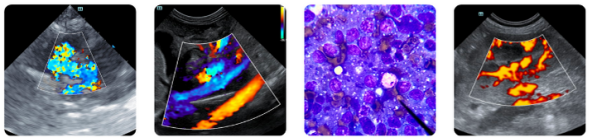

PATIENT

Shelby Tice

SPECIES

Canine

BREED

Rottweiler

SEX

SF

AGE

4 years

WEIGHT

43.5 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

Blue Pearl Wyomissing

REFERRING VET

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PRESENTING CLINICAL SIGNS

AUS to further evaluate azotemia with a low USG, vomiting, intermittent D+. Hypotensive. Vomited multiple times, O did note poss paper towel vs dryer sheet in vomit, green liquid. Known to carry around socks and dryer sheets in mouth. Also reported leaking urine (diaper) but unclear if this is chronic vs intermittent. Rads show possible hepatomegaly and thickened SI loops but no FBO appreciated. BW shows azotemia, hyperphosphatemia, elevated AST (normal ALT/ALP), electrolyte derangements, low Na:K ratio.

Meds: Naraquin (phosphate binder), Metronidazole, Recent prednisone taper (currently off for 1 week) Time of AUS: Very quiet, generalized paresis, Blood Pressure 71, 85, 86, 83 mmHG. HR 140. No murmur or arrythmia, PQFS, MM injected, CRT < 2 sec.

Abnormal PE/Chem/CBC/UA Results: AXR: prominent liver lobe, gas and fluid filled small bowel loops, subjectively thickened small bowel loops, soft stool in colon- no FB obstruction at this time - CBC: Hct 40%, WBC 18.1 H, Mono 1086 H, Neut 11,946 H, Plts 401 H - Chem: Alb 3.3-n, normal ALP, ALT, AST 70H, SDMA 21.3 H, BUN 53 H, Cr 2.1 H, Phos 6.1 H, Na 120 L, Cl 86 L, K 5.1-n, Gluc 122-n, Ca 11.5 H, Amyl 1771 H - UA (free-catch): USG 1.015, pH 9.0 H, Pro 2+, Rods > 100/hpf, Gluc 1+, WBC 11-20/hpf, Triphos Crytals 4-10/hpf H.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately 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.

The right kidney is normal is size (7.99 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 is size (6.84 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

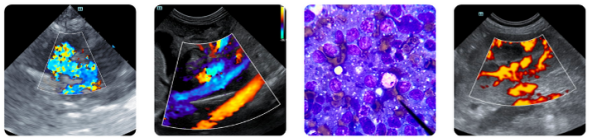
The right adrenal gland is normal in size (0.73 cm at cranial pole and 0.42 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is small (flattened contour) (0.25 cm at the cranial pole and 0.33 cm at the caudal pole). Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

Spleen is largely normal in appearance (shape, echotexture and echogenicity); however, it is volume contracted. Hydration status assessment is recommended.

Liver



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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

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 intestine demonstrates areas of mildly thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. The lumen of the small intestine is empty with no evidence of obstruction or foreign material.

The visible colon is normal in wall thickness (< 0.2 cm) and layering, but is mildly diffusely distended with soft stool.

Pancreas

The pancreas that is observed 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 visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

Other

The visible heart base (RA) and pericardium are unremarkable without obvious pathology noted in these images at this time. If cardiac function evaluation is desired, a full echocardiogram is recommended.

ULTRASONOGRAPHIC FINDINGS

- Mild/emerging inflammatory bowel disease (IBD) pattern – Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No loss of layering or distinct characteristics of malignancy are present. Therefore, differentials cannot be further ranked without tissue sampling.

- Flat left adrenal gland – This can be a normal patient variant and/or a sign of exogenous cortisol administration. If exogenous steroids are not being administered, hypoadrenocorticism (either relative or absolute) should be considered.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Patient's history, lab changes, and even the appearance of at least the left adrenal gland are all concerning for Addison's disease or hypoadrenocorticism. Having said that, those findings need to be interpreted in combination with how long patient was on steroids, the dose of the steroids, etc. Ultimately, a baseline cortisol level or even full ACTH stimulation test is recommended, but the timing of the test too, is in part dependent on patient's steroid history.

In the meantime, additional gastrointestinal evaluation can be considered, beginning with a routine fecal/giardia exam if not recently evaluated.

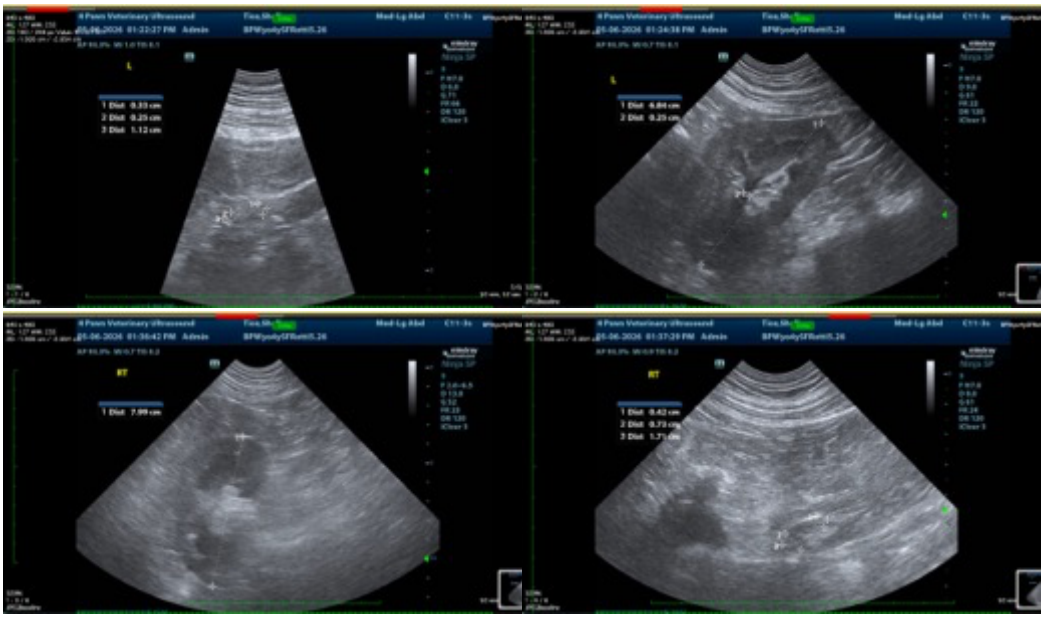
A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

A urine culture could also be considered if not already evaluated.

If another cause for patient's reported azotemia is not found, and it's believed to be true renal azotemia, potentially from an acute kidney insult, then testing for leptospirosis can be considered.

Other than supportive/symptomatic medical management of clinical signs, further diagnostic and treatment recommendations are largely dependent on results of the above.



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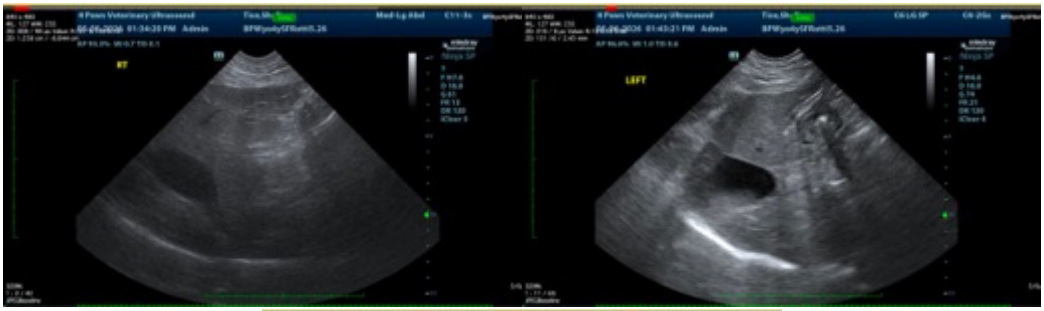

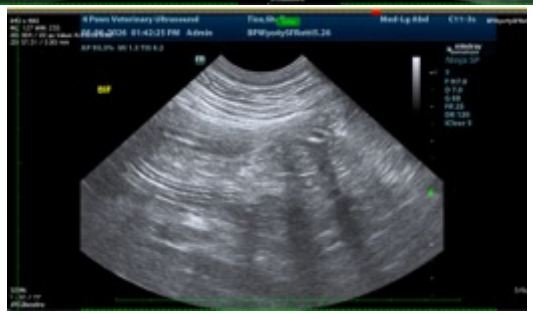

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
info@sonopath.com