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Clinical Sonography & Telecytology
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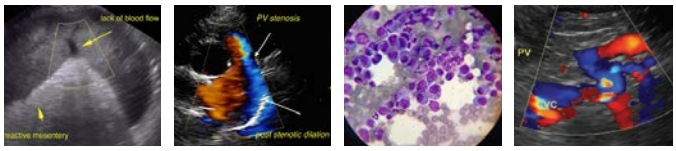

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Maezy Choate

SPECIES

Canine

BREED

Bichon

SEX

Spayed Female

AGE

10 Years

WEIGHT

10.2 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Total Bond VH

REFERRING VET

Dr. Isabel Plourde

INVOICE NUMBER

29770

DATE

11/11/21

PRESENTING CLINICAL SIGNS

Pt presented back in 9/7/21 for a couple day history of decreased appetite, lethargy, vomiting and diarrhea and an episode or two of mild hematemesis. On PE she was tender in the abd, was slightly dehydrated and had a mild fever. BW revealed alb 2.8, BUN 65 and Crea of 1.9, and PSL of 490. Azotemia at the time was attributed to dehydration. Pt was treated symptomatically at the time for gastroenteritis/pancreatitis. Pt partially responded. Os brought a urine sample by a few days later that showed a UTI so the pt was treated with antibiotics for that. The pt continued to have intermittent decreased appetite and vomiting, so we pursued a FAST scan on 9/22 that showed thickened bladder wall, and bright pancreas. The pt still had a fever at that time and recheck of kidney values showed persistent though fairly stable azotemia. At that point I initiated treatment for possibility of pyelonephritis and pt was on a months worth of Zenequin. Since then the pt has intermittently had episodes of decreased appetite, occasional vomiting and occasional play-bowing like she has cranial abdominal discomfort. Pt has lost almost a lb since then. So overall, at initial presentation, there was concern for pancreatitis or even a mild gastric ulcer. Then the pt was treated for a UTI and possible pyelonephritis. Pt has remained intermittently off and has lost weight. Top ddx chronic pancreatitis vs neoplasia vs atypical addisons (though suspect that if it was this last that the pt would have decompensated more).
Abnormal PE/Chem/CBC/UA Results: intermittent fever wt loss initial bw showed PSL of 490, slightly low alb at 2.8, crea 1.9 (this has persisted), initial BUN was 65, but this has decreased

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is moderately 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.

Right kidney is normal in size (4.14 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.

Left kidney is normal in size (3.64 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

Right adrenal gland is normal in size (1.4 cm at cranial pole and 0.42 cm at caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Left adrenal gland is normal in size (0.39 cm at cranial pole and 0.43 cm at caudal pole), shape and contour. Corticomedullary structure is unremarkable. 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.

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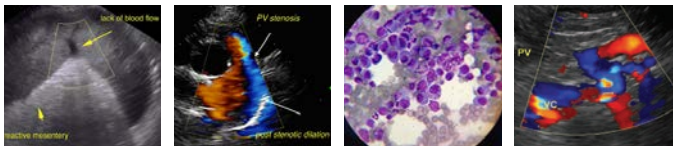

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Liver
Liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed.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

GB contains a moderate amount of non-dependent, mildly aggregated/inspissated sludge. Hypo to anechoic cystic areas are noted between the gallbladder sludge 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 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
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 peritoneal effusion. There is no apparent lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

- Early 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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given this patient's history of urinary tract infection +/- pyelonephritis combined with intermittent pain and fever, recommendations include reculturing the urine to be sure the infection is fully cleared. Given the historically high BUN and reported abdominal pain, empirical therapy for gastric microulcerations +/- helicobacter could be considered to include antacids and antibiotics as appropriate for those conditions. Finally, given the gallbladder changes as well as clinical signs consistent with a mucocele to include intermittent abdominal pain, decreased appetite, etc., therapy with antibiotics and Ursodiol followed by gallbladder monitoring is recommended. If clinical signs do not improve and/or gallbladder changes progress, cholecystectomy may be warranted.

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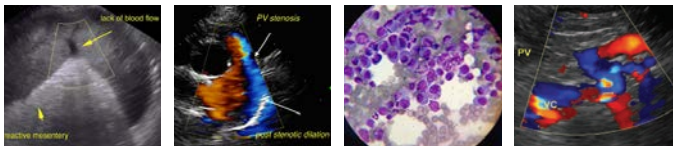

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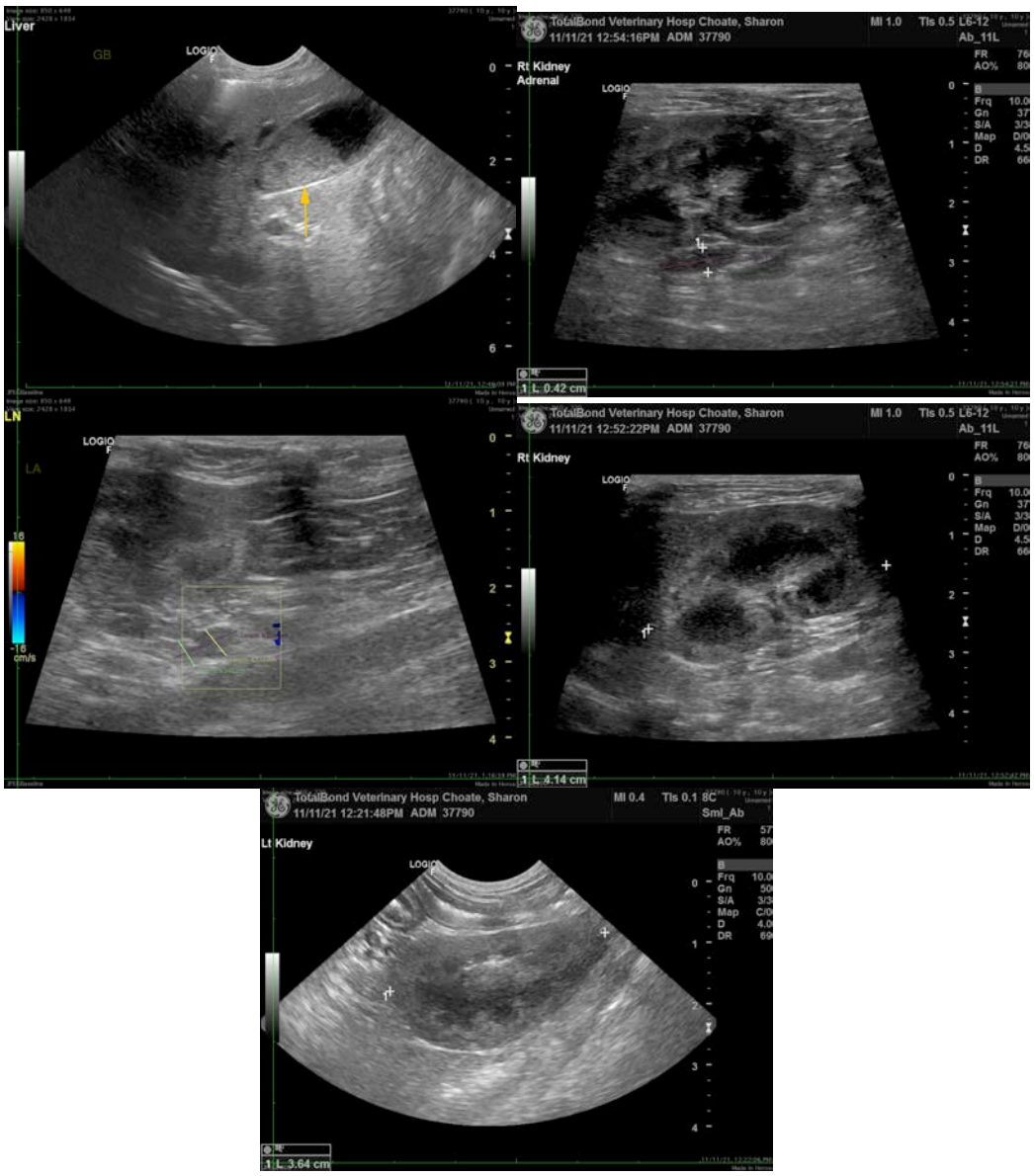

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
Beth.Johnson@sonopath.com