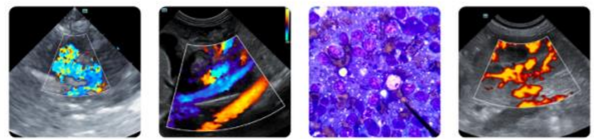

PATIENT

Eva Medeiros

SPECIES

Canine

BREED

Chihuahua

SEX

Spayed Female

AGE

15 Years

WEIGHT

5.57 kg

INTERPRETED BY

Bradley Harris, DVM, DACVECC, DACVIM (cardiology)

IMAGING PERFORMED BY

Michelle DeMelo RVT

HOSPITAL NAME

Woodstock Veterinary Hospital

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Dr. Esther Duschinsky

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PRESENTING CLINICAL SIGNS

Eva presented this am with a 3 days history of melena, vomiting and anorexia. The o also noted some history of collapse at home, but difficult to get a clear picture. Prev hx of heart failure diagnosed approx 5 wks ago - started on Furosemide and Pimobendan - excellent response to these with improvements in her coughing and attitude. Known to be aggressive and difficult to handle in clinic, so the o gave her pre-visit sedation with Gabapentin and Trazodone before presentation this morning - very sedate vs collapsed at presentation. Exam showed melena, pale/muddy mucous membranes, significant dehydration but appeared to be generally cardiovascularly stable with some poss crackles and increased RR, neurologic status not evaluated due to sedation. Radiographs showed evidence of a possible mass associated with the liver vs head of the spleen. Slide agglutination was neg. Looking for an underlying cause of the anemia, hypoalbuminemia and melena. Treatment initiated in clinic with IV fluids, and a basic in clinic blood transfusion, GI protectants and an injection of furosemide IV for pulmonary edema. With Eva being a 15-year-old dog with underlying heart failure, I am looking for prognosis and future care requirements.

Blood work: evidence of blood loss -hematocrit =14.5, mild hypoalbuminemia, uremia suspected to be secondary to dehydration.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with anechoic urine. The bladder, trigone, and pelvic urethra are unremarkable with normal wall thicknesses and normal tone. The ureters were not visualized, which is a normal finding. There are no uroliths or sediment noted. The ureteral papillae appear normal. There is no evidence of inflammatory, infiltrative, or neoplastic disease.

The kidneys are normal in size and structure. The cortices are hyperechoic with a loss of corticomedullary definition. Cortex to medulla ratio is normal. No pyelectasis or pelvic dilation was present with minimally irregular capsule contour. The left kidney measures 3.67 cm. The right kidney measures 3.67 cm.

Adrenal Glands

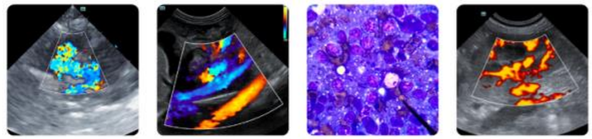
The adrenal glands are thin and flattened with isoechoic parenchymal echotexture and no evidence of capsular distention or vascular invasion. The phrenic vasculature is normal. The left adrenal gland measures 0.33 cm x 1.65 cm. The right adrenal gland measures 0.46 cm x 1.13 cm.

Spleen

The spleen is smooth with homogeneous parenchyma and hyperechoic to liver and renal cortical parenchyma. The capsule is without noticeable irregularity or deformation. The splenic vasculature is normal without signs of congestion, spontaneous echo contrast, or thrombosis. No evidence of acute or chronic inflammatory, neoplastic, or infarct are documented. The spleen measures 1.02 cm at the hilus.

Liver

The liver is subjectively enlarged with a diffusely heterogeneous or mottled parenchyma and subtle ill-defined hyper- and hypoechoic nodular changes. The hepatic capsule is normal with normal vasculature., No evidence of congestion. The gallbladder is mildly distended with echogenic dependent



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sediment and suspended debris. The cystic and common bile ducts are normal. There's no intra- or extrahepatic biliary dilation.

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 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 and mildly hypoechoic with an irregular capsular contour. There's regional hyperechoic mesentery or omental fat which may represent steatitis or peritonitis.

Free Abdomen

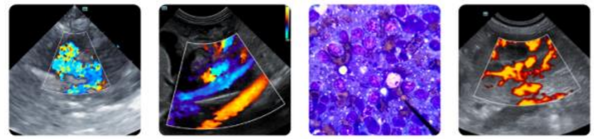
There is no significant lymphadenopathy or free fluid.

ULTRASONOGRAPHIC FINDINGS

- The kidneys are relatively normal in size and structure, and cortex:medulla ratio (cortex 1/3 of medulla) is essentially maintained. There is age-related loss of the normal smooth capsular contour and C/M junction definition. The cortices are largely uniform in texture with mild hyperechogenicity expected for this patient’s age. There is no evidence of pelvic dilation present.
- Both adrenal glands are flattened and isoechoic. This may be normal for this patient or potentially secondary to hypoadrenocorticism or adrenal burnout from chronic disease.
- 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.
- While there's no overt gastrointestinal mucosal lesion, an occult gastrointestinal ulcer cannot be definitively excluded as an underlying cause of the reported melena and hypoproteinemia.

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 liver with cytology are recommended. A coagulation profile and platelet estimate prior to sampling are indicated to ensure the absence of



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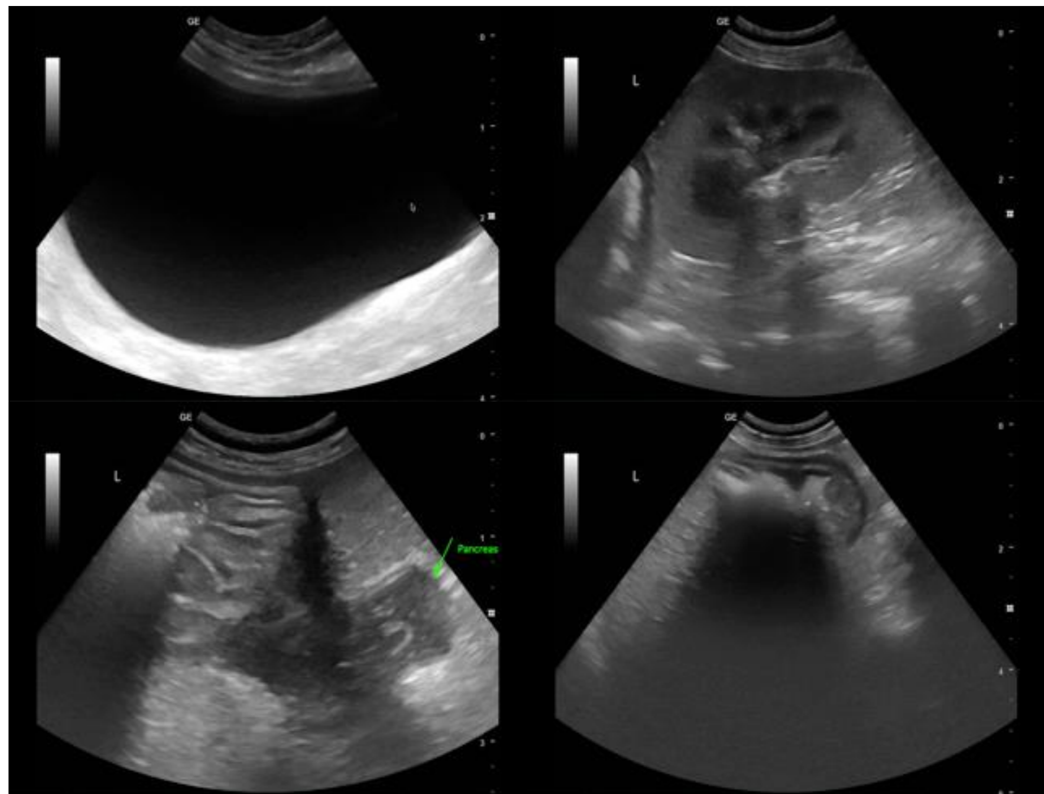
coagulopathy. Occasionally some tissues are poorly exfoliative, or cytology is non-specific, in which case biopsy with histopathology may be required for a definitive diagnosis. An ACTH stimulation test is indicated to evaluate for potential hypoadrenocorticism. A baseline/resting cortisol less than 0.52 µg/dL significantly increases the index of suspicion for hypoadrenocorticism. A gastrointestinal panel (TLI, PLI, B12, folate) via Texas A&M gastrointestinal laboratory is indicated to further evaluate for potential chronic enteropathy. Ultimately, gastrointestinal biopsies may be required for a definitive diagnosis.

A spec cPLI is recommended to further evaluate the pancreas for active pancreatitis or inflammation. Given the history of anemia, a CBC with a pathology review of blood smear by a clinical pathologist is also recommended.



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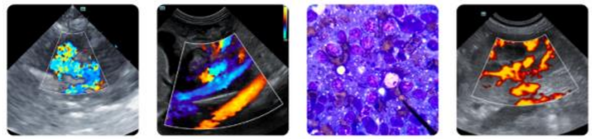
The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Bradley Harris, DVM, DACVECC, DACVIM (cardiology)

info@SonoPath.com



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