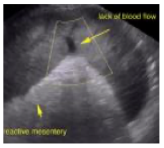
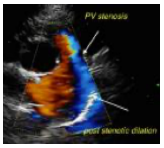
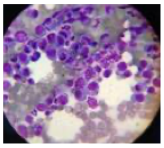
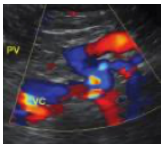
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

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

PATIENT
Barney Pecora

SPECIES
Canine

BREED
Bassett Hound

SEX
Neutered Male

AGE
14 years

WEIGHT
62 lbs

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Jack Reese

HOSPITAL NAME
Willow Run VC

REFERRING VET
Jack Reese DVM

INVOICE
14022

DATE
8.9.23

PRESENTING CLINICAL SIGNS

History: Chronic vomiting, currently unresponsive to ondansetron at home. Patient recently underwent dermal mass removal, at which time pre-operative bloodwork revealed renal value elevation (BUN, SDMA). Isosthenuria with normal UPC suggestive of possible early renal disease. Owner wishes to pursue abdominal U/S to rule out obvious mass or neoplasia causing vomiting before pursuing other diagnostics
Abnormal PE/Chem/CBC/UA Results: SDMA - 16 BUN 51 UPC 0.6

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.

Prostate is normal in size, echotexture and echogenicity for a neutered male.

The kidneys are overall normal in size (left kidney: 6.36 cm / right kidney 6.71 cm) 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. Trace pyelectasia is present is noted bilaterally as well as small bilateral renal cortical cysts. There is no evidence of mineral or infarcts observed.

Adrenal Glands
Adrenal glands are plump/swollen in size (left 0.78 cm at the cranial pole / 2.10 at the caudal pole) (right: 2.00 cm at the cranial pole / 1.80 cm at the caudal pole). Normal shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

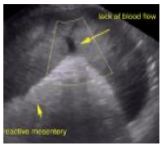
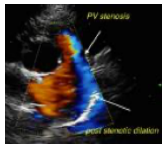
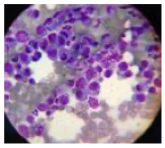
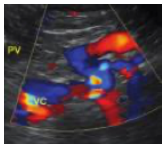
Spleen
Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver
Liver is subjectively 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. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

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.

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.

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

Pancreas

Pancreas is prominent in size with swollen irregular contour. Parenchyma is heterogenous characterized by hyperechoic tissue remodeling intermixed with ill-defined hypoechoic nodules. 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.

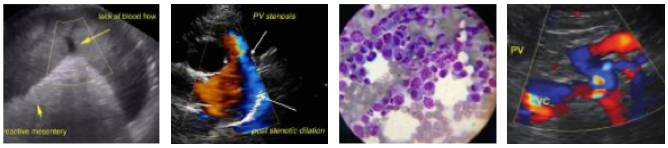
ULTRASONOGRAPHIC FINDINGS

Findings

- Pancreatic nodular hyperplasia – Infiltrative neoplasia cannot be ruled out but is considered less likely. Low-grade smoldering chronic pancreatitis cannot be ruled out and should be suspected in the face of appropriate clinical signs.
- Mild 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.
- Age-related kidney changes with trace bilateral pyelectasia and bilateral cortical cysts.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given this patient's reported laboratory changes involving the kidneys, a blood pressure is recommended (if not recently evaluated) as is testing for Leptospirosis.
- Further evaluation of both pancreatic and bowel function is recommended, beginning with a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory.
- A fine-needle aspirate of the pancreas could be considered (if coagulation status of the patient is appropriate).
- In the meantime, beginning medical management for emerging chronic kidney disease is recommended as is supportive/symptomatic medical management of gastrointestinal signs (i.e., antiemetics, gastric protectants and appetite stimulants, if necessary, etc.)
- Additionally, empirical deworming with a 5-day course of Panacur could be considered.
- While the adrenal glands are suggestive of possible hyperadrenocorticism, further evaluation of hyperadrenocorticism is not typically recommended without supportive clinical signs and/or in the face of concurrent illness. If/when clinical signs of hyperadrenocorticism develop in an otherwise



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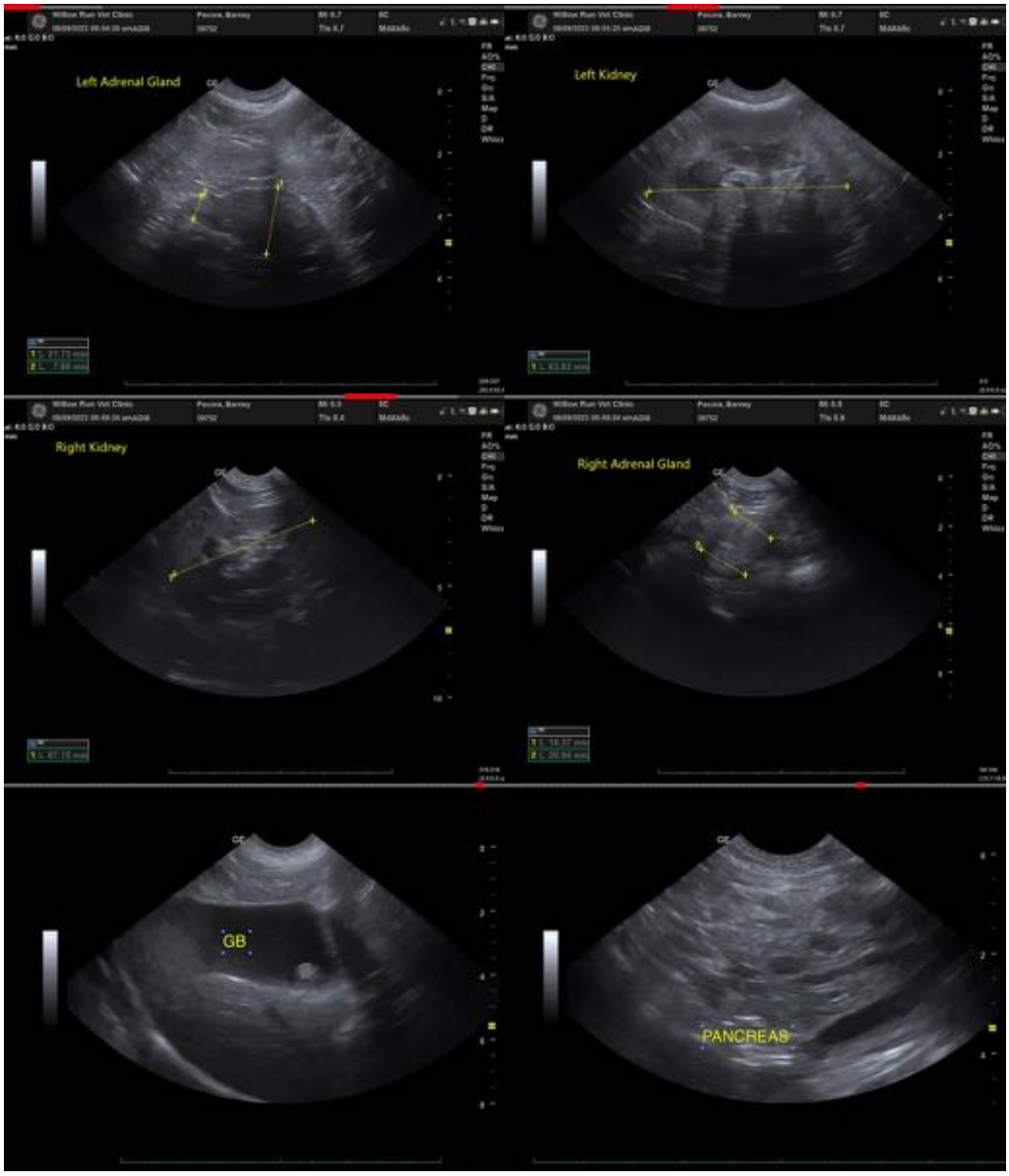
healthy patient, testing could be considered beginning with a low-dose dexamethasone suppression test at that time.



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.

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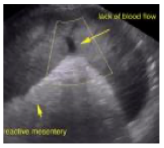
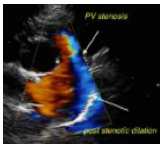
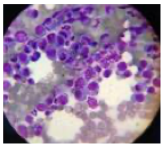
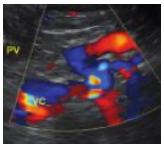

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