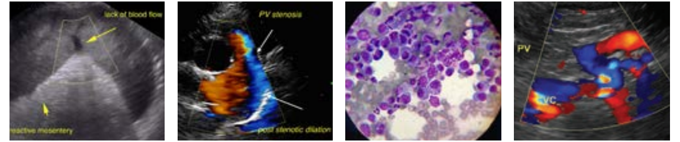

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1-800-838-4268 info@sonopath.com

PATIENT

Ziggy Clingaman

SPECIES

Canine

BREED

Cocker Spaniel

SEX

Neutered Male

AGE

6 Years

WEIGHT

22.8 Pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Jo Goodman

HOSPITAL NAME

Evendale Blu-Ash PH

REFERRING VET

Dr. Jo Goodman

INVOICE

40069

DATE

8/2/22

PRESENTING CLINICAL SIGNS

Hx of Atopy, elevated ALP and ehrlichia positive. Presented 11/2021 for annual exam. Performed full bloodwork and showed elevated ALP, proteinuria. Recommended LDDS or ultrasound with LDDS. Owner wanted to pursue LDDS now. Presented today for it, but lost 6lbs since November, having urinary accidents inside, increased thirst. Opted for in house lab work today and did ultrasound instead of LDDS. Patient was not fasted d/t not anticipating the ultrasound today. Will be pre-emptively starting him on Ursodiol d/t elevated GGT.
Abnormal PE/Chem/CBC/UA Results: lab work results attached

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 (6.45 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 (6.23 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

Adrenal glands are plump/swollen in size. Normal shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. The left adrenal gland measured 0.90 cm in width. The right adrenal gland measured 1.1 cm in width.

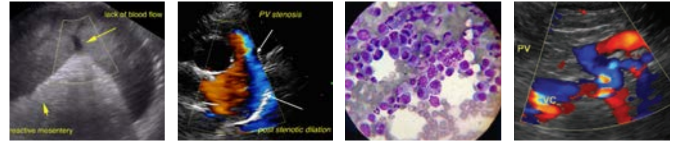
Spleen

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

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.

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. Some of the debris is mineral in appearance. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.



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Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent. **This is reportedly a post-prandial scan.

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 mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is 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

- **Gallbladder debris -** 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. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

- **Bilateral adrenomegaly –** consistent with adrenal hyperplasia secondary to pituitary dependent hyperadrenocorticism vs stress or normal variant. Interpret in combination with clinical signs of hyperadrenocorticism.

SECONDARY FINDINGS

- **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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Differentials for this patient's reportedly increased ALP do include cholangitis/gallbladder debris present in these images, as well as potentially hyperadrenocorticism. However, in the face of a normal appetite, neither of those findings are typically associated with weight loss. Therefore, recommendations include:

Assessment of the patient's caloric intake to ensure adequate caloric intake, and if caloric intake is adequate, 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, to rule out malabsorptive/maldigestive disease process.

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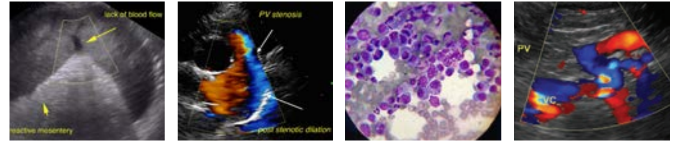

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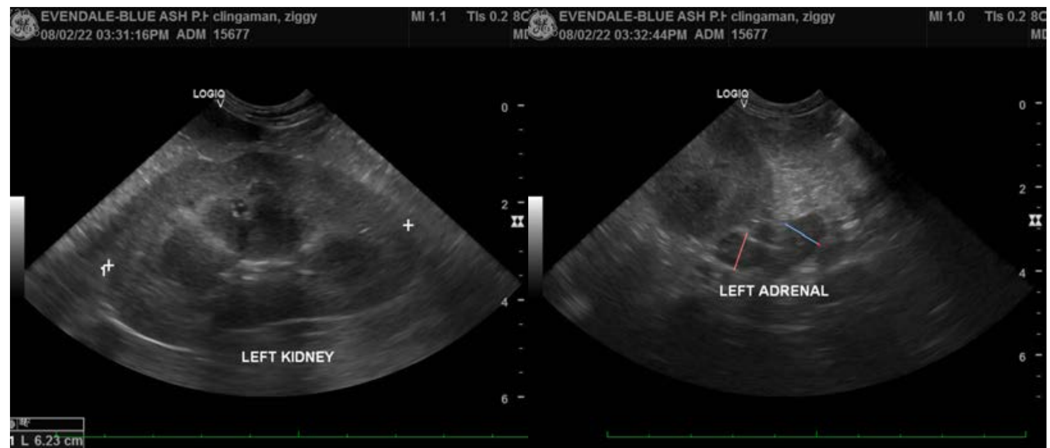
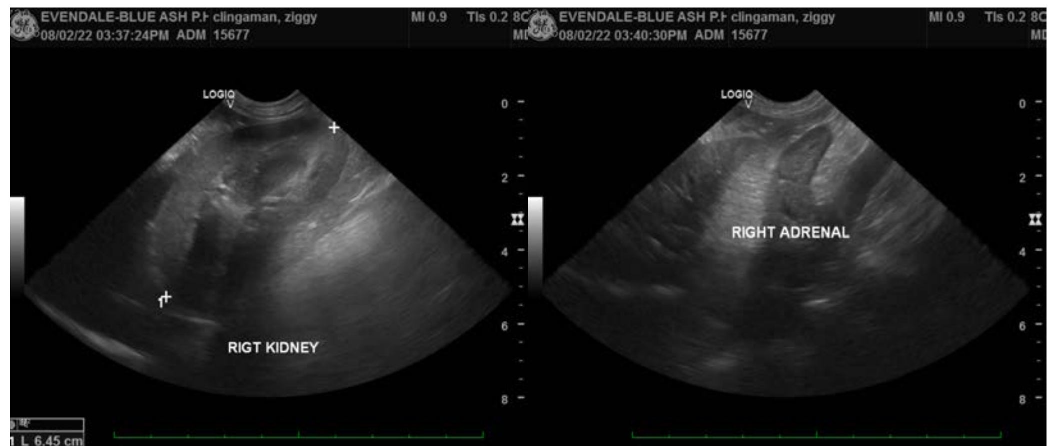
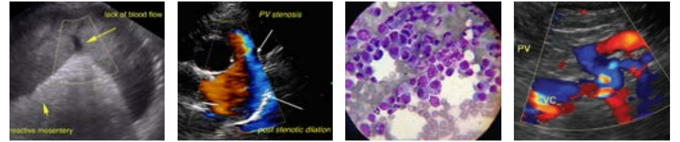
In the meantime, given the mild proteinuria, recommendations include a blood pressure and a urine protein to creatine ratio if not recently evaluated.

In the meantime, empirical therapy with Ursodiol +/- broad-spectrum antibiotics could be considered, given the gallbladder debris, with close monitoring of the ALP for improvement. If the ALP improves, antibiotics should be continued until the value normalizes and/or plateaus, at which time antibiotics can be discontinued. However, Ursodiol can be continued long-term, if effective.

Ultimately, evaluation for hyperadrenocorticism may be warranted in this patient, if clinical signs of hyperadrenocorticism, including PU/PD, etc. are present. However, further investigation is not recommended without clinical signs and/or until concurrent illness resulting in weight loss, etc. is identified and managed.







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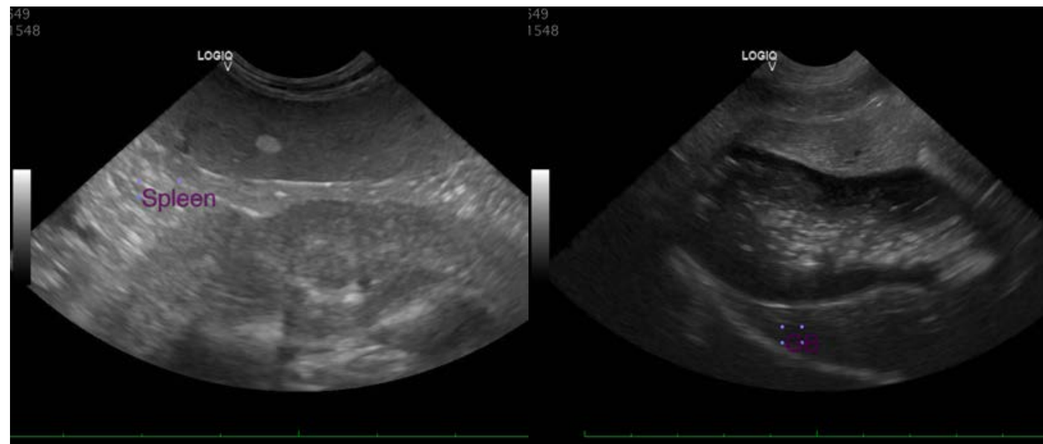

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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