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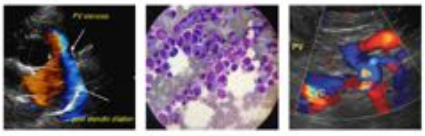

SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

PATIENT

Coco Quesenberry

SPECIES

Canine

BREED

Terrier

SEX

Spayed female

AGE

11 years

WEIGHT

22.8 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Amy Mayhew LVT

HOSPITAL NAME

SVS Imaging Michigan

REFERRING VET

Rochester VH

INVOICE

32805

DATE

9/9/22

PRESENTING CLINICAL SIGNS

History: frequent urination, heavy panting
Abnormal PE/Chem/CBC/UA Results: Increased urine protein despite recent antibiotic therapy, elevated ALP Please see attached labs.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended with primarily anechoic contents and occasional echogenic non-shadowing debris. Apical urinary bladder wall is diffusely thick (X cm). Mucosa is hyperechoic and irregular. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface. The bladder wall measured 0.52 cm.

Left kidney is normal is size (5.27 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 (4.72 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 cranial pole measured 0.66 cm and the caudal pole measured 0.8 cm. The right adrenal gland cranial pole measured 0.63 cm and the caudal pole measured 0.73 cm.

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 0.7 cm, hypoechoic, non-capsular disrupting nodule was noted in the mid body. 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.

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.

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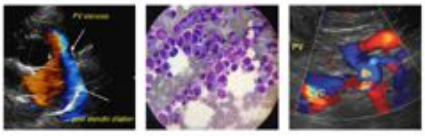

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Gastrointestinal

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 (< 0.2 cm) 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

Reactive medial iliac lymphadenopathy is noted. There is no free fluid.

ULTRASONOGRAPHIC FINDINGS

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

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.

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.

Chronic Cystitis - Urinary bladder wall changes are most consistent with chronic cystitis. Infiltrative neoplasia cannot be ruled out but is considered less likely give the location and diffuse nature of the changes.

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 cannot be ruled out, but is considered less likely.

Pancreatic nodular hyperplasia – Infiltrative neoplasia cannot be ruled out but is considered less likely.

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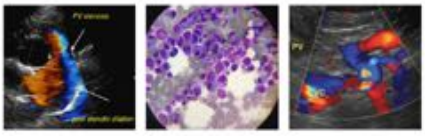

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Reactive medial iliac lymph nodes – are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

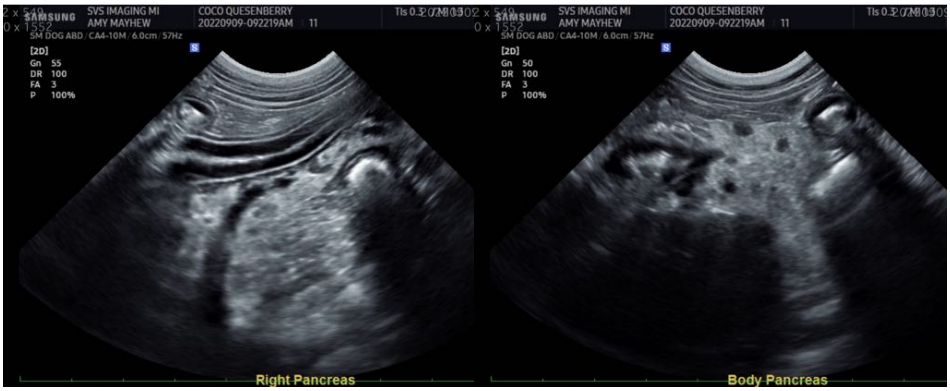
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

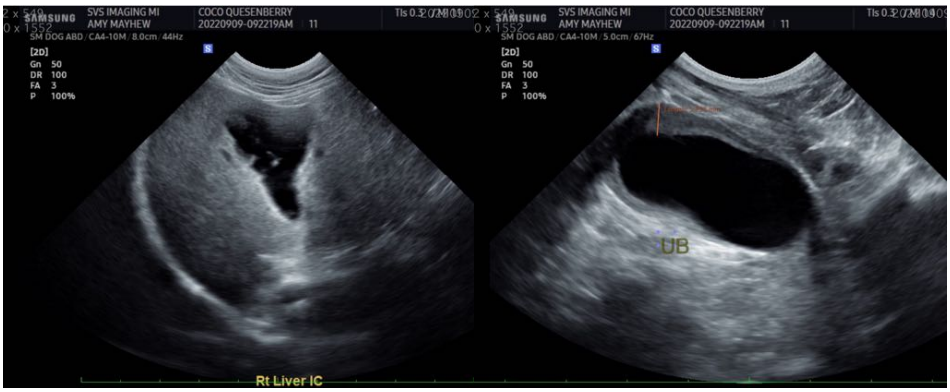
The described history, laboratory changes and ultrasonographic adrenal gland, liver and gallbladder changes can all be seen with hyperadrenocorticism. If clinical signs of hyperadrenocorticism such as polyuria, polydipsia, polyphagia, etc. are present then testing for hyperadrenocorticism with a low dose Dexamethasone suppression test is warranted.

Blood pressure is recommended if not recently evaluated.

Urine culture is recommended 7-10 days or more after finishing the most recent course of antibiotics to prevent a false negative due to recent antibiotics to rule out an occult urinary tract infection causing the pollakuria.

In a non-azotemic patient a urine protein to creatinine ratio of 2 does not require medical management at this time. However, recommendations are to look for underlying causes such as hyperadrenocorticism as well as closely monitor the urine protein to creatinine ratio for progression to a level that would warrant therapy in the form of ace inhibitors, etc.





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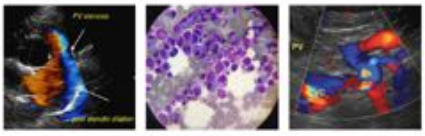

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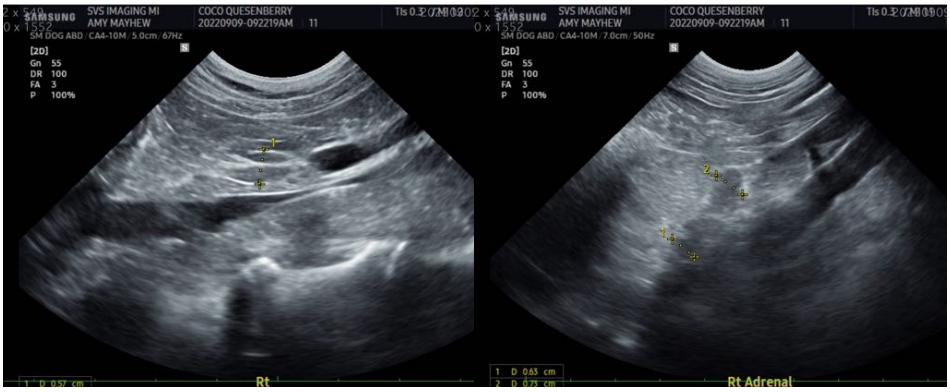

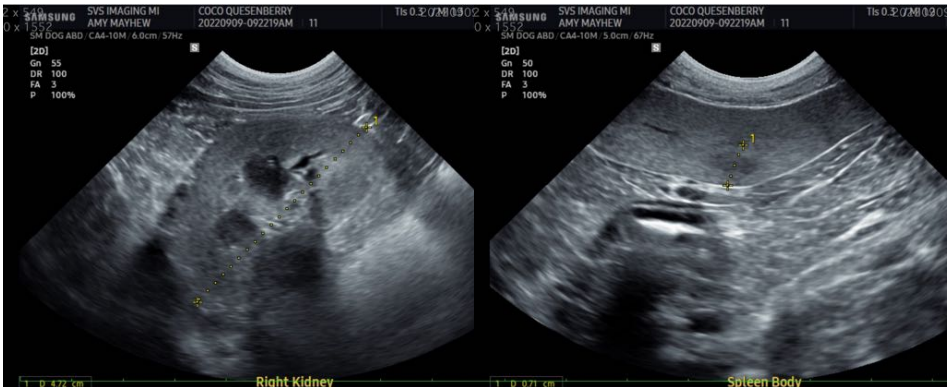

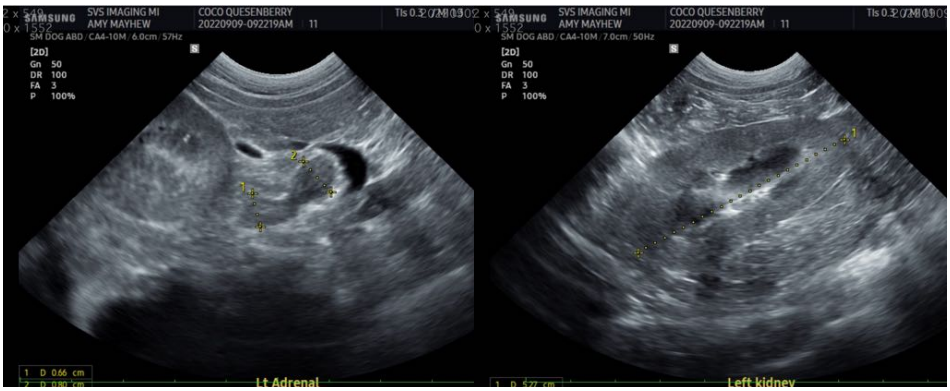

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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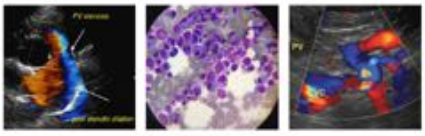

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