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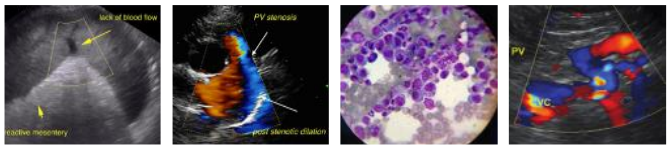
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Tripp Rono

SPECIES

Canine

BREED

Mini Poodle

SEX

Neutered Male

AGE

11 Years

WEIGHT

5.9 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Tiffany Moore, DVM

HOSPITAL NAME

Lone Mtn. AH

REFERRING VET

Tiffany Moore, DVM

INVOICE

17391

DATE

9/19/22

PRESENTING CLINICAL SIGNS

History: presenting for vomiting bile and diarrhea. O states that P began vomiting bile on Saturday, he has been vomiting after eating meals. O noted that P has been having diarrhea since Sunday as well - no blood in diarrhea, but mucoid. O noted that P does get human food sometimes from family members.

Abnormal PE/Chem/CBC/UA Results: Large urinary bladder, bilateral cataracts, periodontal disease grade IV/IV, hyperextension of carpi bilaterally - toe-touching on right front leg. ALT 933, ALP 318, EOS 0.96, HCT 62.02 %. cPli abnormal. PT 18.9, PTT 105.8.

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 not well visualized in these images.

Left kidney is normal is size (4.4 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.

Right kidney is normal is size (4.8 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, mineral or infarcts observed.

Adrenal Glands

The areas of both adrenal gland are examined without evident pathology.

Spleen

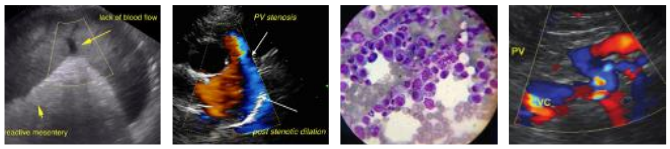
Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). A 1.0 cm mildly heterogeneous mildly hypoechoic nodule is noted, creating a subtle capsular bulge. Splenic vasculature appears normal.

Liver

Liver is normal to subjectively small in size with slightly undulating or scalloped capsular contour or margins. Parenchyma is diffusely heterogenous with increased portal markings and coarse architecture. No focal nodules or masses 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 mildly thick, hyperechoic and irregular. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

Gastrointestinal



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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

- Chronic inflammatory hepatopathy
- 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. Given the concurrently thick irregular wall and hepatic changes, cholangitis or potentially chronic but resolved or smoldering cholangitis is suspected.
- Hypo to anechoic splenic nodule – likely represents a benign lesion such as a cyst, hematoma, nodular hyperplasia, extramedullary hematopoiesis, etc., however while considered less likely, infiltrative neoplasia can mimic benign lesions, and cannot be ruled out.

Secondary Findings

- Urinary bladder debris

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Differentials for the nonspecific inflammatory liver changes include a microscopic disease such as leptospirosis, bacterial cholangiohepatitis, chronic active hepatitis, copper associated hepatotoxicity versus other hepatotoxicity. Infiltrative neoplasia is considered possible but less likely and cannot be definitively ruled out.

Recommendations include testing for leptospirosis, as well as a fine needle aspirate of the liver if patients coagulation status is appropriate, bile acids are recommended if total bilirubin is normal, followed by an empirical course of broad-spectrum antibiotics and hepatic nutraceuticals while monitoring the liver for improvement. If a diagnosis is not obtained cytologically, and/or liver enzymes don't improve or progress, a liver biopsy may be warranted.

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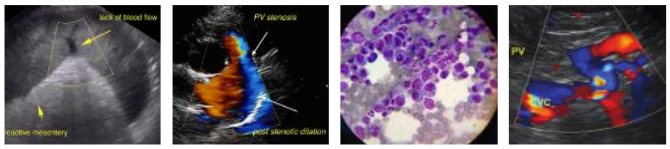

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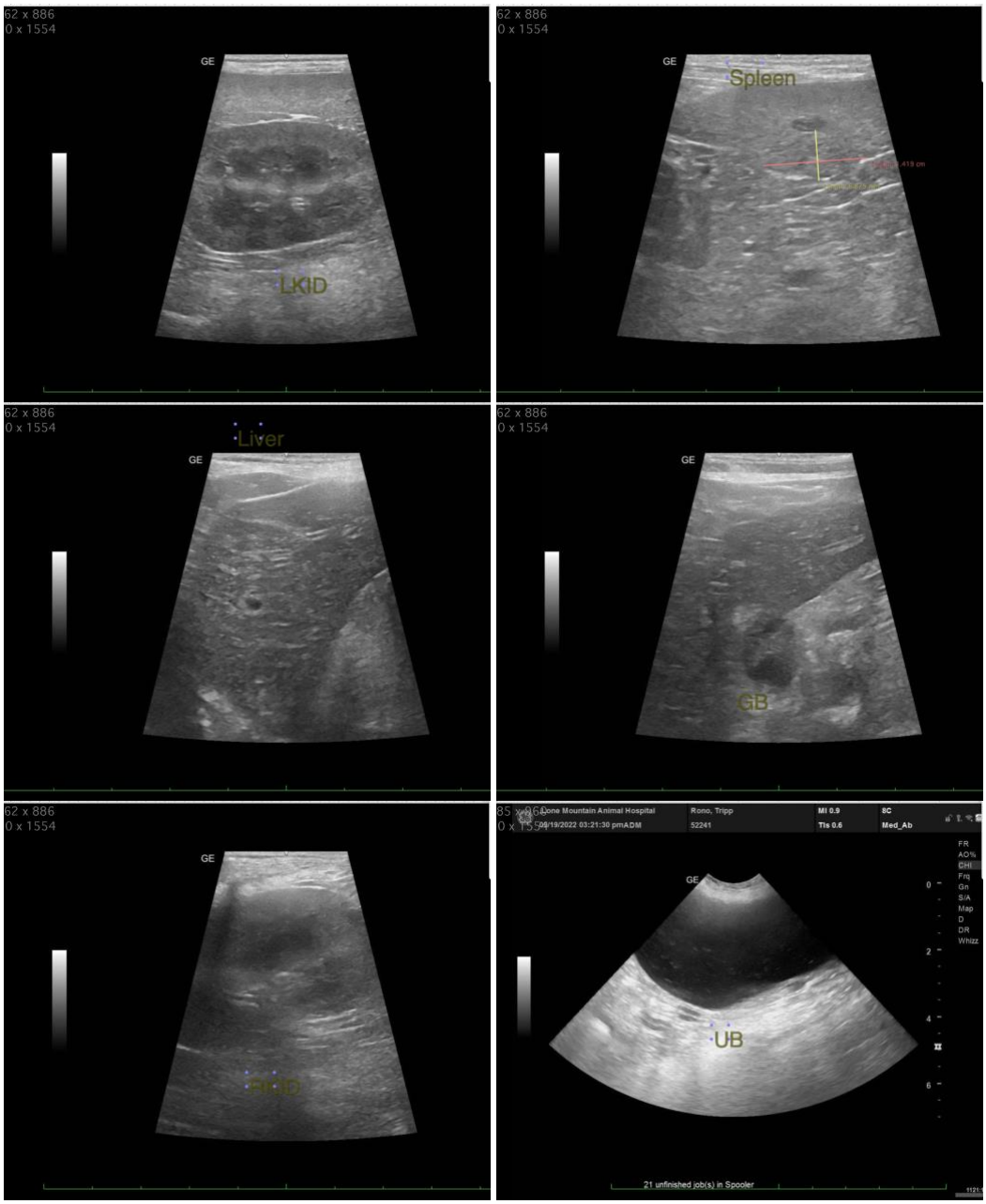

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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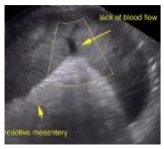

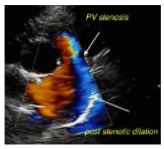

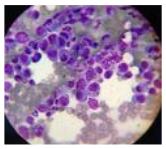
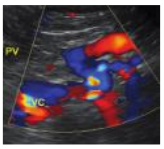

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