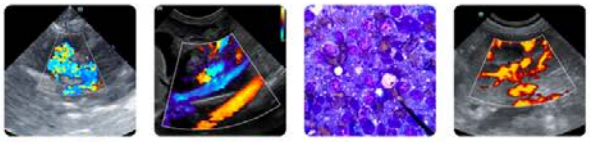

PATIENT

Scout Williams

SPECIES

Canine

BREED

Scottish Terrier

SEX

Spayed Female

AGE

12

WEIGHT

7.2

INTERPRETED BY

Brad Harris, DVM, DACVECC, Residency trained in cardiology

IMAGING PERFORMED BY

Dr. Sarah Burns

HOSPITAL NAME

Wilvet Salem

REFERRING VET

Dr. Sarah Burns

INVOICE

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PRESENTING CLINICAL SIGNS

P has been very lethargic for past couple days; no energy. Not eating. Straining to defecate w/ little to no stool production. Vomited a couple times over past few days. Diarrhea today. No known toxin/poison exposure. No dietary indiscretion. Has been on Denamarin and Telmisartan for approximately 2 months.

Abnormal PE/Chem/CBC/UA Results: BUN - 27 PTT > 300 diagnostics from rDVM: CBC: mild lymphopenia (0.26) Chem: hyperphosphatemia (5.6), hypocalcemia (8.6) elevated ALT (>1000) elevated AST (1.45) elevated ALT (<993) elevated GGT (33) elevated TBili (0.6) cPl: abnormal

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are unremarkable with normal wall thicknesses and normal tone. The ureters were not visualized, which is a normal finding. The bladder is moderately distended with anechoic urine and a mild amount of suspended mobile echogenic debris. The ureteral papillae appear normal. There is no evidence of inflammatory, infiltrative, or neoplastic disease.

The kidneys are normal in size. The cortices are hyperechoic with a decrase in normal corticomedullary definition. The cortex to medulla ratio is appropriate with no significant pyelectasis or pelvic dilation. There are multifocal small renal cortical cystic changes as well as dystrophic mineralization with no evidence obstruction. The renal capsules are mildly irregular bilaterally. Left kidney measures 4.8 cm. Right kidney measures 4.9 cm.

Adrenal Glands

Both adrenal glands are visualized and have normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. Left measures 0.53 cm x 2.2 cm. Right measures 0.64 cm x 1.6 cm.

Spleen

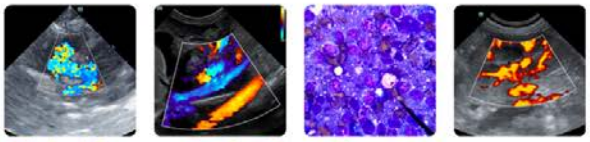
The spleen measures 1.4 cm at the hilus. It is slightly prominent with an isoechoic mass effect that distorts the splenic capsule at the head of the spleen. The splenic vasculature is normal without signs of congestion, spontaneous echo contrast, or thrombosis.

Liver

The liver is subjectively enlarged with a diffusely mottled parenchyma. There are scattered, ill-defined, heterogeneous mass effects throughout the liver that do not distort the smooth hepatic capsule. Vasculature is within normal limits with no evidence of congestion. The gallbladder is moderately distended with echogenic dependent sediment and suspended, unorganized debris. The gallbladder wall is appropriately thin. There is no evidence of intra- or extra-hepatic biliary dilation. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach and intestines are free of stasis and peristaltic activity, with no significant dilation noted. There is normal wall thickness and acceptable curvilinear mural detail. The pyloric-duodenal junction



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and ileocecocolic junction are patent, and the colon contains normal shadowing feces. There is no evidence of shadowing obstructive material or overt infiltrative disease noted. No associated abnormal lymphatic activity is documented.

Pancreas

The pancreas is prominent with irregular margins and a hypoechoic parenchyma with mixed hyper- and hypoechoic nodular changes throughout. The regional mesentery in that area is hyperechoic, consistent with steatitis or peritonitis.

ULTRASONOGRAPHIC FINDINGS

- The urinary bladder contains echogenic, suspended debris contrasted with anechoic urine. This is often related to urinary tract infection but may represent exfoliated debris or sterile inflammation.
- There is increased renal cortical echogenicity and thickening with a mildly irregular capsular contour. Multifocal cystic cortical changes are noted. This is secondary cystic formation consistent with degenerative changes and remodeling. There is no evidence of abscessation or suspicion of neoplasia. Dystrophic mineralization was noted and is non-obstructive at this time, with no evidence of pylectasis.
- The isoechoic mass effect at the head of the spleen likely represents benign change such as lymphoid hyperplasia or extramedullary hematopoiesis. However, infiltrative disease such as round cell neoplasia or hemangiosarcoma can't be definitively excluded.
- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory, immune-mediated, metabolic, or endocrine disease. Infiltrative neoplasia or acute hepatitis cannot be ruled out.
- The gallbladder contains echogenic, suspended and dependent unorganized debris. This is not yet to the level of an organized mucocele, however early/developing mucocele cannot be ruled out. This dependent sediment is often an incidental finding or may be associated with concurrent endocrine disease such as hyperadrenocorticism or diabetes mellitus.
- The prominent, hypoechoic pancreas with an irregular contour and mixed ill-defined hyper and hypoechoic changes is most consistent with pancreatic remodeling and nodular hyperplasia. This may be secondary to active or acute-on chronic inflammatory disease or pancreatitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A urinalysis and urine culture via cystocentesis are recommended to evaluate the urinary tract changes for potential urinary tract infection.

Fine needle aspirates of the spleen and liver with cytology are recommended. A coagulation profile and platelet estimate prior to sampling are indicated to ensure the absence of coagulopathy. Occasionally some tissues are poorly exfoliative, or cytology is non-specific, in which case biopsy with histopathology may be required for a definitive diagnosis.

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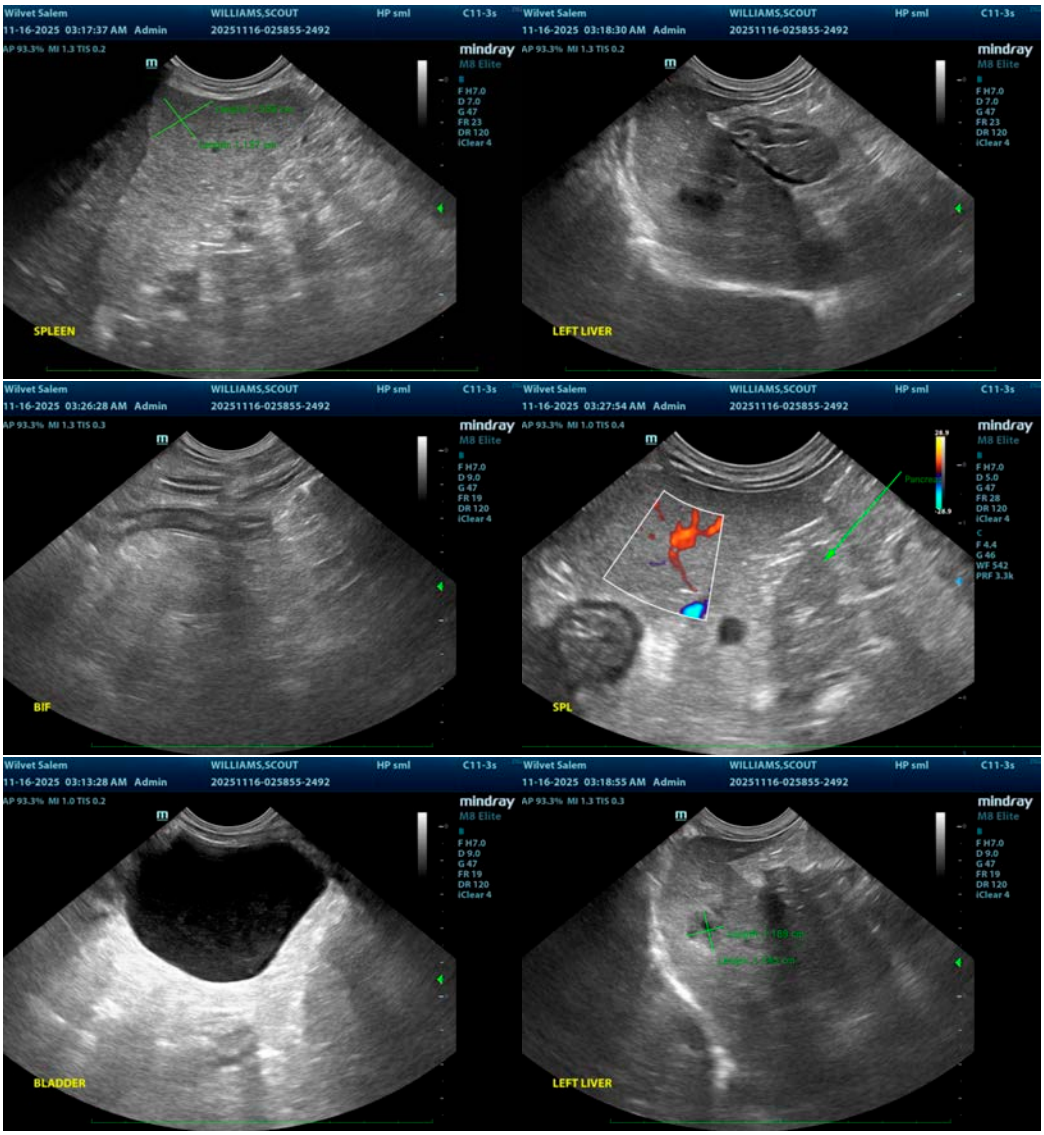
Supportive care for suspected pancreatitis is recommended as clinically indicated. Serial monitoring of the liver enzymes and bilirubin is recommended to ensure improvement in those values. Correlate with clinical signs.



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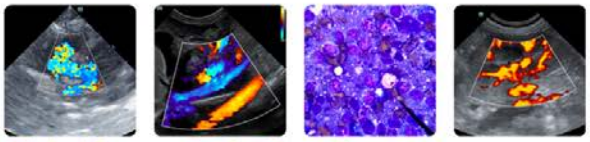

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Brad Harris, DVM, DACVECC, Residency trained in cardiology

info@SonoPath.com