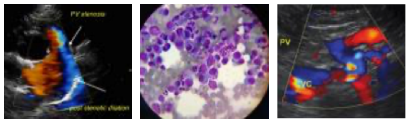
IMAGING PERFORMED BY

IntraPet.com



SonoPath
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DATE

8.16.23

PATIENT

Polly Spring

SPECIES

Canine

BREED

Beagle Mix

SEX

Female Spayed

AGE

4/2/2012

WEIGHT

33.2 lbs

INTERPRETED BY

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

HOSPITAL NAME

Paradise AH

REFERRING VET

Dr. Twardzik

INVOICE

14120

PRESENTING CLINICAL SIGNS

Patient presented for acute lameness. History of a chronically elevated ALP that has been rising. On exam, she was non-weight-bearing on her right rear leg with a meniscal click, cranial drawer movement. Mild dental tartar. Adenomas. 5/5 BCS.

Current Medications: Trazodone 50-75 mg PO PRN for vet visits
Lab Results: CBC: Decreased retic HGB, elevated PCT. Chem: Elevated ALP 1094 U/L
USG 1.050 with a small amount of proteinuria, inactive sediment. T4 normal.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Rachel Brilhart, RDMS.

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 visible portion of the proximal urethra are normal.

The left kidney is normal in size (5.60 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. A thin, hyperechoic medullary band is observed at the corticomedullary junction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (5.53 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. A thin, hyperechoic medullary band is observed at the corticomedullary junction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.60 cm at cranial pole) (0.68 cm at caudal pole) (2.14 cm in length) 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 mildly enlarged (0.92 cm at cranial pole) (0.87 cm at caudal pole) (2.30 cm in length) 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 overall normal in size (1.23 cm in width at the level of the hilus). There is mild swelling of the capsule at the medial aspect, distal to the hilus. The remaining peripheral margins are curvilinear. The parenchyma is of appropriate echogenicity and echotexture. A few small myelolipomas are observed in the region of the hilus. Splenic vasculature appears normal no evidence of thrombosis.

Liver

The liver is normal to slightly prominent in size with normal curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and exhibits subtle heterogeneity. No distinct focal lesions

are observed. 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 scant amount of gravity-dependent echogenic-to-mineralized debris 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 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 and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. There is no evidence of an obstructive pattern.

Pancreas
The base and right limb of the pancreas are 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. 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.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- 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.
- Echogenic-to-mineralized gallbladder debris, non-mucocele

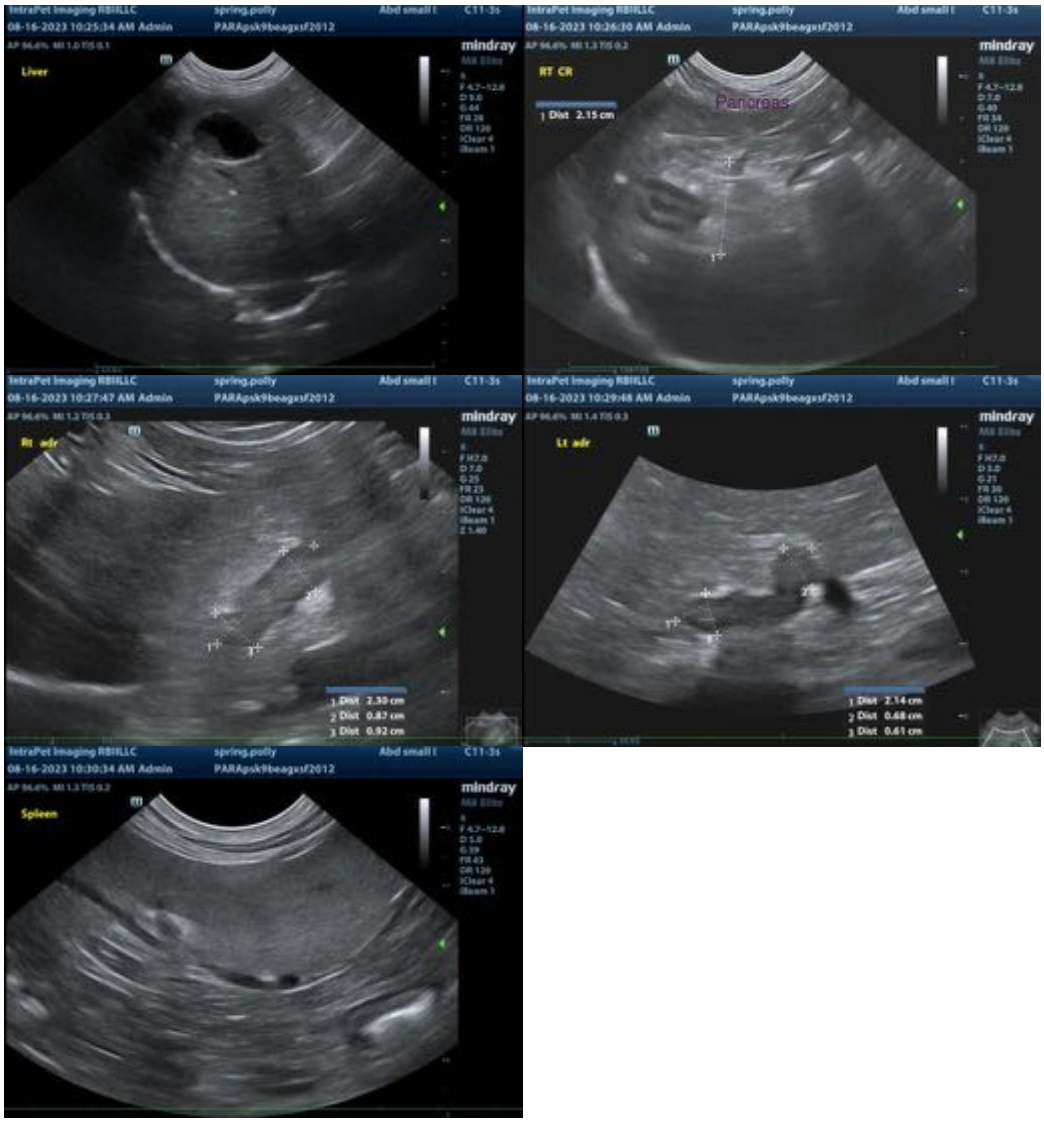
Secondary Findings

- Minor bilateral chronic renal changes
- Mild left adrenomegaly
- Minor pancreatic parenchymal remodeling
- The splenic swelling near the hilus may represent a normal variant for this patient, a benign process (i.e., lymphoid hyperplasia or similar), or less likely, an emerging tumor.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Serial monitoring (i.e., every 3-4 months) of the patient's liver values is recommended. If values continue to increase, a repeat abdomen ultrasound +/- a more advanced hepatic work-up (i.e., 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.

- Regarding the splenic swelling, consider fine-needle aspiration (if clotting status is appropriate) or a recheck ultrasound in 4-6 weeks to assess for growth.



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.

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