



PATIENT PRESENTING CLINICAL SIGNS

Mia Treib Pancreatitis September 2018. Recovered. Vomit July 2021 treated Denosyl, Cerenia, Amoxicillin. Murmur July 27, 2022. Congestive heart failure radiographically and less endurance on walks. Restarted Denosyl indefinitely, started Pimobendan, Furosemide, Enalapril. August 26, 2022 more activity, less coughing. October 3, 2022 CHF controlled clinically. Coughs with excitement. Radiographs still pulmonary edema added Spironolactone. November 3, 2022 coughs in cold weather lungs clear.

Canine Abnormal PE/Chem/CBC/UA Results: September 2018 ALT 244 (1-125) GGT 52 (1-22) Abnormal CPL. Normal Liver after Denosyl October 2018. Normal Liver June 2020. July 2021 ALT 5186 (10-125) ALKP 2673 (23-212), GGT 77 (0-11), TBILI 2.7 (0-.9), normal RBC. August 2021 Liver normal except ALKP 226 (230-212). July 2022 ALT 638 (10-125), ALKP 1272 (23-2122), GGT 20 (0-11). August 26, 2022 BUN 30 (7-27), ALT 140 (10-1250, ALKP 270 (23-212). October 3, 2022 BUN stable 31 (7-27), ALT 218 (10-125), ALKP 1267 (23-212). November 3, 2022 BUN stable 29 (7-27), ALT 270 (10-125), ALKP 1776 (23-212).

SPECIES

BREED

Miniature Pinscher

SEX

Spayed Female

AGE

12 Years

WEIGHT

7.7 Pounds

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The 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.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. The right kidney measured 4.45 cm and the left kidney measured 3.6 cm.

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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. The right adrenal gland measures 1.8 cm long x 0.64 cm and 0.53 cm at the caudal pole. The left adrenal gland measures 1.0 cm at the caudal pole, the cranial pole is not well visualized.

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Dr. Heather Brenner

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.

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Liver

Liver is subjectively enlarged (swollen contour) without disruption of architecture. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen and falciform fat. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

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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.

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Canine

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.

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

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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.

AGE

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Free Abdomen

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

WEIGHT

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There is no apparent lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- **Bilateral adrenomegaly** – consistent with adrenal hyperplasia secondary to pituitary dependent hyperadrenocorticism vs stress or normal variant. Interpret in combination with clinical signs of hyperadrenocorticism.
- **Hyperechoic hepatomegaly** - This appearance is non-specific and most consistent with a benign steroid (endocrine) or vacuolar hepatopathy or reactive or idiopathic hepatopathy. Inflammatory and/or infiltrative disease (such as round cell neoplasia) are also possible, but considered less likely.
- Age related kidney changes

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is no ultrasonographic evidence visible in these images of pancreatitis. However, pancreatitis cannot definitively be ruled out with normal ultrasound. Therefore, recommendations should be based on clinical signs. If this is a wellness ultrasound, no additional follow up is recommended. However, if the patient is ill, recommendations include:

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A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function, or just a quantitative PLI if a full GI panel is not possible.

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Additionally, a fine needle aspirate of the liver could be considered if patient's coagulation status is appropriate.

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If pancreatitis is suspected or diagnosed based on PLI results, transition to a long-term low-fat diet could be considered if tolerated and if not already in place.



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After complete resolution of this episode, when patient has returned to normal and is stable, if clinical signs of hypoadrenocorticism are present, testing for that could be considered in the form of a low-dose Dexamethasone suppression test, given the mild adrenomegaly. However, testing, treatment, etc. is not indicated without supporting clinical signs and/or in the face of other illness.

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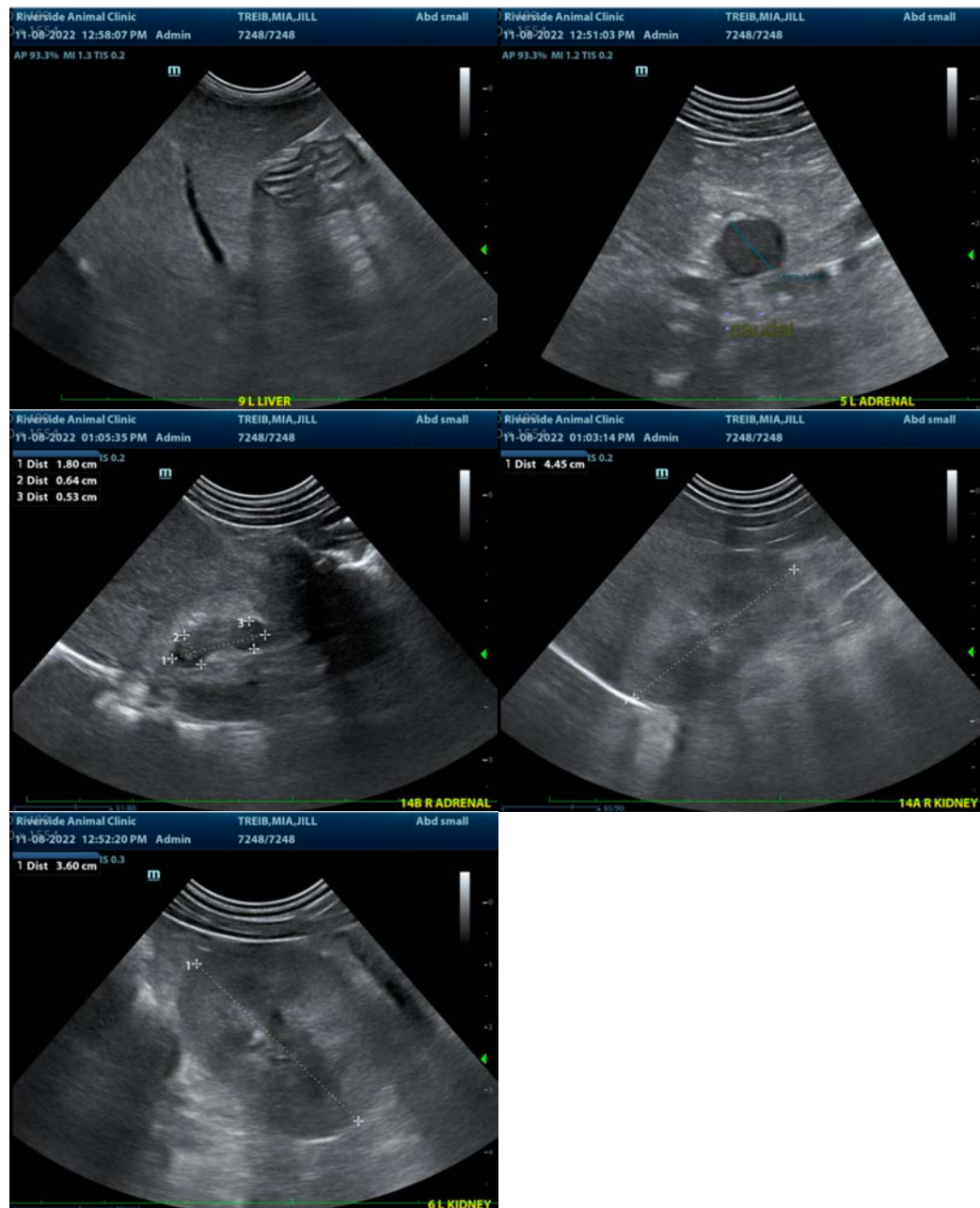
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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Canine

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.

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