

PATIENT

Dini Sundberg

SPECIES

Canine

BREED

Bichon Frise

SEX

Male Neutered

AGE

11 years

WEIGHT

17 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Heidi Putnam

HOSPITAL NAME

Bush Animal Hospital

REFERRING VET

Dr. Gibson

DATE

8/11/21

INVOICE
11618kk

PRESENTING CLINICAL SIGNS

History: This is a follow up ultrasound to his previous study on 7/14. (echo and AUS) Today's study is 2 hours post prandial to evaluate his gallbladder function and to briefly look at his previously noted prostatic mineralization. Chem/CBC/UA Results: ALP= 1225, rising (previously in the 400-500 range), ALT=147, normal T bili, normal CBC, T4 is at the upper end of normal. Gets supplementation with Thyroxine.

Abnormal PE/Chem/CBC/UA Results: Rising ALP 1225, ALT=147 Meds; thyroxine 0.1 mg bid, PPA 12.5 mg bid

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended. The wall is normal in thickness with a smooth mucosal surface. A small amount of gravity-dependent, mineralized sand +/- tiny calculi is observed within the lumen. The region of the trigone and the visible portion of the proximal urethra are normal.

The prostate is normal in size (1.97 x 0.56 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 (4.25 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. Several nephroliths are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (4.64 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. A few small nephroliths are present. A 0.80 cm cortical cyst containing echogenic material is observed at the cranial medial aspect. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

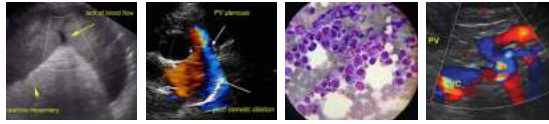
Adrenal Glands

The left adrenal gland is normal size (0.37 cm at cranial pole) (0.46 cm at caudal pole) (1.58 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 (1.10 cm at cranial pole) (0.50 cm at caudal pole) (1.71 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 normal in size (0.91 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A few myelolipomas are observed at the hilus. Splenic vasculature is normal.



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The liver is subjectively enlarged with rounded peripheral contours. The parenchyma is isoechoic relative to the spleen and mottled in appearance with one to two small hyperechoic nodules and a few ill-defined, hypoechoic areas. In addition, a 1.39 x 1.20 cm loculated cyst is observed deep mid to right liver, adjacent to the gall bladder. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion. The gall bladder is moderately distended. The wall is normal in thickness. Several polypoid-like lesions are arising from the luminal surface. 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

The gastric lumen is 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 pancreas is diffusely prominent in size with minimal deviation from the normal peripheral contours. The parenchyma is isoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible (0.22 cm in diameter) but not overtly dilated. There is no evidence of peripancreatic 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:

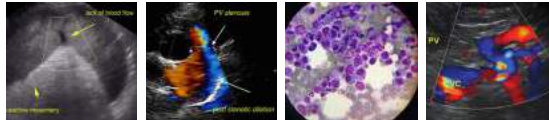
- Gall bladder sludge, non-mucocele. Changes are similar to marginally improved compared to the previous scan.
- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory and infiltrative disease are considered less likely. The cystic area trends towards the benign with a lower possibility of emerging neoplasia.

Secondary Findings:

- Bilateral, non-obstructive nephroliths.
- Urinary bladder sand +/- tiny calculi.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

1. Consider repeat blood work, particularly the liver values, and repeat sonogram of the gallbladder in 2-3 months to assess for progression. Depending on the results at that time,



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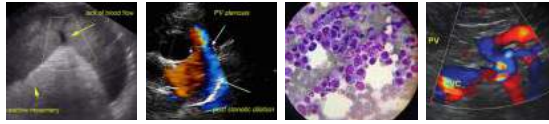
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Ursodiol can be considered.

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. Abdominal radiographs are recommended to assess for discrete cystic calculi. If present, consider a cystostomy with stone removal, analysis and culture is recommended. Alternatively, medical dissolution of the stones can be considered with a prescription renal diet and broad-spectrum antibiotic therapy. If there is no improvement in stone size after 4 weeks of therapy, a cystostomy should be reconsidered. If the stone size is reduced, continue therapy until complete dissolution has been achieved.





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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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