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Clinical Sonography & Telecytology
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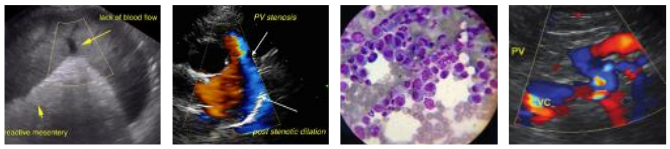


SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Daisy Robinson

SPECIES

Canine

BREED

Mixed Breed

SEX

Spayed Female

AGE

9 Years

WEIGHT

88.5 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Amy Mayhew, LVT

HOSPITAL NAME

SVS Imaging MI

REFERRING VET

Dr. Fit'z-Bayside AC

INVOICE

20340

DATE

1/2/23

PRESENTING CLINICAL SIGNS

History: O unsure if pet is PU/PD, no V/D/C/S noted.

Abnormal PE/Chem/CBC/UA Results: Elevated liver enzymes, borderline positive for hyperadrenocorticism on LDDST

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Left kidney is normal is size (7.68 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.

Right kidney is normal is size (7.98 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

Left adrenal gland is normal in size (0.77 cm at cranial pole and 0.63 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (1.05 cm at cranial pole and 0.92 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

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). No focal nodules or masses are observed. Splenic vasculature appears normal.

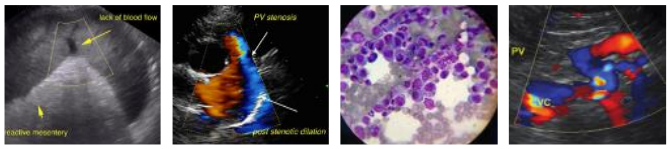
Liver

Liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is moderately distended with anechoic bile as well as mild suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

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.



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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 and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The observed pancreas 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 evidence of peritoneal effusion. There is no apparent lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

- Mild gallbladder debris- 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. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

- An obvious cause for the reported increased liver enzymes is not identified in these images. Microscopic disease such as Leptospirosis, bacterial cholangiohepatitis, chronic active hepatitis, copper-associated hepatotoxicity, other hepatotoxicity, infiltrative neoplasia (considered unlikely), etc. cannot be definitively ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given this patients reported borderline increased low dose Dexamethasone suppression test, if not recently evaluated, a blood pressure is recommended, as is urinalysis and, if indicated based on urinalysis results, urine culture are recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

Without obvious clinical signs of hyperadrenocorticism, further evaluation of hyperadrenocorticism is not necessary. If clinical signs develop, then recheck of the LDDST is recommended at that time to help determine whether or not treatment is indicated.

Regarding the increased liver enzymes, if the increase is a cholestatic pattern and could be explained by early or emerging hyperadrenocorticism, no follow up may be necessary, however, if the enzyme increase is more of a hepatocellular injury pattern, further diagnostic recommendations include testing for leptospirosis, followed potentially by liver sampling, beginning with a fine needle aspirate of the liver, if the patients coagulation status is appropriate.

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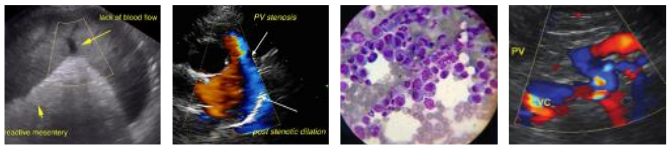

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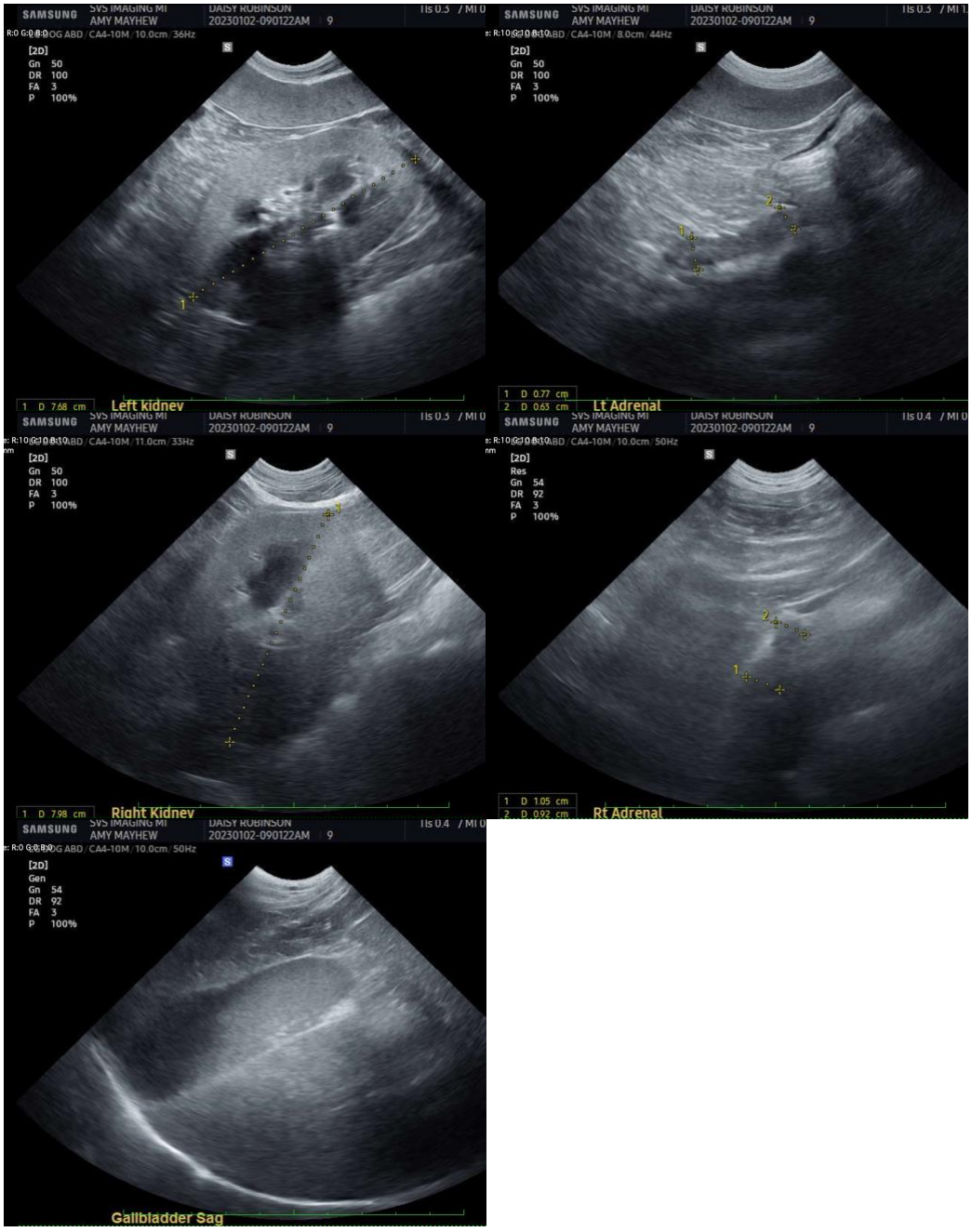

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM DACVIM

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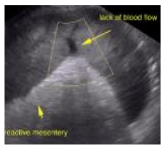
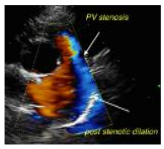
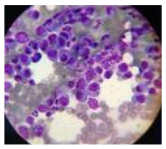
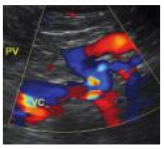

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