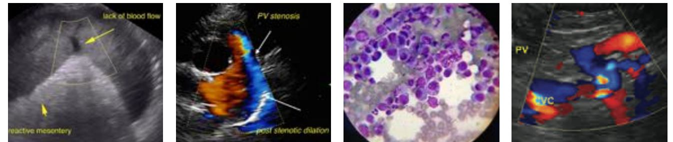
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Tiffi Baehner

SPECIES
Canine

BREED
Maltese

SEX
Spayed Female

AGE
10 years

WEIGHT
6.9 lbs

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Dr. Plourde

HOSPITAL NAME
TotalBond VH

REFERRING VET
Dr. Plourde

INVOICE
96027

DATE
2/11/22

PRESENTING CLINICAL SIGNS

10 yo FS Maltese who presented on 2/7 for a 2 week history of lameness on right rear limb and 1 week of not eating well- only eating treats/human foods. On 2/7 pt was diagnosed with cruciate rupture right rear leg and 2 lbs of weight loss. Pt was started on Rimadyl. BW was sent to the lab because of the decreased appetite and weight loss and showed significant changes: TP 3.1 Alb 2.1 Gloculin 1.0 Alt<3 Glucose 51 Ca 8.5 (corrected 9.9) K 6.2 WBC 22.4 Platelets 519 HCT 51- normal BUN 15- normal Pt returned 2 days later for "constipation", which was diarrhea and continued decreased appetite. BW results came back this day, so Rimadyl was stopped and supportive care was started with appetite stimulant, Metro, Cerenia and B12. BW was rechecked and values were consistent though Albumin was at 1.5 on in-house machine. BG after being fasted for 16 hours today and after sedation was 44.
Abnormal PE/Chem/CBC/UA Results: Torn cruciate RR with associated lameness TP 3.1 Alb 2.1 Gloculin 1.0 Alt<3 Glucose 51 Ca 8.5 (corrected 9.9) K 6.2 WBC 22.4 Platelets 519 HCT 51- normal BUN 15- normal

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is moderately distended with anechoic contents. It has normal uniform wall thickness (< 0.2 cm). No masses or cystoliths are observed.

Left kidney is normal in size (3.17 cm), shape and echogenicity. It has smooth peripheral margination and appropriate corticomedullary distinction. There is no pyelectasia noted. No mineral is observed.

Right kidney is normal in size (3.61 cm), shape and echogenicity. It has smooth peripheral margination and appropriate corticomedullary distinction. There is no pyelectasia noted. No mineral is observed.

Adrenal Glands

Left adrenal gland is normal in size (0.38 cm at cranial pole and 0.38 cm at caudal pole), shape and contour. Corticomedullary structure is unremarkable.

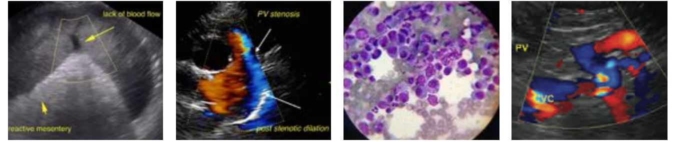
Right adrenal gland is normal in size (0.34 cm at cranial pole and 0.59 cm at caudal pole), shape and contour. Corticomedullary structure is unremarkable.

Spleen

Spleen is subjectively normal in size with normal smooth margins. Parenchyma is normal in echogenicity and echotexture. No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

Liver is subjectively small in size with normal, smooth curvilinear peripheral contour. The parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature appears normal. Gallbladder is mildly distended with anechoic contents. The wall is smooth without visible thickening. There is no evidence of common bile duct dilation.



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Gastrointestinal

The visible gastric wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm). The stomach is empty.

The small intestines are at the upper end of normal in wall thickness ranging from 0.39-0.42 cm in thickness. The layering is normal. Mildly speckled mucosa is noted. Small intestinal motility appears adequate (1-3 contractions per min). There are no luminal contents noted within small intestines.

Colon is normal in wall thickness (< 0.2 cm) and layering.

Pancreas

Pancreas has normal homogenous echotexture and is normal in echogenicity and smooth margination. There is no evidence of peripancreatic inflammation.

Free Abdomen

There is mild jejunal lymphadenopathy characterized by round, hypoechoic lymph nodes.

ULTRASONOGRAPHIC FINDINGS

- **Primary Findings**
- Subjective microhepatica which could be a normal patient variant versus while not present in these images, a vascular anomaly such as a portosystemic shunt or microvascular dysplasia, etc. cannot be ruled out.
- Mildly thick small bowel with mildly hyperechoic speckled mucosa. Primary differential for which includes inflammatory bowel disease +/- concurrent protein losing enteropathy cannot be ruled out.
- Reactive jejunal/mesenteric lymphadenopathy. Infiltrative neoplasia cannot be ruled out, but is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Recommendations for this patient's hypoglycemia, given concurrent hypoalbuminemia include beginning the work-up with a gastrointestinal malabsorption panel to include TLI, PLI, folate and cobalamin as well as a baseline cortisol to rule out hypoadrenocorticism. If the baseline cortisol is less than 2 a follow-up full ACTH stimulation test is recommended. Bile acids are also recommended given the subjective microhepatica combined with the reported laboratory abnormalities. While considered less likely a paired insulin to glucose ratio sample obtained when the glucose is less than 50, is also recommended if the aforementioned diagnostics do not reveal an underlying cause for the hypoglycemia. In the meantime, empirical deworming with a 5 day course of Panacur is recommended followed by a low-fat diet +/- empirical steroids in addition to supportive care addressed at clinical signs. Ultimately, pending the results of the recommended diagnostics, biopsies of the gastrointestinal tract and mildly enlarged lymph nodes may be necessary to definitively determine the underlying disease process. If not already performed a urinalysis is also recommended and if there is protein in the urine and otherwise quiet sediment a urine protein to creatinine ratio is recommended.

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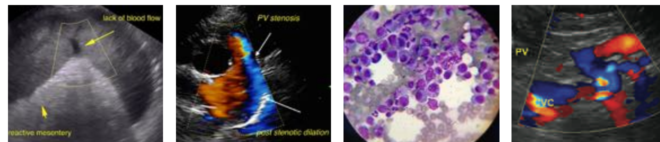

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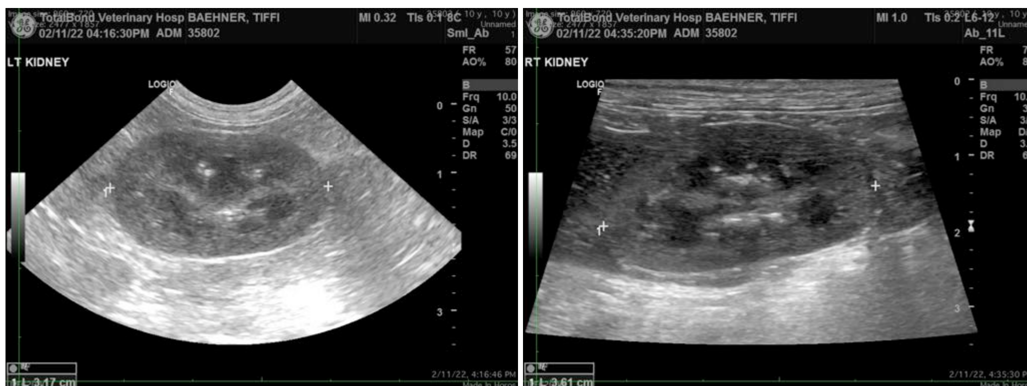

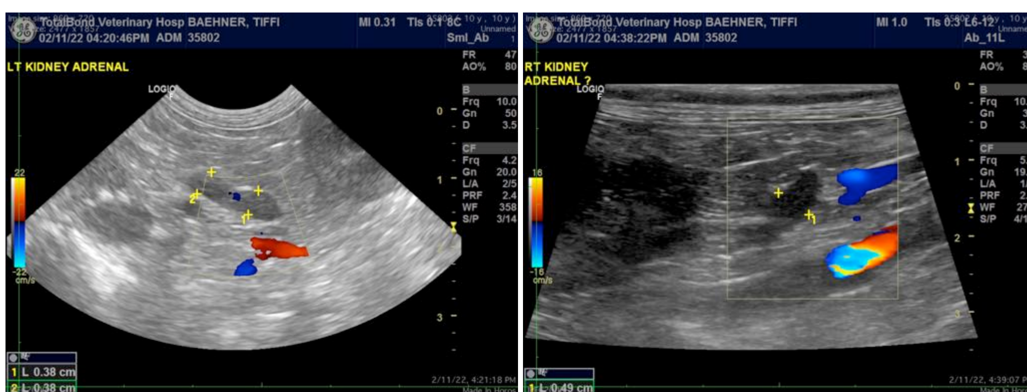

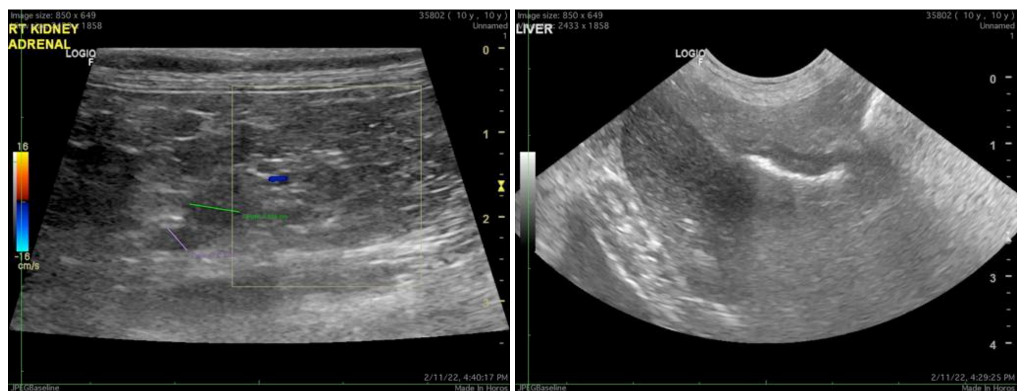

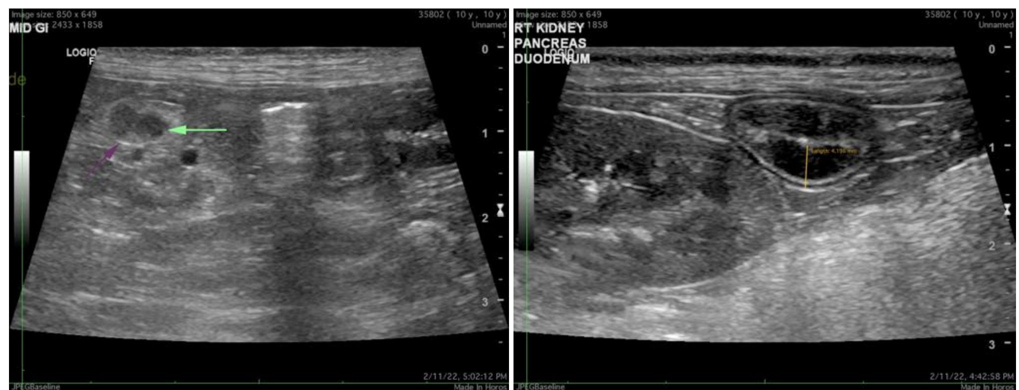

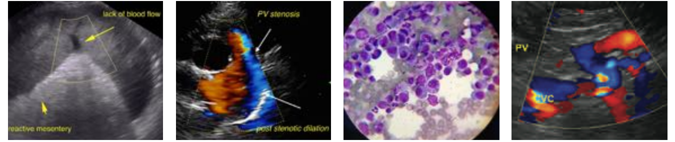

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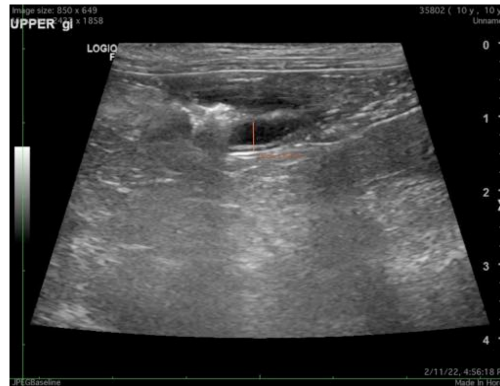

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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