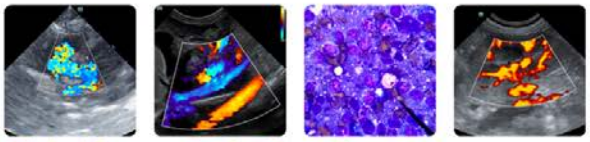

PATIENT

Charlie Alongi

SPECIES

Canine

BREED

Golden Retriever

SEX

Neutered Male

AGE

11.5

WEIGHT

67

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Christensen

HOSPITAL NAME

Tranquility Veterinary Clinic

REFERRING VET

Dr. Peng

INVOICE

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PRESENTING CLINICAL SIGNS

Patient is PUPD for past 1-2 months and weight loss (dropped from 72lbs in July to 67.4lbs in Dec). Previous history of dermatitis over the summer (resolved). BW done with elevated liver values, decrease in albumin, and high UPC

Abnormal PE/Chem/CBC/UA Results: CBC: eosinopenia (0.032). Chem: Creat low (0.4), Cl low (105), ALB low (2.6), ALT (230), ALP (315), GGT (23), Cholesterol (665) Lipase (1191), CK (203), T4 (0.8). UA (first morning sample): UPC high (2.9), USG low (1.013)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with occasional echogenic non-shadowing debris, most consistent with exfoliated cells, mucous and/or small blood clots, as well as dependent mineral “sand” (crystals) debris. Both sterile inflammation as well as urinary tract infection can present with echogenic debris. No masses or discrete definitive cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Prostate is normal in size, echotexture and echogenicity for a neutered male.

The right kidney is normal is size (7.76 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal is size (6.76 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

Adrenal glands are plump/swollen in size. Normal shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. Left measures 0.90 cm at the cranial pole and 0.87 cm at the caudal pole. Right measures 0.88 cm at the cranial pole and 1.0 cm at the caudal pole.

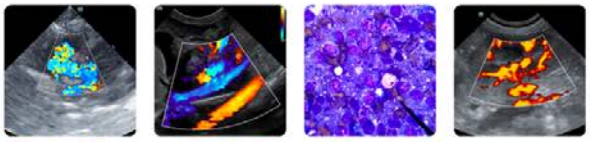
Spleen

The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver), except for an approximately 0.90 cm x 1.2 cm non-capsule disrupting hypo- to anechoic nodule near the cranial aspect of the spleen. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is moderately heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is mildly overdistended with a moderate amount of non-dependent, mildly aggregated/inspissated sludge. Hypo to anechoic cystic areas are noted between the gallbladder sludge



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and luminal wall. The wall is otherwise smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The pancreas that is observed appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

The visible heart base (RA) and pericardium are unremarkable without obvious pathology noted in these images at this time. If cardiac function evaluation is desired, a full echocardiogram is recommended.

PRIMARY FINDINGS

- Bilateral adrenomegaly – In a patient diagnosed with hyperadrenocorticism, this finding is most consistent with adrenal hyperplasia secondary to pituitary dependent hyperadrenocorticism. This finding can also be seen with stress and/or normal patient variant. Interpret in combination with clinical signs of hyperadrenocorticism and/or other adrenal disease.

- Moderately heterogenous liver – These changes are most consistent with benign processes such as nodular hyperplasia, steroid (vacuolar) hepatopathy, extramedullary hematopoiesis or possibly chronic inflammatory disease and less commonly infiltrative round cell or metastatic neoplasia.

- Emerging mucocele – Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. The non-dependent nature of this sludge combined with the cystic areas are suggestive, however, of possible emerging cystic mucosal hyperplasia or early gallbladder mucocele.

- Mild to moderate amount of echogenic urinary bladder mineral/sand debris.

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SECONDARY FINDINGS

- Hypo to anechoic splenic nodule – likely represents a benign lesion such as a cyst, hematoma, nodular hyperplasia, extramedullary hematopoiesis, etc., however while considered less likely, infiltrative neoplasia can mimic benign lesions, and cannot be ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

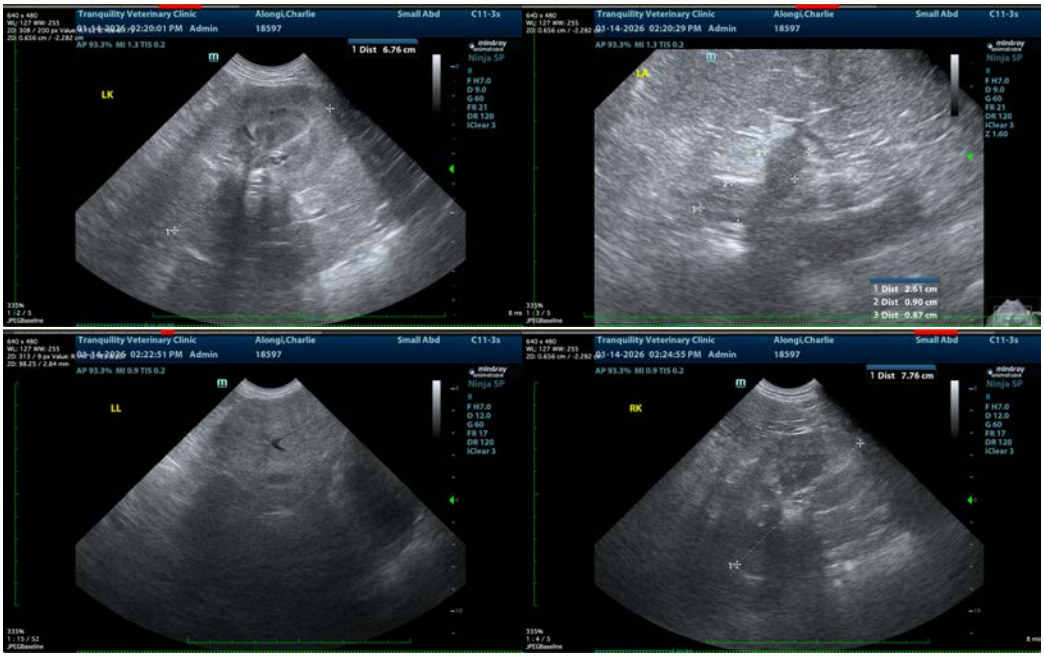
Based on the ultrasound findings, patient's reported PU/PD, as well as potentially some of the proteinuria could be secondary to emerging adrenal disease such as hyperadrenocorticism. However, hyperadrenocorticism typically does not result in hypoalbuminemia or weight loss. Therefore, true renal proteinuria should be ruled out prior to pursuing endocrinopathy contribution. Therefore, if not recently evaluated, a urine culture is recommended.

A blood pressure is recommended.

Comprehensive infectious disease evaluation including testing for Leptospirosis could be considered.

In the meantime, while the weight loss may be in part secondary to the protein loss, especially in the face of a normal or even increased appetite, further evaluation of digestion and absorption could also be considered, beginning with a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory for further evaluation of GI and pancreatic function.

If proteinuria is persistent in an otherwise quiet sediment, then in addition to looking for and treating the underlying if present, treatment recommendations include enalapril (or benazepril if azotemic) +/- ARB, anti-thrombotic (low dose aspirin or clopidogrel), a renal diet if tolerated and fatty acid supplementation. Begin FA supplementation slowly to prevent GI upset. If hypertension is present, additional therapy with amlodipine may be necessary to manage hypertension.



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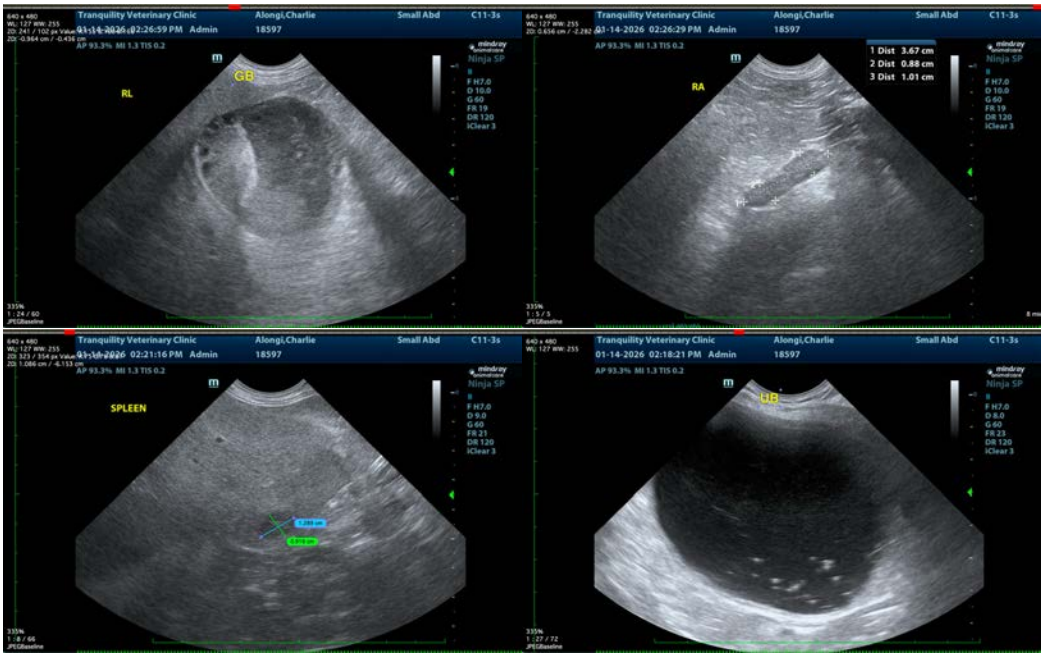

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM
info@sonopath.com