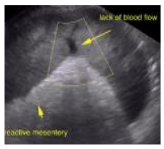

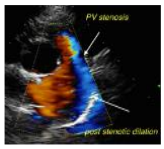

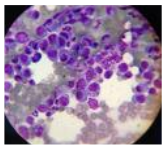
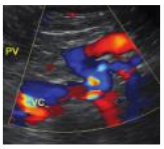

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1-800-838-4268 info@sonopath.com

PATIENT

Blackie Blanco Boschetti

SPECIES

Canine

BREED

Toy Poodle

SEX

Neutered Male

AGE

11 Years

WEIGHT

13.5 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Ferrer, DVM

HOSPITAL NAME

Paseos VC

REFERRING VET

Dr. Juan Torres

INVOICE

16613

DATE

7/29/22

PRESENTING CLINICAL SIGNS

History: Presented as a referral for an abdominal ultrasound to evaluate and rule out a possible abdominal mass. Pt presented to rDVM with main complaint for abdominal pain. A possible mass was palpated on the cranial ventral abdomen cavity.

Abnormal PE/Chem/CBC/UA Results: PE: Tender on abdominal palpation BW: no provided Rads: added in this report as supporting documents.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with occasional echogenic non-shadowing debris, most consistent with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can also present with echogenic debris. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The prostate is normal for a neutered dog.

Left kidney is normal is size (4.0 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 or infarcts observed. Non-obstructive areas of mineralization/nephroliths are noted.

Right kidney is normal is size (3.7 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 or infarcts observed. Non-obstructive areas of mineralization/nephroliths are noted.

Adrenal Glands

Left adrenal gland is normal in size (0.5 cm at cranial pole and 0.7 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal. A hyperechoic nodule is present in the caudal pole that does not result in capsular expansion or escape.

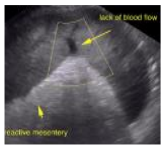
Right adrenal gland is normal in size (0.54 cm thick), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

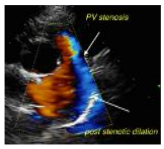
Spleen

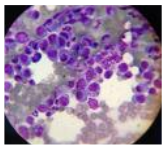
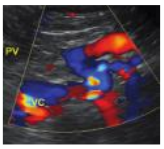
Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged (swollen contour) without disruption of architecture. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen and falciform fat. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.





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Gallbladder is mildly overdistended with a moderate amount of non-dependent, mildly aggregated/inspissated sludge. Hypo to anechoic cystic areas are noted between the gallbladder sludge and luminal wall. The wall is otherwise smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is moderately fluid distended. 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.

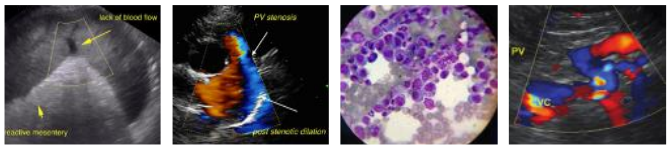
ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Emerging gallbladder mucocele – Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. The non-dependent nature of this sludge combined with the cystic areas are suggestive, however, of possible emerging cystic mucosal hyperplasia or early gallbladder mucocele.
- Hyperechoic hepatomegaly– This appearance is non-specific and most consistent with a benign steroid (endocrine) or vacuolar hepatopathy or reactive or idiopathic hepatopathy. Inflammatory and/or infiltrative disease (such as round cell neoplasia) are also possible, but considered less likely.
- Mild fluid gastric distention could be secondary to mild gastritis or gastric ileus, which could be contributing to the cranial abdominal discomfort. Outflow obstruction can't be ruled out, but there is no visible evidence of one present in these images.

Secondary Findings

- Nonobstructive small nephroliths bilaterally
- Urinary bladder debris
- Hyperechoic adrenal nodule in the left caudal pole – Differentials include primary adrenal cortical adenoma or adenocarcinoma, pheochromocytoma, myelolipoma, adrenal hyperplasia secondary to pituitary disease or metastatic disease. Ultrasound alone cannot differentiate



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between functional and non-functional nodules and/or between benign and malignant disease. Small nodules without other evidence of abdominal disease (to suggest metastatic disease) and/or clinical signs (to suggest adrenal disease) are most often incidental and should be monitored.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

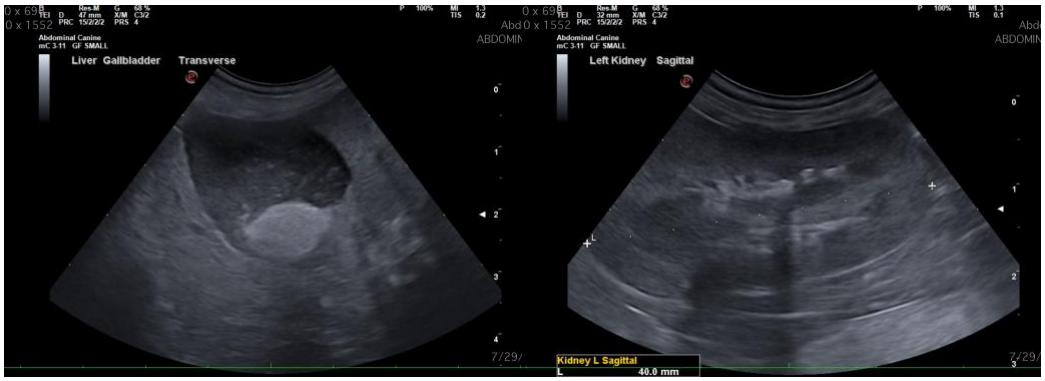
There is no evidence of an abdominal mass present in these images. The reported cranial abdominal discomfort could be secondary to the emerging gallbladder mucocele or potentially secondary to mild gastritis or non-ultrasonographically visible pancreatitis. Therefore, recommendations include:

CBC chemistry panel, electrolytes and urinalysis, if not recently evaluated to look for evidence of increased liver enzymes, total bilirubin and/or inflammatory changes on the CBC.

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.

The reportedly palpable abdominal mass could have been palpable hepatomegaly. Further investigation of the hepatomegaly could be considered with a fine needle aspirate of the liver, if patients coagulation status is appropriate, especially if there is suggestion of a hepatopathy based on lab work.

In the meantime, supportive symptomatic medical management with antiemetics, gastroprotectants to address possible mild gastritis, pain. management if indicated, etc., in addition to ursodiol, given the gallbladder debris is recommended. However, if clinical signs persist, cranial abdominal pain progresses and/or laboratory changes are suggestive of cholestasis, a cholecystectomy may need to be considered.



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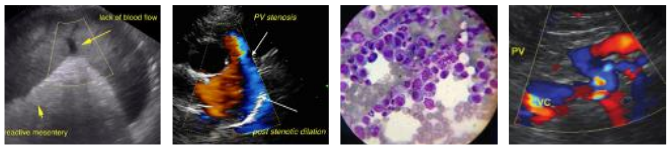

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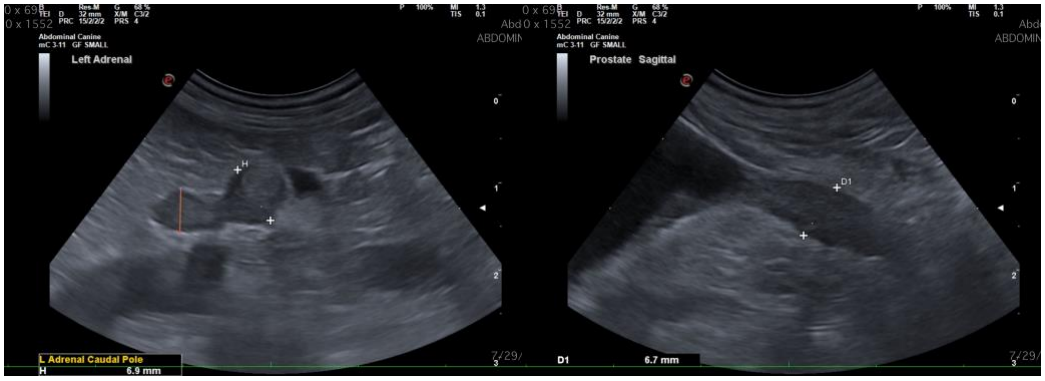

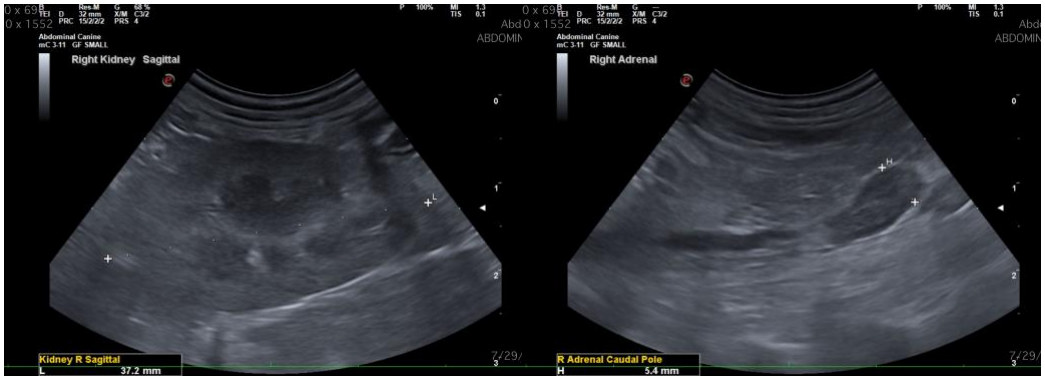

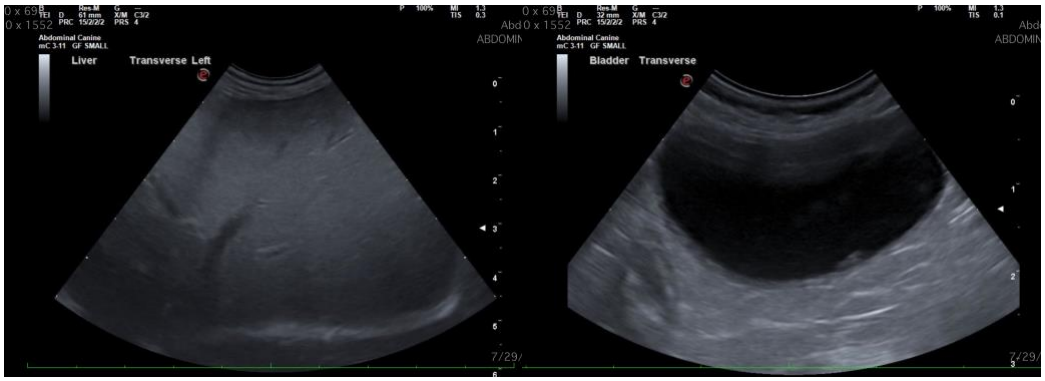

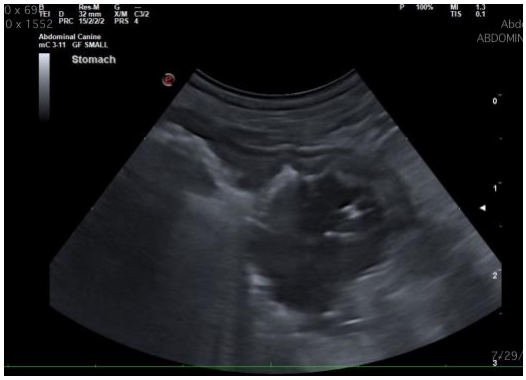

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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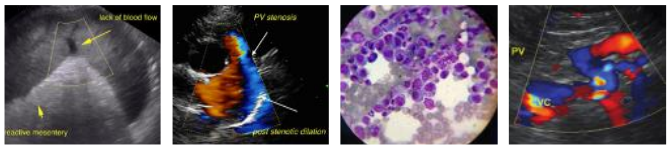

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Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

Beth Johnson, DVM DACVIM

Beth.Johnson@SonoPath.com