10 cm at cranial pole) (0.89 cm at caudal pole) (2.96 cm in length); with a relatively normal shape. The parenchyma is mildly heterogenous with some loss of glandular detail. The phrenicoabdominal vein and surrounding vasculature are normal.

The **right adrenal gland** is mildly enlarged (1.44 cm at cranial pole) (0.85 cm at caudal pole) (3.34 cm in length); with a relatively normal shape. The parenchyma is mildly heterogenous with some loss of glandular detail. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The **spleen** is normal in size (1.30 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 diffusely heterogenous in appearance. An ill-defined hypoechoic area is observed deep on the left side. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1: 1.

The **gall bladder** is distended. The wall is normal in thickness. A large amount of aggregated, echogenic suspended sludge in a partially stellate pattern is observed within the lumen. 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 is 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 retention of the normal layering pattern. In at least one small intestinal segment, there is disruption in the normal 1:3 muscularis: mucosal ratio. The mesentery effacing the serosal surface in this segment is hyperechoic. Discreet masses are not identified. The colonic wall is normal. There is no evidence of an obstructive pattern.

Pancreas

The **pancreas** is prominent in size with slightly irregular peripheral contours. The region of the left limb is hyperechoic relative to surrounding omental fat and slightly mottled in appearance. The base and right limb are largely isoechoic relative to surrounding omental fat and mildly heterogenous. No distinct focal lesions are observed. The pancreatic duct is not overtly dilated.

Free Abdomen

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Gall bladder changes consistent with a developing to fully-formed mucocele. Changes are similar to slightly worse compared to previous sonogram.

- Nonspecific diffuse hepatopathy. If the liver values are normal or if only ALP is elevated, a benign hepatopathy (i.e., regenerative nodular hyperplasia and/or vacuolar hepatopathy) would be considered mostly likely. If the ALT is substantially elevated, other hepatopathies (i.e., inflammatory disease, hepatotoxicosis, fibrosis, other) need to be considered.

*There is no obvious evidence of metastatic disease neoplasia in the abdomen.

Secondary Findings

- The bilateral adrenomegaly is most consistent with hyperplastic change. Changes are similar to the previous sonogram.

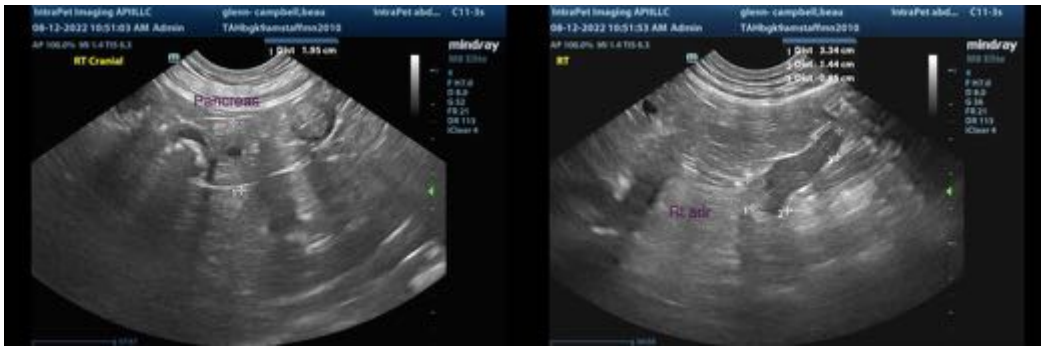
- Bilateral chronic, age-related renal changes with dystrophic mineralization.

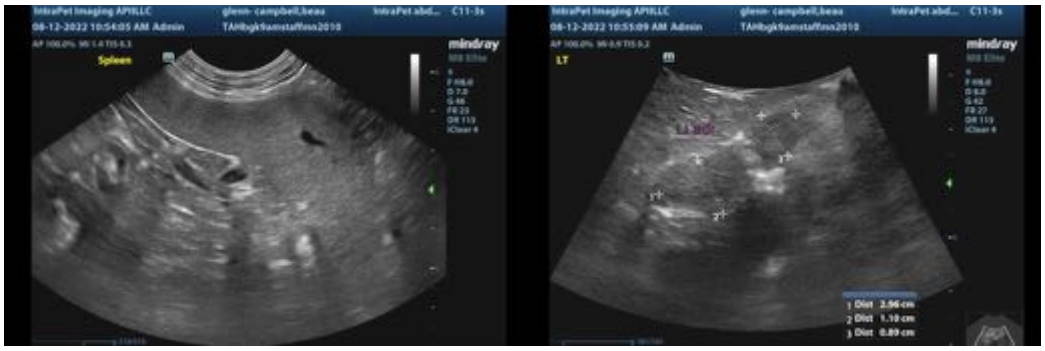
- The pancreatic changes are consistent with age-related remodeling and fibrosis. Mild, chronic, pancreatitis is also possible, particularly if the patient's clinical history is supportive of this diagnosis.

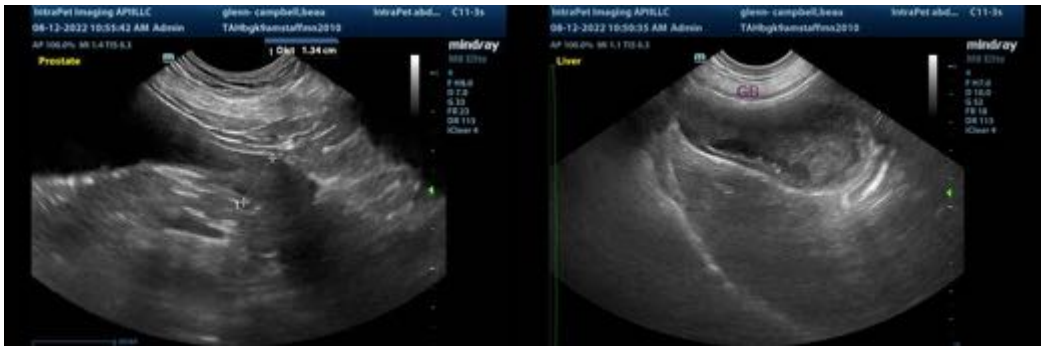
- The segment of small intestinal which contains thickening of the muscularis layer could be consistent with inflammatory bowel disease or emerging lymphoma. Adjacent peritonitis is present. This finding was seen on the previous sonogram.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the gall bladder changes, consider a cholecystectomy. If pursued, referral to a board-certified surgeon is recommended due to the potential for perioperative complications. If surgery is not pursued, continue Ursodiol therapy with serial sonographic monitoring (i.e., every 4-6 weeks) of the gall bladder to assess for progression.







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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