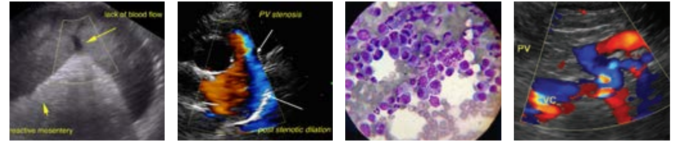
SonoPath

Clinical Sonography & Telecytology

EDUCATIONAL TELECONSULTATION SERVICES™



SonoPath.com™

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

PATIENT

Chance Hoffman

SPECIES

Canine

BREED

Mini Schnauzer

SEX

Intact Male

AGE

11 Years

WEIGHT

8.7 kg

INTERPRETED BY

Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Erin Wicks

HOSPITAL NAME

Shores VEC

REFERRING VET

Dr. Zippay

INVOICE

26767

DATE

10/29/21

PRESENTING CLINICAL SIGNS

Presented at our hospital for V+ and not eating since Bladder Stone surgery on Monday. Patient is getting his meds but only ½ doses of Insulin. Previous Health Concerns: Diabetic, Cataracts, Bladder Stones, Suspect Cushings Current Medications: Convenia, Insulin, Gabapentin, Tramadol Abnormal PE/Chem/CBC/UA Results: BG: 370 mg/dl AFAST – No free fluid, blood clot in urinary bladder Chem: BUN 45, Phos 7.4, TBil 1.0, GGT 24, ALP >993, ALT 135, BG 381, Glob 3.8, Chol 440 CBC: Marked neutrophilia, monocytosis EPOC: K+ 3.4, increased lactate cPL: normal

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The ureters were not visible which is normal. No uroliths or sediment were visualized and anechoic urine was present. No evidence of inflammatory or neoplastic changes were noted. Ureteral papillae were normal. Reactive iliac lymph nodes noted.

The prostate was thickened and irregular with regional inflammation and bright mesentery. The prostate measured approximately 2.5 cm.

The **kidneys** presented a relatively uniform cortical hyperechogenicity when compared to the renal medulla, spleen and liver. No overt masses were noted. Corticomedullary definition was nebulous and the ratio favored the cortex slightly. The ureters were not visible and assumed to be normal. These changes are most consistent with chronic interstitial nephritis yet infiltrative disease could not be entirely ruled out without biopsy though neoplasia is not suspected. Cortical mineralization noted in both kidneys. The right kidney measured 6.28 cm. The left kidney measured 6.41 cm.

Adrenal Glands

Both **adrenal glands** were swollen and slightly mineralized. The left adrenal gland measured 1.88 cm x 0.60 cm at the cranial pole and 0.54 cm at the caudal pole. The right adrenal gland measured 1.0 cm at the cranial pole and 0.8 cm at the caudal pole.

Spleen

The **spleen** was normal size and relatively normal contour with multifocal hyperechoic areas of mineralization. This is a benign change; however, can be related to Cushing's disease or other endocrinopathies.

Liver

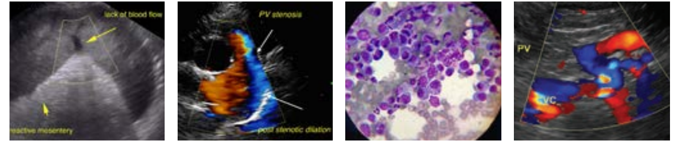
The **liver** present non-specific, coarse architecture and increased portal markings. Minor degenerative changes. The **gallbladder** was mildly over distended with suspended and dependent debris, yet not to the level of emerging mucocele, yet sludge appears to be mildly excessive. No adjunctive inflammation was noted.

Gastrointestinal

The **stomach** was filled with ingesta. The small intestine and colon were unremarkable.

Pancreas

Heterogeneous **pancreatic** changes noted, suggestive for inflammation.



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ULTRASONOGRAPHIC FINDINGS

- Prostatitis/lower urinary inflammatory pattern, likely secondary from surgery/cystotomy
- Chronic renal changes with cortical mineralization
- Splenic mineralization
- Possible underlying Cushing's/PDH
- Acute cholangitis liver pattern

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Leptospirosis titers should be considered. FNA of the liver warranted if bilirubin is persistent. Otherwise, supportive care indicated and eventual workup for PDH. Full urinary workup and culture indicated. No overt evidence of neoplasia. Blood pressure measurements indicated.

Potential Causes of Diabetic Dysregulation

This is a suggestive checkoff list when faced with an unregulated diabetic patient:

UTI

Dietary indiscretion/intolerance

Pancreatitis

Hyperthyroidism/hypothyroidism

Exogenous steroids (including topical eye meds)

Cushing's

Acromegaly

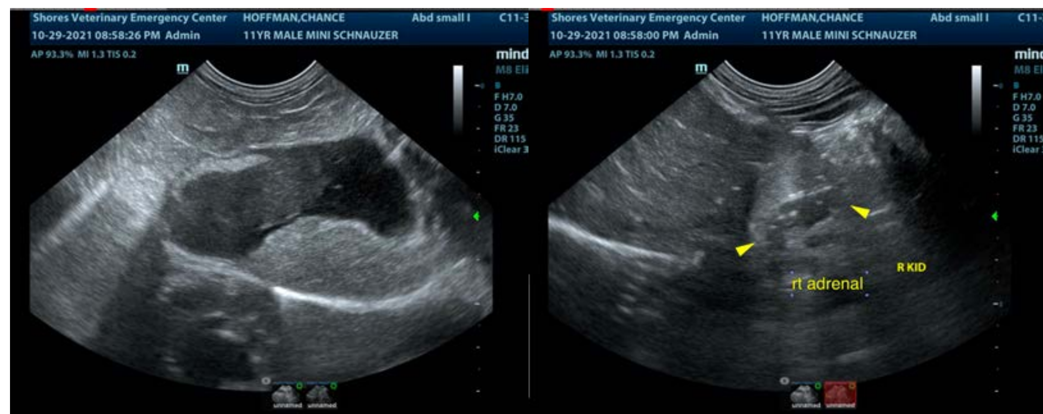
Owner compliance

Insulin quality issues

Antibodies to insulin

Underlying Neoplasia

Diffuse liver disease



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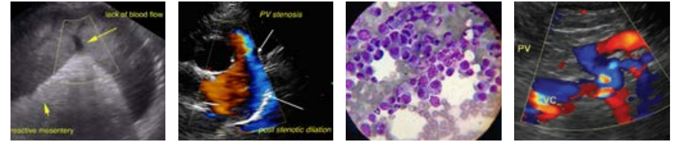

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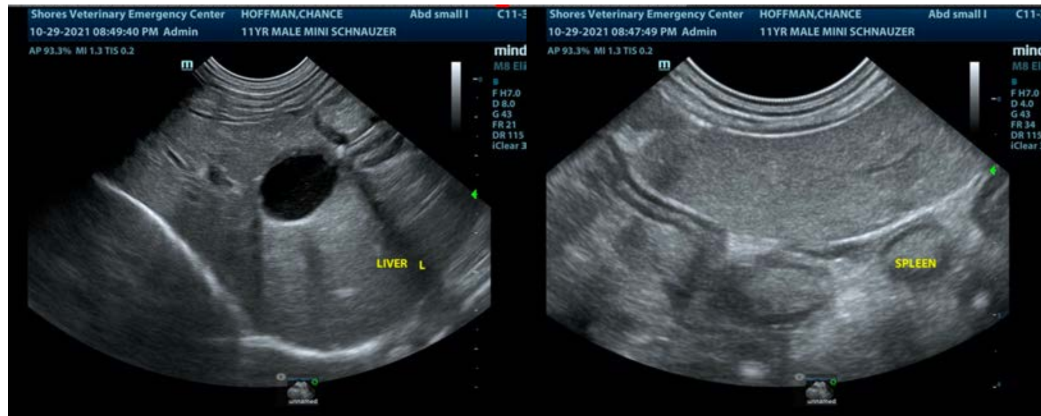

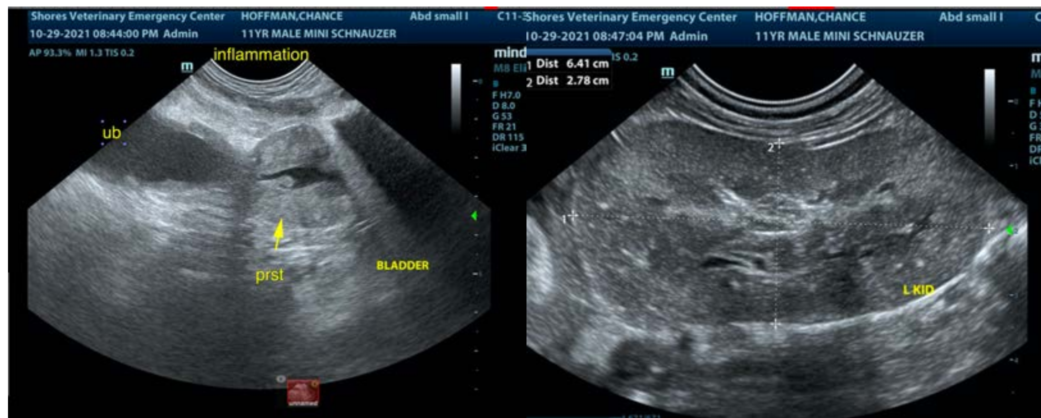

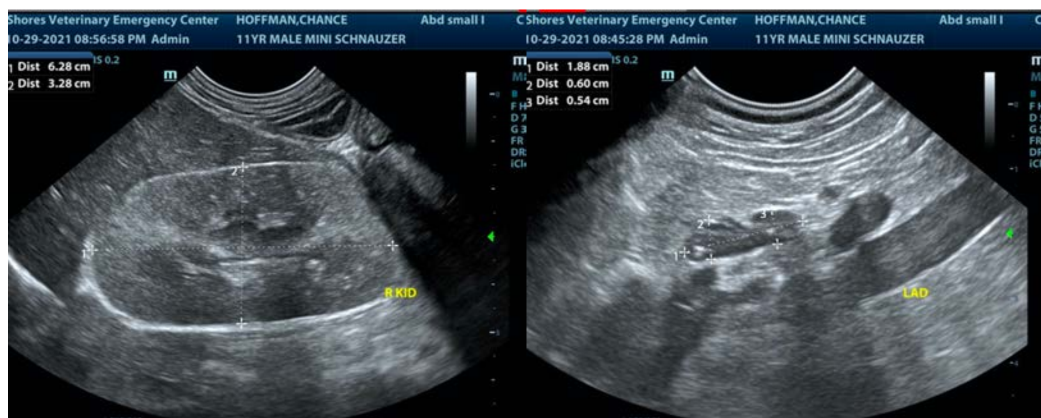

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Eric Lindquist, DMV, DABVP, Cert. IVUSS, CEO of SonoPath.com
info@SonoPath.com