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Clinical Sonography & Telecytology
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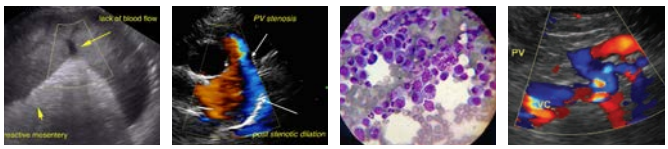


PATIENT

Carter Rougeux

SPECIES

Canine

BREED

Mixed

SEX

Neutered Male

AGE

14 Years

WEIGHT

26.8 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Erin Wicks

HOSPITAL NAME

Shores VEC

REFERRING VET

Dr. Lupole

INVOICE

40967

DATE

10/5/22

PRESENTING CLINICAL SIGNS

Presented at our hospital for transfer from RDVM- newly diabetic. Patient not eating over the last few days. He did eat some chicken and rice yesterday. PU/PD, urinary incontinence for about 1 month, vomiting, trouble walking Previous Health Concerns: arthritis, urinary incontinence Current Medications: vitamin, PPA

Abnormal PE/Chem/CBC/UA Results: Abdominal: sl tense on caudal abd palp Genitourinary: leaking urine occ rDVM – Blood work – Glu > 686, SDMA 24, Creat 1.9, BUN 50, ALP 409, Cl 104; cPL= abnormal; Radiographs – no heart enlargement noted, age related bronchial changes; U/A – glu 1000, spg 1.025

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended with primarily anechoic contents and occasional echogenic non-shadowing debris. Apical urinary bladder wall is diffusely thick (0.80 cm). Mucosa is hyperechoic and irregular. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface.

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

The right kidney is normal in size (6.83 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. Small cortical cysts noted.

The left kidney is normal in size (7.08 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. Small cortical cysts noted.

Adrenal Glands

The area of the right adrenal gland was examined without evident pathologyl

The left adrenal gland is normal in size (2.5 cm long x 0.48 cm at the cranial pole and 0.51 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

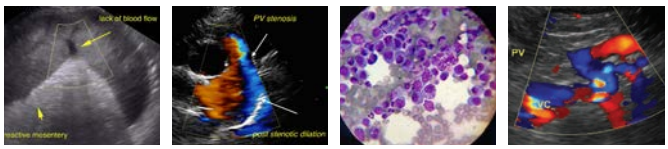
Spleen

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

Liver

The 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.

The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.



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Gastrointestinal

The stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) 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 (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). 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 pancreatic parenchyma is appropriately isoechoic to surrounding tissue. Visible capsule is smooth and normal in contour. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is no evidence of free peritoneal effusion noted in these images.

There is no apparent lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- **Chronic Cystitis -** Urinary bladder wall changes are most consistent with chronic cystitis. Infiltrative neoplasia cannot be ruled out but is considered less likely give the location and diffuse nature of the changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The cause of this patient's decreased appetite is not obvious ultrasonographically in these images. Mild pancreatitis or gastroenteritis cannot be definitively ruled out based on ultrasound alone. However, the top differential is likely the newly diagnosed diabetes, given the marked hyperglycemia, as marked prolonged hyperglycemia can result in a reduced appetite in some patients. Recommendations include:

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.

Supportive/symptomatic medical management of possible mild pancreatitis, gastroenteritis, etc. with antiemetics, gastroprotectants, an appetite simulant, as well as pain medication if indicated, fluid therapy, etc. is recommended combined with frequent short-acting doses of insulin as needed until patient's blood sugar is closer to normal and patient is eating, at which time transition back to longer-acting at-home insulin therapy could be pursued.

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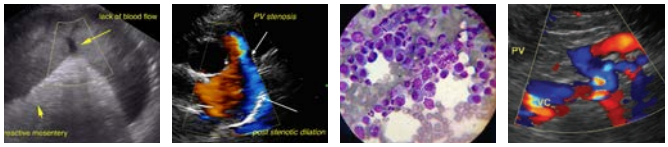

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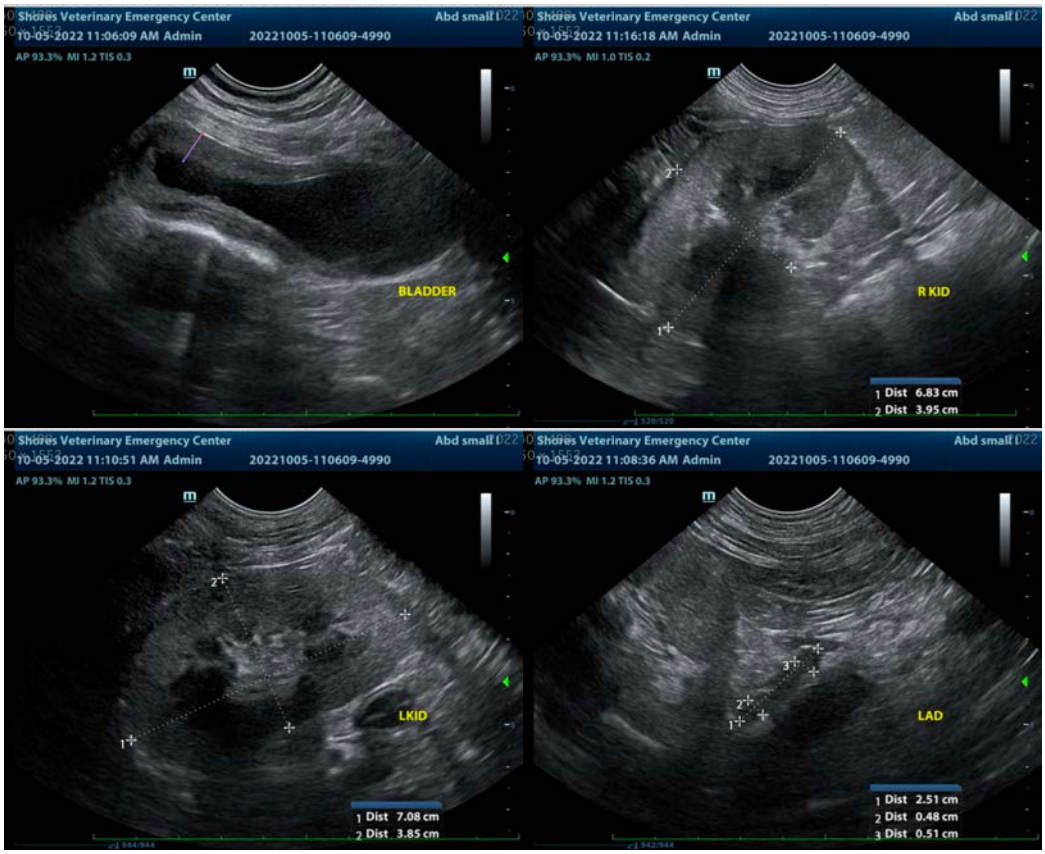

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM
Beth.Johnson@sonopath.com