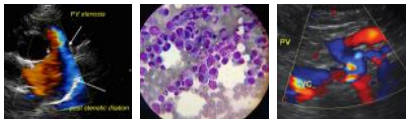
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

DATE

3/27/23

PATIENT

Princess Shade

SPECIES

Canine

BREED

Yorkie

SEX

Spayed Female

AGE

3/24/10

WEIGHT

12 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Banfield Timonium

REFERRING VET

Dr. Borrison

INVOICE

21837

PRESENTING CLINICAL SIGNS

History of on and off abdominal distention. Per O, P will sporadically have a very distended abdomen and then she will have bloody, liquid stool for 1-2 days. After that, all resolves. Currently has a pot bellied appearance. Also was diagnosed with 'border line Cushing's' and is currently under no treatment.

Current Medications: None currently.
Lab Results: NSF on 3/21, ALT 126.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Andi Parkinson, BS, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is only mildly distended (empty). Visible contents are anechoic. Urinary bladder wall is unable to be fully assessed for pathology without further distension. There does appear to be some mineral/sand or crystalline debris present. A small cystolith cannot be ruled out. No visible masses are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface. If there are urinary signs and/or concern for urinary bladder pathology, reassessment after complete filling is recommended.

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 or infarcts observed. The left kidney measures 3.87 cm. The right kidney measures 3.37 cm. Punctate/small nonobstructive nephroliths are noted bilaterally.

Adrenal Glands

Left adrenal gland is normal in size (1.6 cm long x 0.52 cm at cranial pole and 0.48 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (1.65 cm long x 0.65 cm at cranial pole and 0.53 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. 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). Multifocal well-demarcated hyperechoic homogenous nodules are noted. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is moderately distended with anechoic bile as well as mild suspended and gravity dependent echogenic debris. The wall is mildly thick, hyperechoic and irregular with polypoid changes. Infiltrative

neoplasia cannot be ruled out but is considered less likely. There is no evidence of effusion or inflammation. Accumulated sludge or debris, giving the appearance of polyps is also possible.

Gastrointestinal

The visible stomach wall is normal in thickness 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. 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 and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The observed pancreas appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. 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

Primary Findings

- Heterogenous Liver – These changes are most consistent with benign processes such as nodular hyperplasia, steroid (vacuolar) hepatopathy, extramedullary hematopoiesis or possibly chronic inflammatory disease and less commonly infiltrative round cell or metastatic neoplasia.

- Suspect gallbladder polypoid hyperplasia, however, mucus/debris cannot be ruled out as described above.

Secondary Findings

- Age-related kidneys with bilateral punctate nonobstructive nephroliths

- Hyperechoic splenic nodules – most consistent with benign myelolipomas. Other differentials such as fibrosis or calcification caused by old hematomas or infarcts, chronic inflammation, granulomatous disease or metastatic disease cannot be ruled out, but are considered less likely.

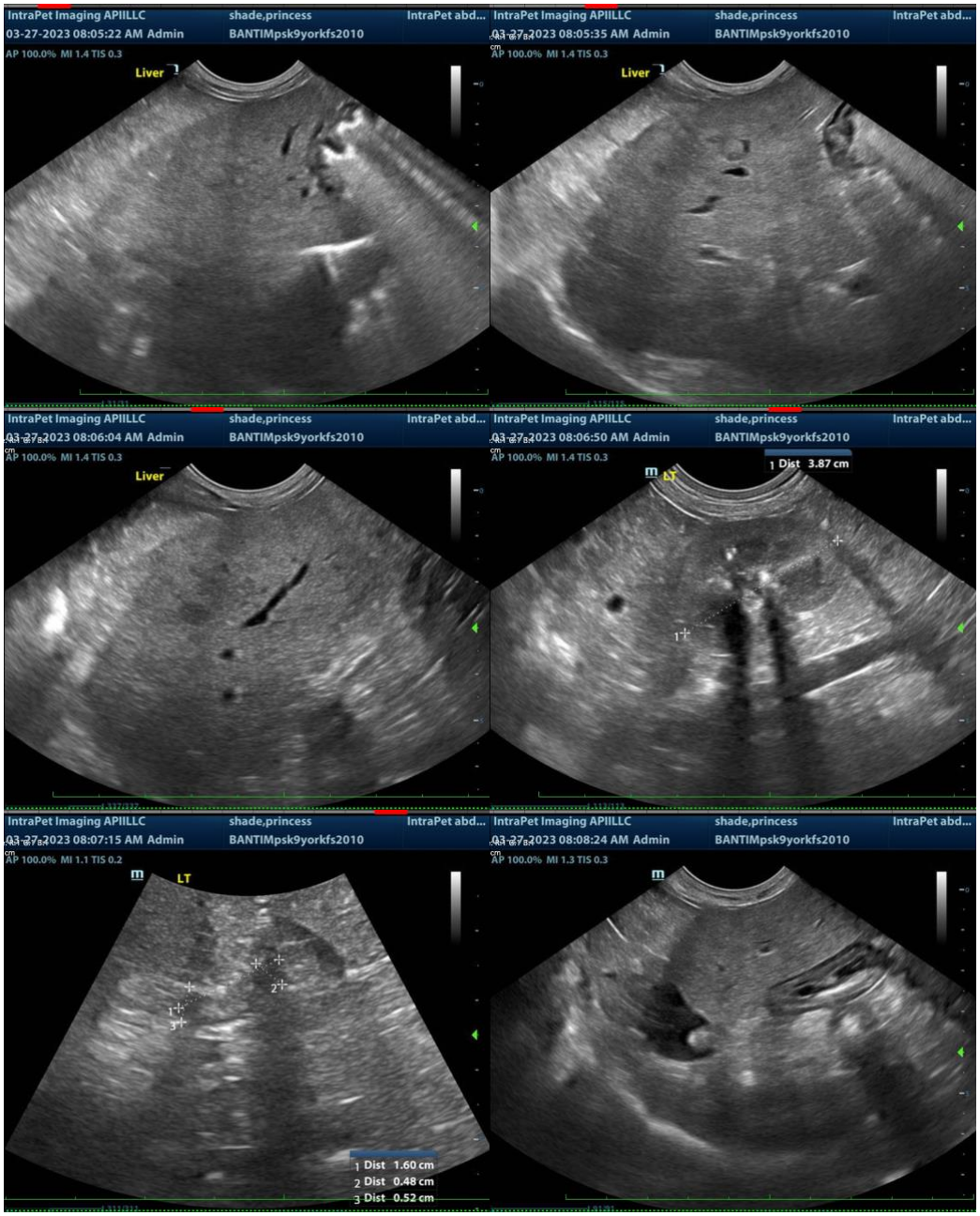
- Mineral/sand urinary bladder debris. A small cystolith cannot be ruled out.

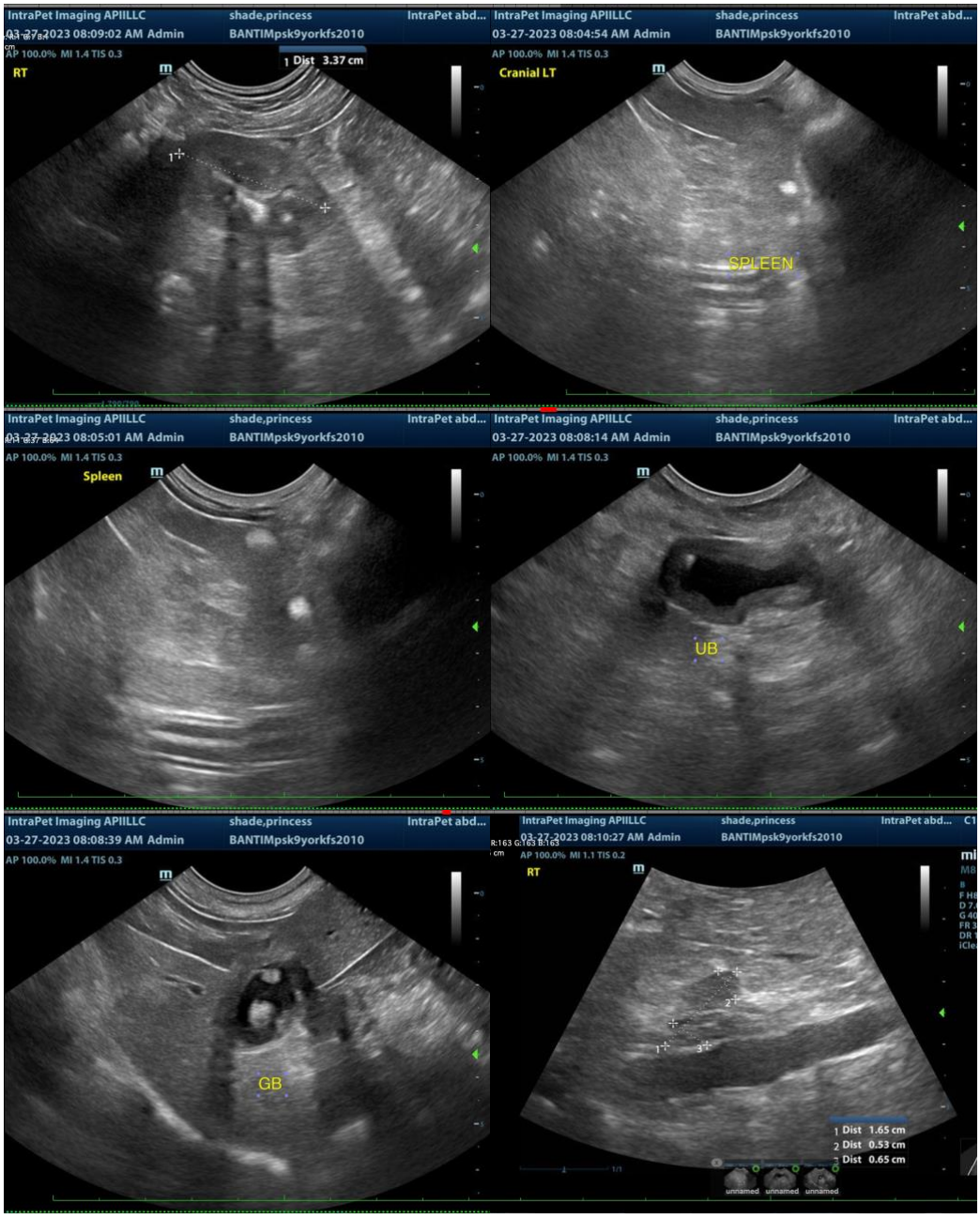
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This is a relatively unremarkable study in terms of the presented complaint of intermittent hematochezia, therefore, recommendations include a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory, for further evaluation of GI and pancreatic function. A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. A baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

In the meantime, supportive/symptomatic medical management of the clinical signs, possibly intermittent hemorrhagic gastroenteritis, etc., is recommended in the form of antiemetics, gastroprotectants, including Sucralfate, a probiotic, such as Visbiome or Proviable, empirical deworming with a 5-day course of Panacur, +/- Tylosin, and if tolerated, a short-term course of a bland easy-to-digest, or possibly fiber responsive diet.

Ultimately, if clinical signs persist, and a diagnosis is not reached, further evaluation of the GI tract, via upper and lower endoscopy, for visualization and biopsies, may be warranted.





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