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Clinical Sonography & Telecytology
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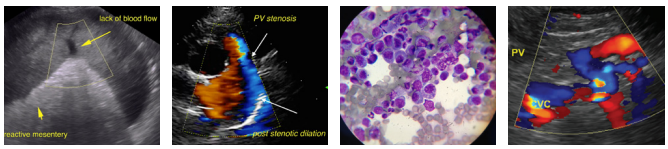


PATIENT
Kasey Stern

SPECIES
Canine

BREED
Australian Cattle Dog

SEX
Spayed Female

AGE
9 Years

WEIGHT
59.2 Pounds

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Dr. Hannah Fearing

HOSPITAL NAME
Lanier AH

REFERRING VET
Dr. Hannah Fearing

INVOICE
36112

DATE
3/10/22

PRESENTING CLINICAL SIGNS

MM: 03-07-22 at 5:00p: Mom said that currently when defecated at first was formed but soft the end of it was loose at end of it w/ poss blood; seems to vomit at least 2 times during the day; 6-8 hours after last feeding; this is the third year of row that in spring starts strange vomiting/diarrhea combo- told about UTI on the UA says not having clinical signs at this time; we can recheck this; also talked about due to clinical signs and increased liver enzymes recommended an ultrasound.
Abnormal PE/Chem/CBC/UA Results: CBC: NSF Chem: moderately elevated ALP (625), ALT (717), AST (166), and GGT (38) UA: moderate cocci and 10-15 WBCs/hpf T4: WNL 4Dx: BDLx4 Fecal: NADx3

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is mildly to moderately distended with anechoic contents. Apical urinary bladder wall is diffusely thick (0.3 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.

The right kidney is normal in size (6.0 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 (5.2 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

The right adrenal gland is normal in size (0.49 cm at the cranial pole and 0.58 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.48 cm at the cranial pole and 0.71 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.

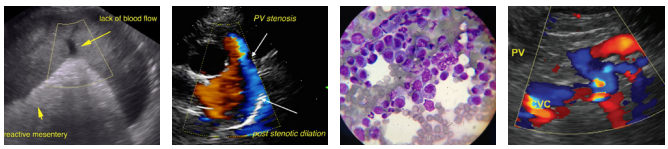
Liver

The liver is subjectively small with an irregular scalloped appearance, most prominent immediately cranial to the stomach, where the liver lobe is forming an almost mass-like appearance. Parenchyma is diffusely hypoechoic, characterized by more prominent than normal portal vein walls. Visible vasculature and biliary tree appear normal without distention 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

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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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 peritoneal effusion. There is no apparent lymphadenopathy.

PRIMARY FINDINGS

- Nodular, irregular hypoechoic microhepatica – differentials include chronic hepatitis versus infiltrative disease including possible neoplasia given the mass-like appearance of the mid liver.

SECONDARY 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

Given the reported bacteriuria and the appearance of the urinary bladder, recommendations include a urine culture and/or antibiotics to address the suspected UTI. Bile acids are recommended if total bilirubin is normal to further assess liver function. Testing for Leptospirosis could be considered if not recently evaluated.

Given the concurrent chronic gastrointestinal signs, especially if they've been present when liver enzymes were not increased, a gastrointestinal malabsorption panel including TLI, PLI, folate and cobalamain to Texas A&M GI laboratory +/- fecal enteropathogen PCR panel to Texas A&M Gi laboratory could be considered. A fine needle aspirate of the rounded mass-like portion of the mid liver is recommended if patient's coagulation status is appropriate.

In the meantime, empirical therapies with a 5-day course of Panacur as well as management of chronic hepatitis with antibiotics and liver protectants is recommended pending diagnostic results. If antibiotics and supportive care do not results in improvement of liver enzymes, a liver biopsy +/- concurrent GI biopsies may be warranted.

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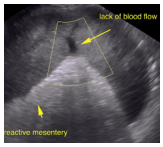

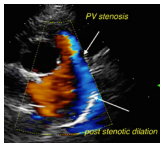

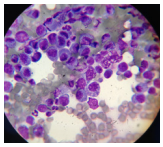
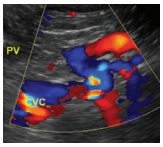

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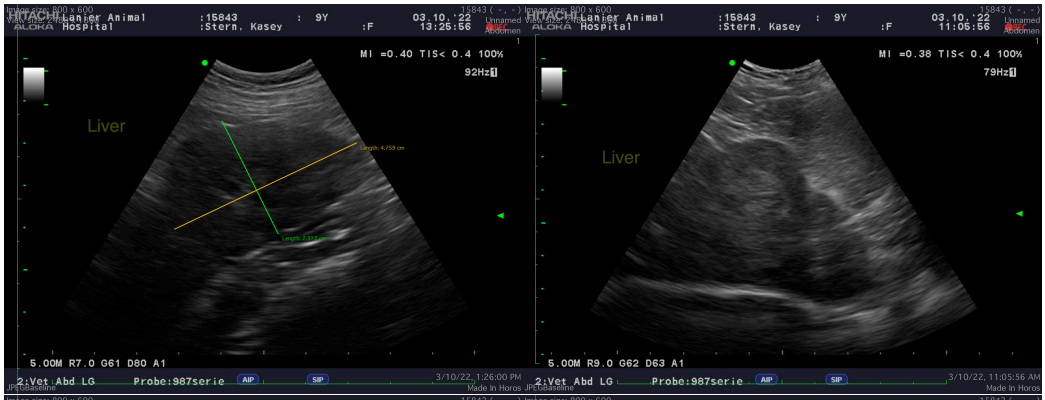

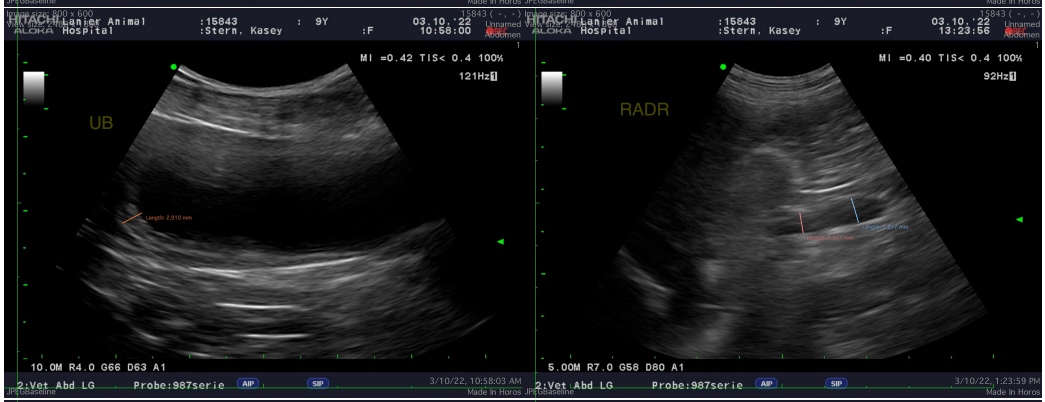

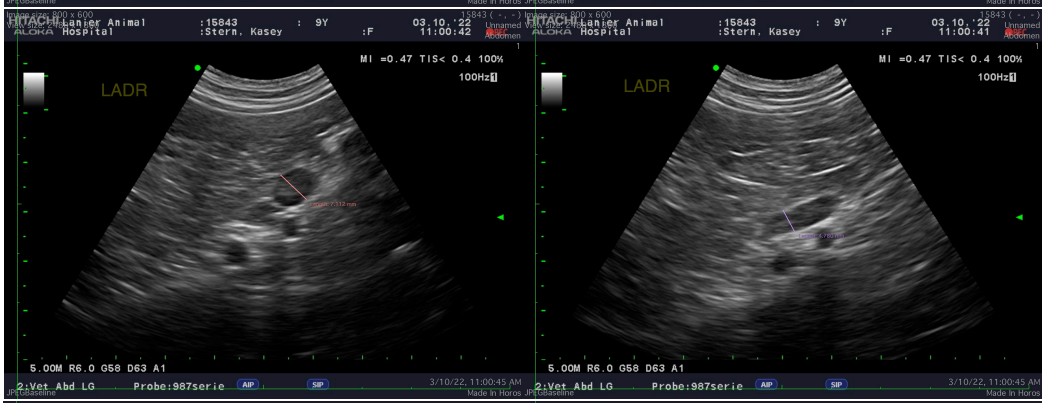

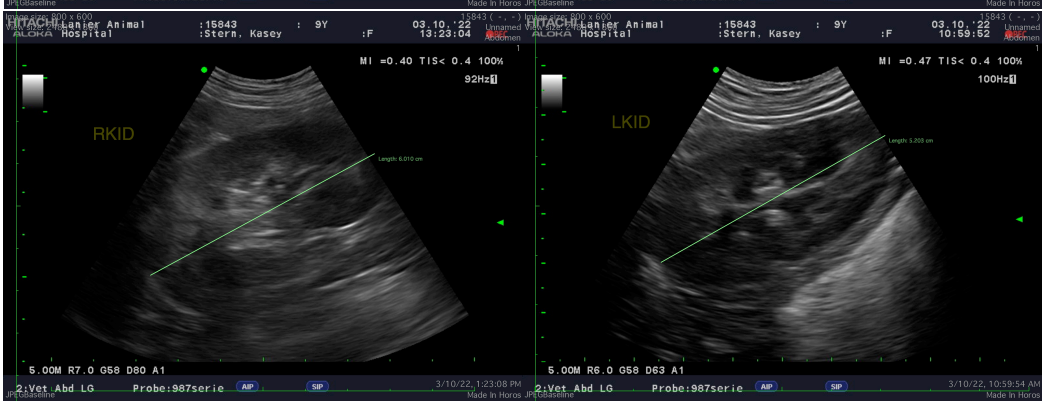

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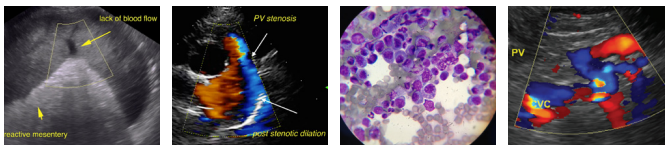

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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