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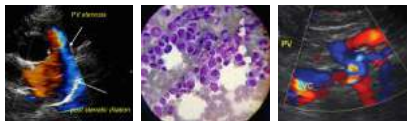

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DATE

9/29/21

PATIENT

Buddy Duvall

SPECIES

Canine

BREED

Terrier Mix Breed

SEX

Male Neutered

AGE

7/19/06

WEIGHT

14 lbs.

INTERPRETED BY

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

HOSPITAL NAME

Paradise AH

REFERRING VET

Dr. Pearson

INVOICE

11926kk

PRESENTING CLINICAL SIGNS

History: Continuing to elevate ALP and ALT with Denamarin. History of heart murmur.

Current Medications: Enalapril 5mg 1 tablet every 12 hours, Vetmedin 5 mg 1 PO BID.

Lab Results: ALT 197, ALP 767.

Radiographs: Not provided by the veterinarian.

Date of Previous IntraPet Ultrasound: No previous IntraPet scans.

Sedation: Sedation not required for scan.

Stat Report: STAT report not requested by the veterinarian.

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 (0.87 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 (4.65 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal size (4.30 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.51 cm at cranial pole) (0.51 cm at caudal pole) (1.59 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 (0.57 cm at cranial pole) (0.43 cm at caudal pole) (1.51 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 subjectively normal in size (1.00 cm in width at the level of the hilus) with normal curvilinear peripheral contour. The parenchyma is slightly mottled in appearance. Numerous, irregular, hyperechoic nodules are observed throughout the organ. Splenic vasculature appears normal with no evidence of thrombosis.

Liver
The liver is subjectively prominent in size with swollen curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and exhibits heterogeneity. No distinct focal lesions are observed. Hepatic vasculature and biliary tracts are of normal volume with no evidence of congestion. The gall bladder is moderately distended. The wall is normal in thickness. Several varying sized polypoid-like lesions are arising from the luminal surface. Luminal contents are otherwise mostly anechoic. 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. The pyloric antrum appears thickened (up to 0.99 cm) with apparent retention of the 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 body 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. A 0.96 x 0.53 cm septated cystic lesion appears to be arising from the pancreatic parenchyma in this region. 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.

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.
- Gall bladder debris – incidental.

Secondary Findings:

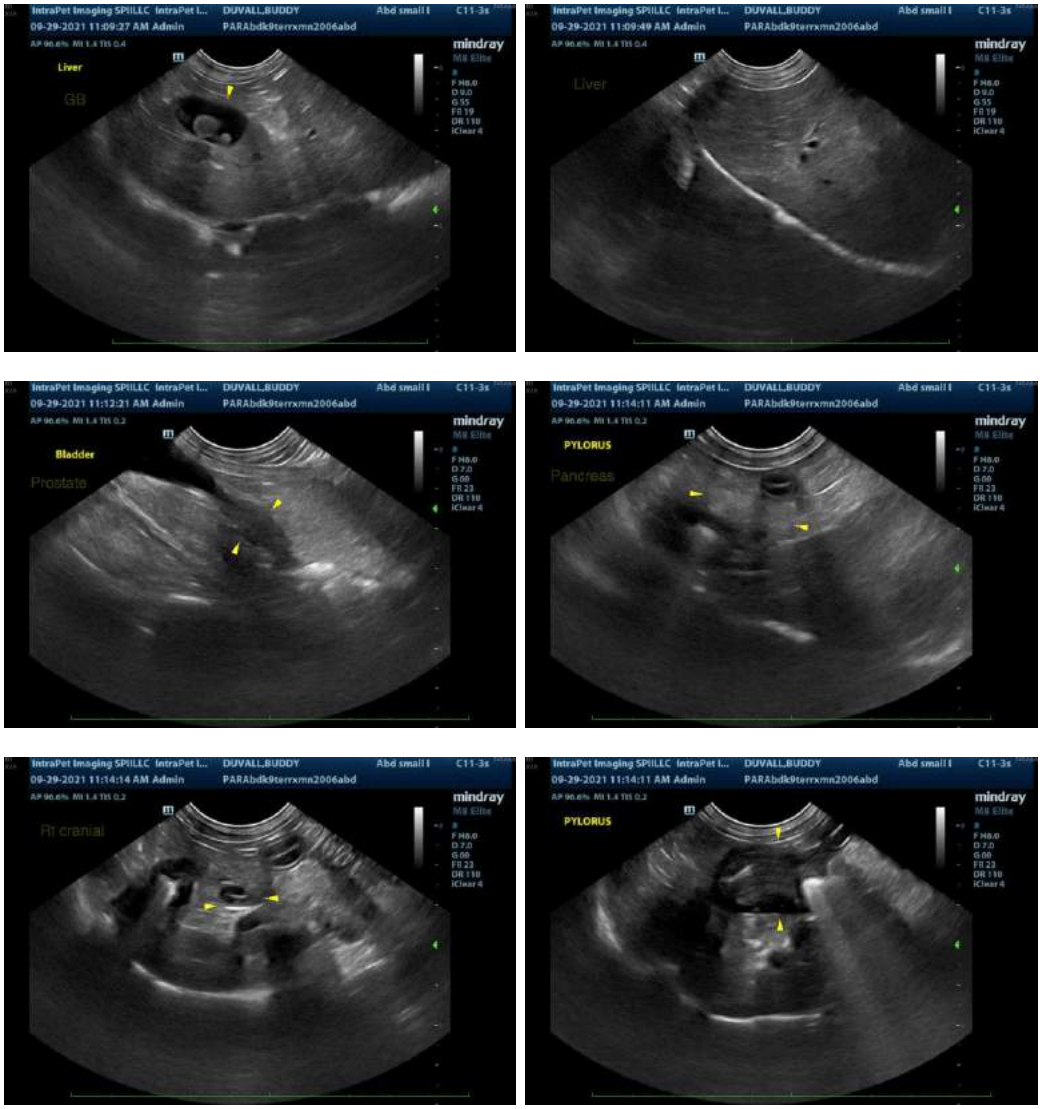
- Bilateral, age-related renal changes with dystrophic mineralization.
- The splenic parenchyma changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis or splenitis with a low possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia). The hyperechoic splenic nodules are most consistent with myelolipomas with a lower possibility of a neoplastic process.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis, or chronic pancreatitis. A small parenchymal cyst is suspected.
- The pyloric antral wall thickening could be consistent with inflammation, hypertrophy, or emerging neoplasia. Correlation with the patient's clinical signs is recommended.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

1. Serial monitoring (i.e., every 3-4 months) of the patient's liver values is recommended. If values continue to increase, a repeat ultrasound +/- hepatic tissue sampling may be warranted.

2. Consider testing for hyperadrenocorticism with a low-dose dexamethasone suppression test or ACTH stimulation test if clinical signs (i.e., PU/PD) develop.

3. Given the patient's age and history of a heart murmur, three-view thoracic radiographs +/- an echocardiogram, ECG, and blood pressure measurement should be considered.



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.

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