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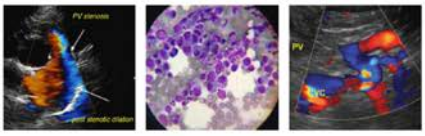

SonoPath
Clinical Sonography & Telecytology
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PATIENT
Baron Beverly

SPECIES
Canine

BREED
Boxer

SEX
Neutered Male

AGE
10 Years

WEIGHT
75 Pounds

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Amy Mayhew, LVT

HOSPITAL NAME
SVS Imaging MI

REFERRING VET
Dr. Steep

INVOICE
45401

DATE
2/21/23

PRESENTING CLINICAL SIGNS

Found blood on bed twice, coughing, excessive thirst and urination

Abnormal PE/Chem/CBC/UA Results: 12/30/22 Labwork results reveal mild lymphocytopenia, eosinopenia (total WBC WNL), elevated ALT, ALP and GGT, hyperlipasemia, elevated CK and low T4. SG on urinalysis 1.004, CPL 1052 (SDMA, Creatinine and BUN WNL). 2/16/23 ALT 372 (was 212 12/28/22), ALP 1400 (was 853), cPL 1245 (was 1052)

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.

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

The right kidney is normal in size (7.65 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.

The left kidney is normal in size (7.69 cm), shape and echogenicity. Multiple small cortical cysts are noted. 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

The right adrenal gland is normal in size (0.94 cm at the caudal pole, cranial pole is unable to be well visualized), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.90 cm at the cranial pole and 0.92 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.

Gastrointestinal

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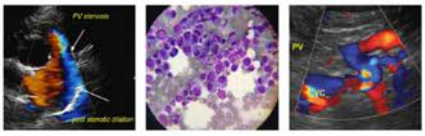

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The stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) and layering. The lumen contains a bright curvilinear interface with strong acoustic shadow, concerning for a non-obstructive gastric foreign body. Pyloric outflow tract 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.

PRIMARY FINDINGS

- Suspect non-obstructive gastric foreign body – Normal gas/ingesta can't be ruled out, and this finding should be interpreted in combination with clinical signs and progression/versus resolution.

SECONDARY FINDINGS

- Cortical cysts noted in the left kidney

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given this patient's reported cough, if not recently evaluated, three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

Given the reported PU/PD, if not very recently evaluated, a 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.

This patient's laboratory changes and PU/PD, etc. could be suggestive of hyperadrenocorticism. Therefore, further investigation beginning with a low-dose Dexamethasone suppression test could be considered if another underlying cause is not diagnosed, as concurrent illnesses can cause false positive results with cortisol testing. Therefore, further evaluating and working up/treating this patient's cough and the reported blood of unknown origin is recommended prior to further evaluation for possible hyperadrenocorticism.

Finally, given the suspicion of a gastric foreign body, options include additional fasting (12-24 hours) with recheck imaging both with radiographs and ultrasound to monitor progression versus resolution, versus potentially a barium swallow or a more invasive gastroscopy. Given the lack of reported vomiting, normal appetite, etc., a conservative approach is recommended via monitoring or additional imaging versus endoscopy or surgery at this time.

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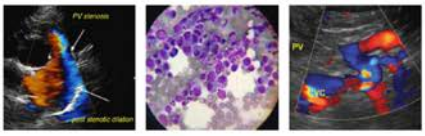

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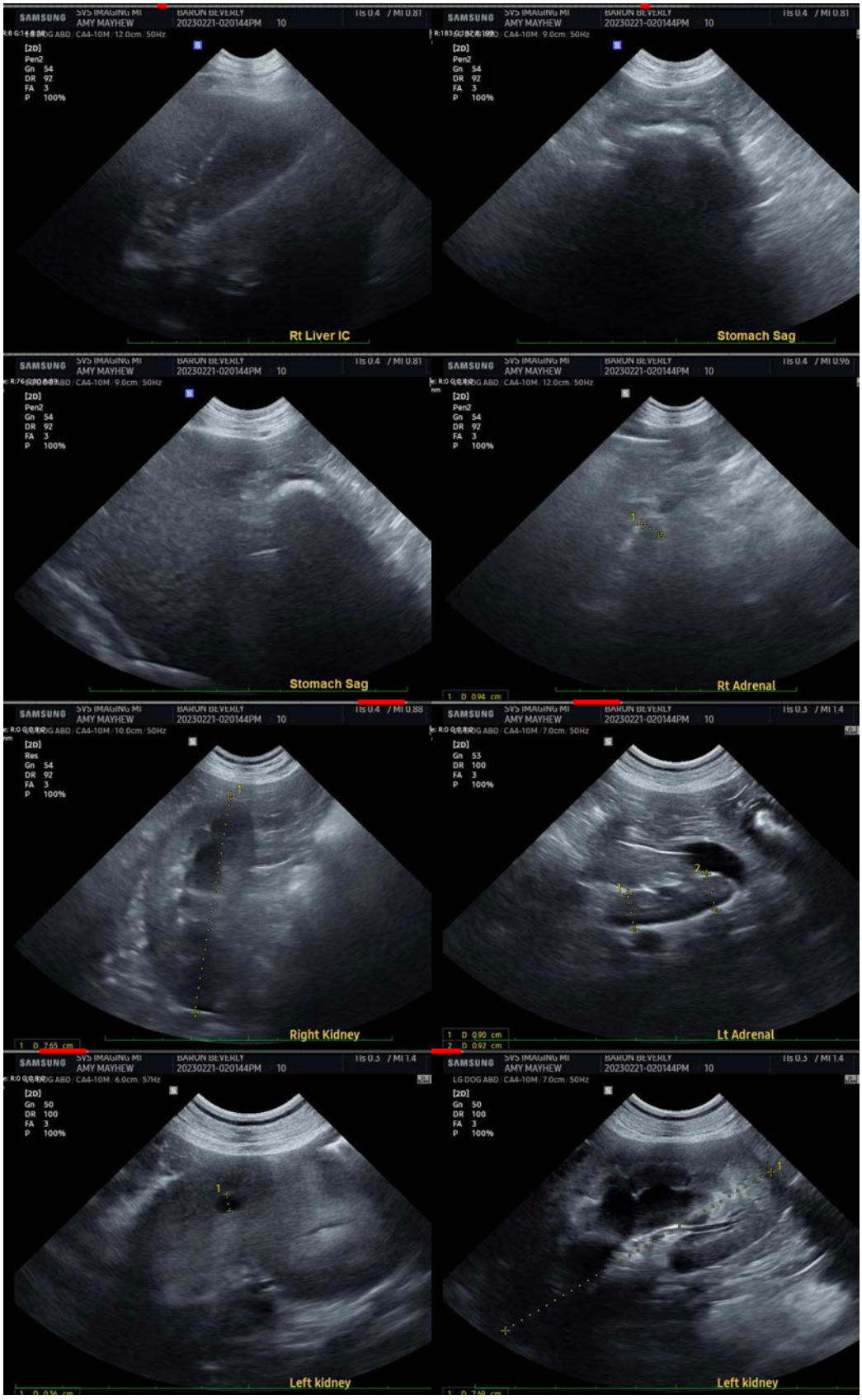

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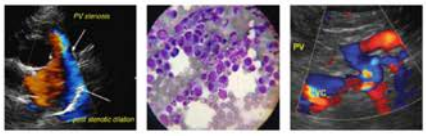

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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