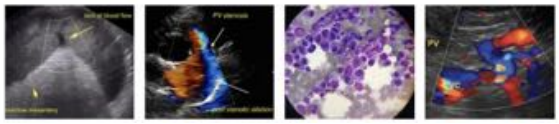


PATIENT

Papi Bazinet

SPECIES

Canine

BREED

Boston Terrier

SEX

Male, neutered

AGE

16 Yrs. 3 months

WEIGHT

25 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

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

HOSPITAL NAME

Meadowlawn AS

REFERRING VET

Dr. Bryson Gale

INVOICE

14543

DATE

2/7/23

PRESENTING CLINICAL SIGNS

History of ALP of 1116. ALT was elevated but is now normal since starting hepatoprotectants. Also having episodes where the patient will wake up out of nowhere and start howling and barking. These episodes initially lasted 45 min to an hour but now are much shorter.

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 (0.81 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 (4.70 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. Several small cortical cysts are visualized, a few of which are irregular in shape. Mild pyelectasia is present (0.33 cm in the longitudinal plane). There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (5.03 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. Several small cortical cysts are visualized, a few of which are irregular in shape. Mild pyelectasia is present (0.33 cm in the longitudinal plane). There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.72 cm at cranial pole) (0.75 cm at caudal pole) with a slightly irregular shape. The parenchyma is mildly heterogeneous with some loss of glandular detail. The phrenicoabdominal vein and surrounding vasculature are normal.

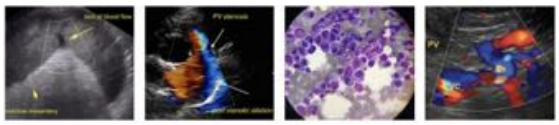
The right adrenal gland is mildly enlarged (0.99 cm at cranial pole) (0.74 cm at caudal pole) with a slightly irregular shape. The parenchyma is mildly heterogeneous with some loss of glandular detail. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (1.07 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 normal to slightly prominent in size with normal curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion. The portal vein: caudal vena cava ratio is approximately 1:1. The gall bladder lumen is mildly distended. The wall is normal in thickness.



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The lumen contains gravity-dependent mineralized sand vs tiny choleliths. 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 mildly thickened (up to 0.67 cm) with retention of the normal layering pattern and a prominent muscularis layer. The pyloric outflow tract is patent. The small intestinal lumen is segmentally dilated with chyme. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. The ileocecocolic junction is normal. A focal area of descending colonic wall is mildly thickened (up to 0.37 cm) with retention of the normal layering pattern. The remaining colonic wall is normal. No obvious obstructive disease is noted.

Pancreas

The right 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. 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.

Other

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

ULTRASONOGRAPHIC FINDINGS

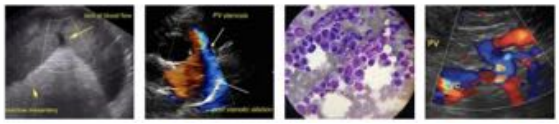
Primary Findings:

- Non-specific diffuse hepatopathy. Vacuolar hepatopathy (i.e., idiopathic, endocrine) is the top differential. Given the normal ALT, inflammatory disease is considered less likely. Infiltrative neoplasia is possible but also considered unlikely based on the sonographic changes.
- The bilateral adrenomegaly is most consistent with hyperplastic change.
- Gallbladder sand +/- tiny choleliths- incidental/non-obstructive.

Secondary Findings:

- Bilateral, chronic renal changes with cortical cysts and pyelectasia.
- Minor, age-related pancreatic remodeling.
- The gastric and colonic wall thickening is most consistent with an inflammatory process. However, emerging neoplasia cannot be completely excluded.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS



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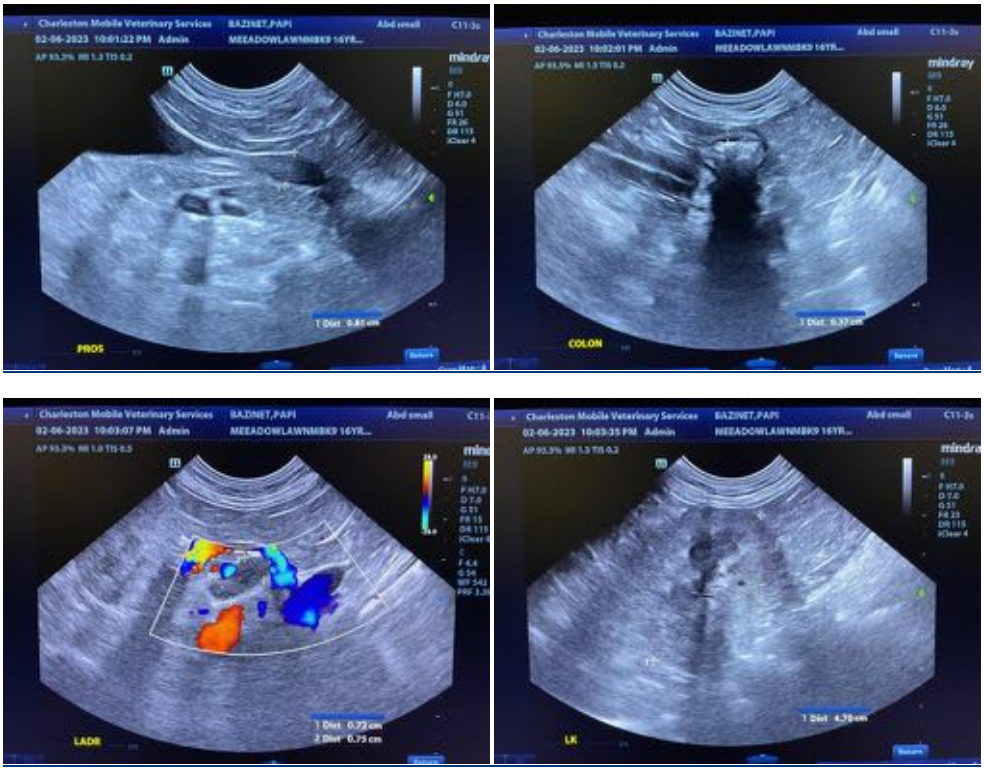
- Given the patient's seizure like episodes, consider the following:
    1. T4/free T4 by equilibrium dialysis, if not already performed.
    2. Baseline blood pressure measurement to assess for systemic hypertension.
    3. Pre and post prandial serum bile acids to evaluate for occult hepatic encephalopathy.
    4. Consider consultation with a board certified neurologist for further workup (i.e., brain MRI +/- CSF tap).
- Consider testing for hyperadrenocorticism with a low-dose dexamethasone suppression test or ACTH stimulation test if clinical signs (i.e., PU/PD) develop.
- Serial monitoring (i.e., every 3-4 months) of the patient's liver values is recommended. If liver values continue to increase, a repeat abdominal ultrasound +/- hepatic tissue sampling may be warranted.
- Given the patient's age, three-view thoracic radiographs are recommended to assess cardiopulmonary status.



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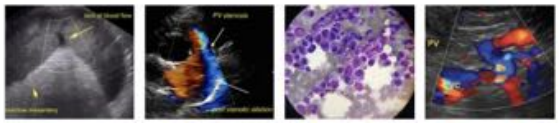

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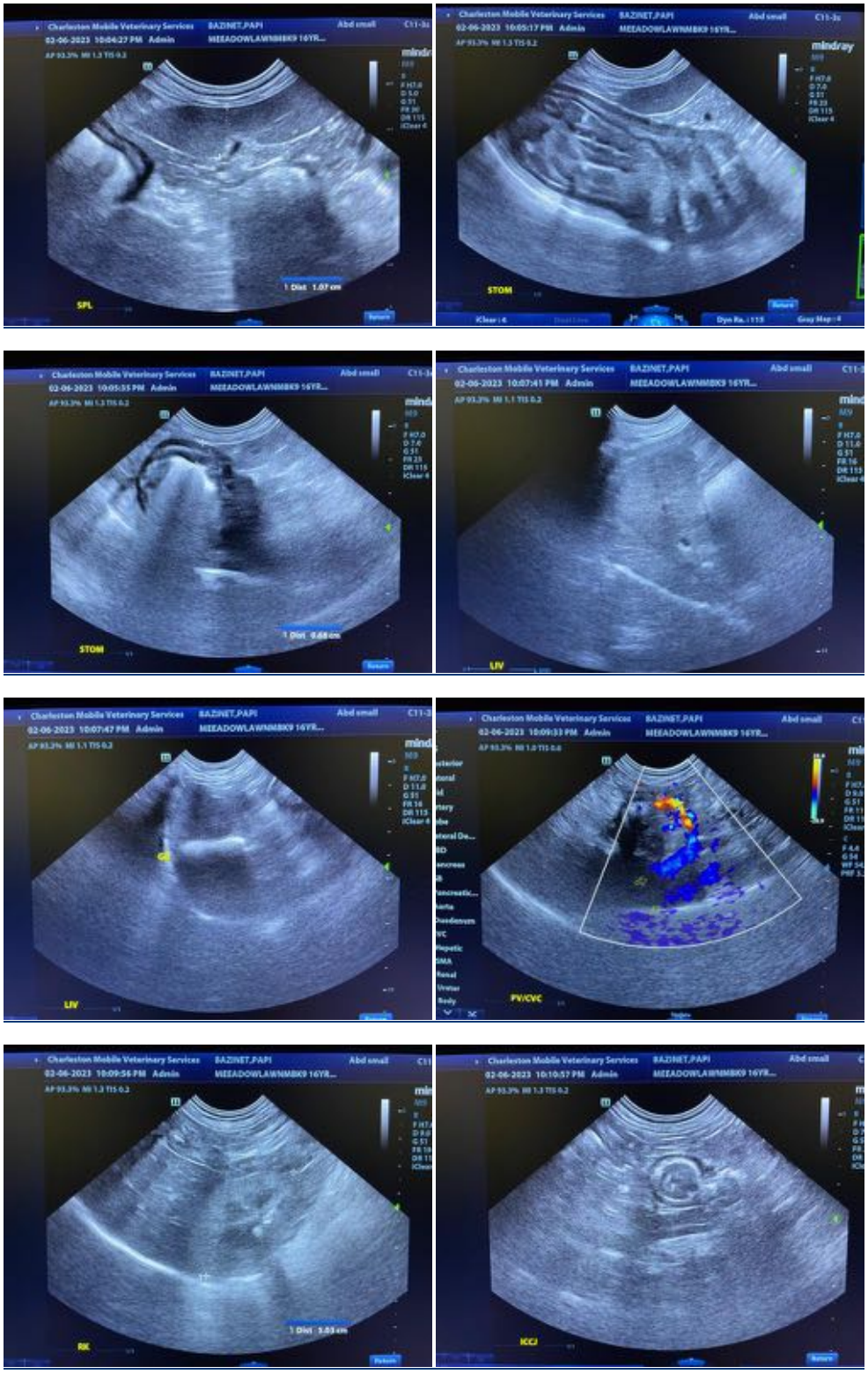

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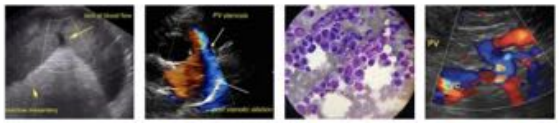

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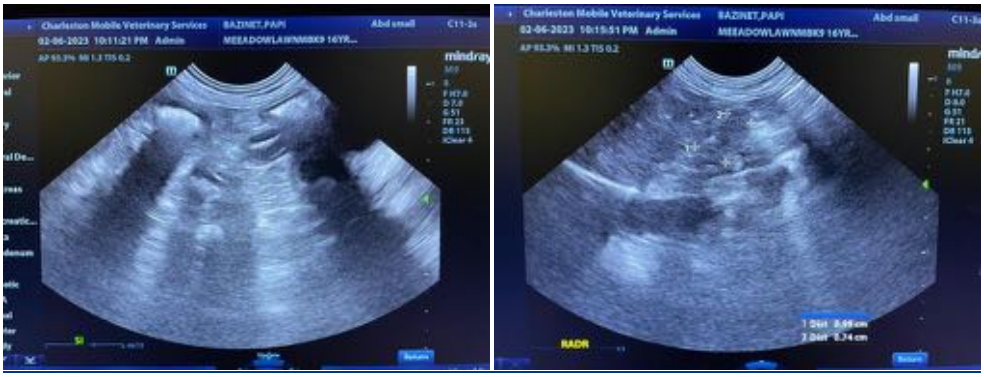

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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