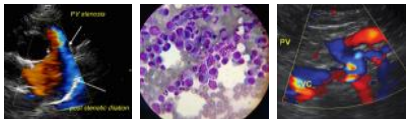
IMAGING PERFORMED BY

IntraPet.com



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

DATE
8/29/22

PATIENT
Sophie Camen

SPECIES
Canine

BREED
Shetland Sheepdog

SEX
Spayed Female

AGE
9/15/2007

WEIGHT
18.4 Pounds

INTERPRETED BY
Beth Johnson, DVM DACVIM

HOSPITAL NAME
Everhart VH

REFERRING VET
Dr. Baumler

INVOICE
17108

PRESENTING CLINICAL SIGNS

History: Presenting complaint: PU/PD of 2weeks, variable appetite for about 1-2 months. PE WNL. Prior medical history before this practice: pancreatitis episode requiring hospitalization in 2020, gallbladder sludge 2020
treated with ursodiol and low-fat diet. Fractured leg 7 years prior requiring surgical correction. Latest dental procedure April 2022.

Current Medications: Low fat i/d stew diet permanently, dasuquin daily
Lab Results: 8/24/2022:Chem -- BUN 34, all else NSF. CBC -- mild monocytosis, all else NSF. UA -- USG 1.016, trace proteinuria
Labwork 8/1/2022: Chem -- BUN 34, cholesterol 447, all else WNL. CBC -- platelets 436, all else WNL. UA -- USG 1.014, protein 1+, inactive sediment, T4 -- 1.5, accuplex4 -- negativex4.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Stephanie Warga RDCS, RVT.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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.

Left kidney is normal is size (3.8 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 (4.22 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 (1.7 cm long x 0.57 cm at cranial pole and 0.45 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (1.8 cm long x 0.49 cm at cranial pole and 0.52 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 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. A 0.5 cm discreet hypoechoic nodule is noted in the mid liver. Visible vasculature and biliary tree appear normal without distension or congestion.

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 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

- Emerging 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.

- Nonobstructive nephrolithiasis bilaterally

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.

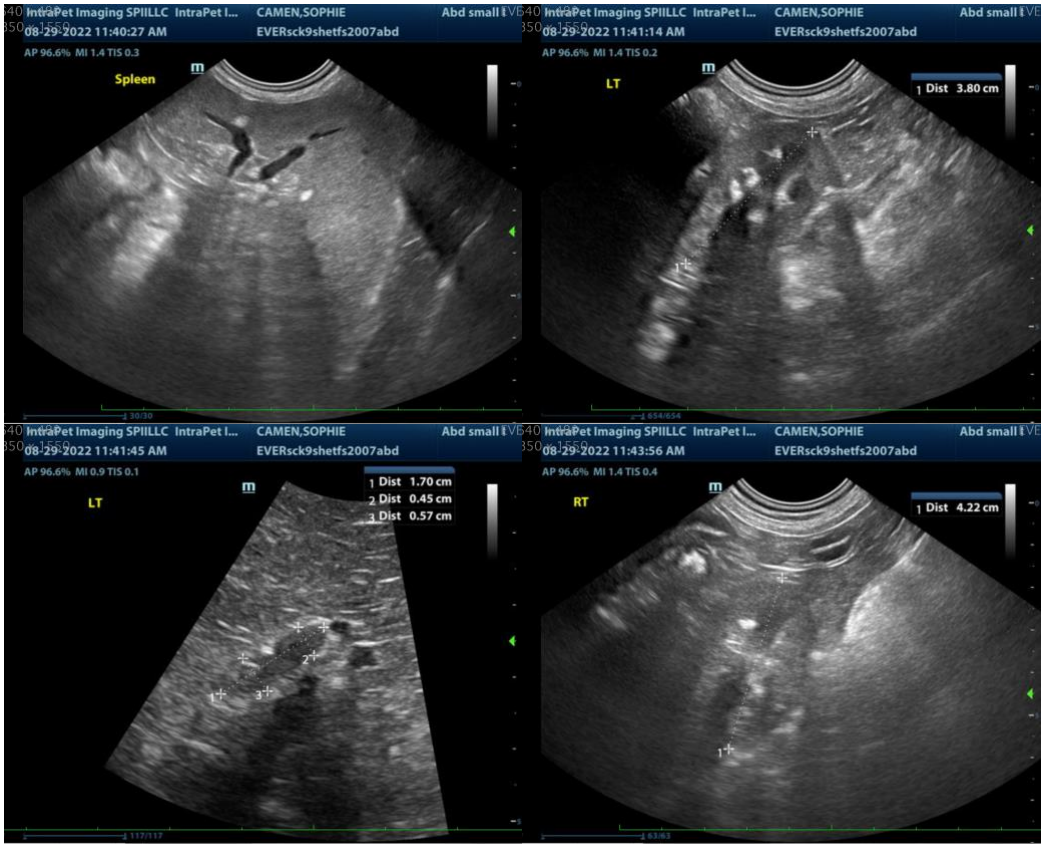
- Liver nodule – Differentials for a discrete liver nodule include primarily benign changes such as nodular hyperplasia, fibrosis of an old hematoma, granuloma, etc.; however, while considered less likely, primary hepatic neoplasia, infiltrative round cell neoplasia and metastatic disease can mimic benign lesions and cannot be definitively ruled out.

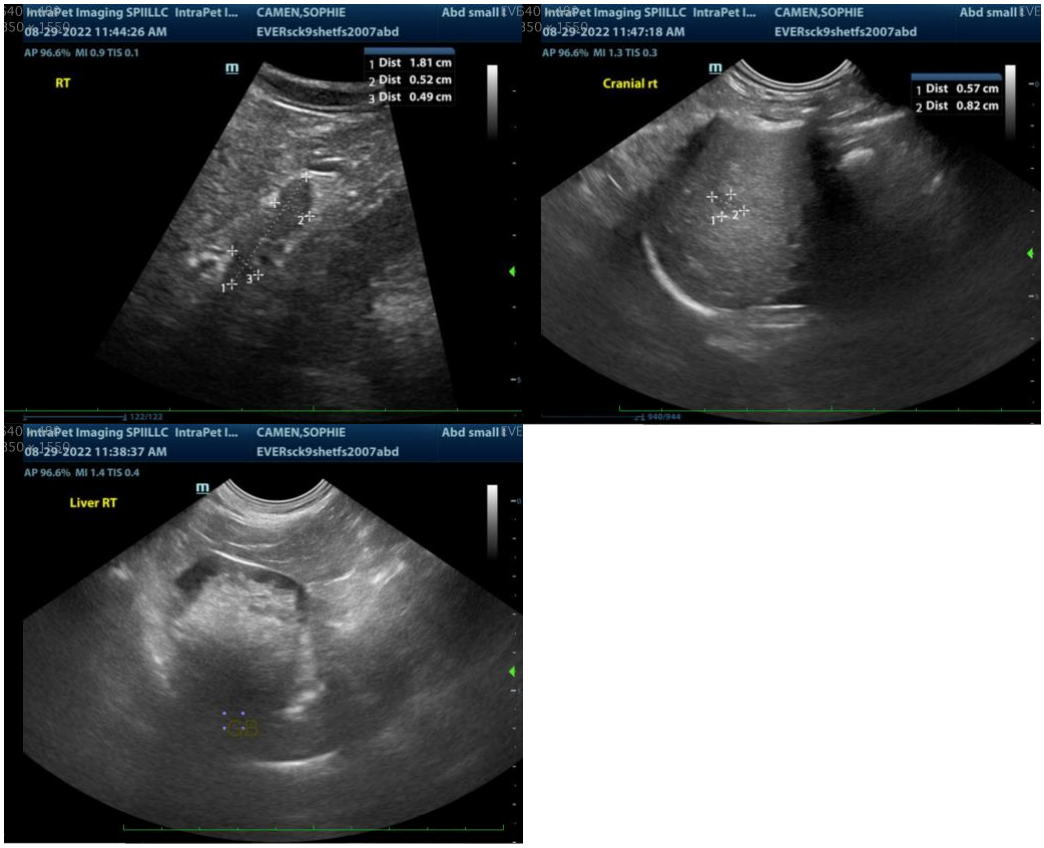
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given this patients isosthenuria and proteinuria, a UPC is recommended if not recently evaluated, as is a blood pressure.

Otherwise, next steps to investigate this patients reported polyuria/polydipsia could include a urine culture to rule out an occult urinary tract infection versus an empirical course of antibiotics with monitoring for improvement. A low dose dexamethasone suppression test to rule out hyperadrenocorticism, a T4 to look for evidence of hyperthyroidism, bile acids, leptospirosis testing, etc.

The emerging mucocele may be contributing to the patients intermittently low appetite, in which care a cholecystectomy could be considered. However, an alternative approach is continued medical management, as is currently in place unless clinical signs progress.





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