



**PATIENT**

Gwendalyn Rennewanz

**SPECIES**

Canine

**BREED**

Pit Bull

**SEX**

Spayed Female

**AGE**

12 years

**WEIGHT**

70 lbs

**INTERPRETED BY**

Eric Lindquist, DMV  
DABVP, Cert. IVUSS

**IMAGING PERFORMED BY**

Dr. Reese

**HOSPITAL NAME**

Willow Run VC

**REFERRING VET**

Dr. Reese

**INVOICE**

96734

**DATE**

3/9/22

**PRESENTING CLINICAL SIGNS**

History: Several month history of decreased appetite. Recent history of PU/PD at home. Chronic elevation of liver enzymes- treated with Denamarin, supportive care. Recent weight loss (6lbs). Diagnosed with proteinuria, hypertension - currently taking enalapril 10mg, amlodipine 5mg. Abnormal PE/Chem/CBC/UA Results: ALT 364 (18-121) ALP 940 (5-160) GGT 32 (0-13) Cholesterol 725 (131-345) Lipase 399 (0-250) UPC: 5.1 (<0.5) Hypertensive - systolic blood pressure measurements consistently >180

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The pelvic urethra was imaged 2.0 cm beyond the cystourethral junction. 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 was noted. Ureteral papillae were normal.

The **kidneys** revealed normal size and structure, corticomedullary definition and ratio for this age. The cortices presented largely uniform texture with normal echogenic relationship to liver and spleen. Medullary structure differed distinctly from the cortex and no evidence of pelvic dilation was present. The capsules were acceptably uniform without significant irregularities. The right kidney measured 6.8 cm.

**Adrenal Glands**

The right adrenal gland is heterogenous and measured 1.0 cm at the cranial pole and 0.8 cm at the caudal pole. The left adrenal gland was uniform and measured 0.6 cm.

**Spleen**

The **spleen** was uniformly enlarged and folded upon itself cranially.

**Liver**

The **liver** revealed coarse architecture with heterogenous, isoechoic, nodular changes. The gallbladder and common bile duct were unremarkable.

**Gastrointestinal**

Examination of the **gastrointestinal tract** revealed a stomach and intestine free of stasis, of normal wall thickness, acceptable curvilinear mural detail, and peristaltic activity. Small and large intestine demonstrated normal luminal chyme and stool consistency respectively. No obstructive or overt infiltrative disease was noted. No associated abnormal lymphatic activity was noted.



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**Pancreas**

The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour were acceptably normal and parenchyma respected normal curvilinear patterns. No overt evidence of active inflammatory or neoplastic disease was noted.

**ULTRASONOGRAPHIC FINDINGS**

Heterogenous liver, minor splenic enlargement.

Heterogenous right adrenal gland.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Screening FNA of the spleen and liver is recommended from a screening standpoint. However, there was no obvious neoplasia. Emerging round cell neoplasia of the spleen and liver is possible. However, pronounced nodular hyperplasia is most likely with a potential for emerging cirrhosis. Bile acid profile is warranted. There is a possibility of emerging carcinoma or pheochromocytoma of the right adrenal gland. However, further imaging would be necessary as acoustic drop out was present in the images in this region. Maldigestion panel, three view chest radiographs and full CNS examination is recommended to examine for occult disease that could be responsible for the weight loss. Evaluation for competitive eating environments should also be considered.

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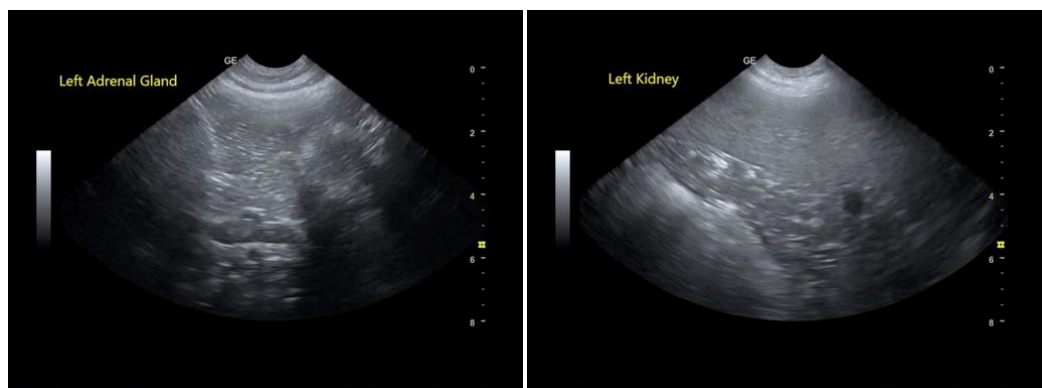
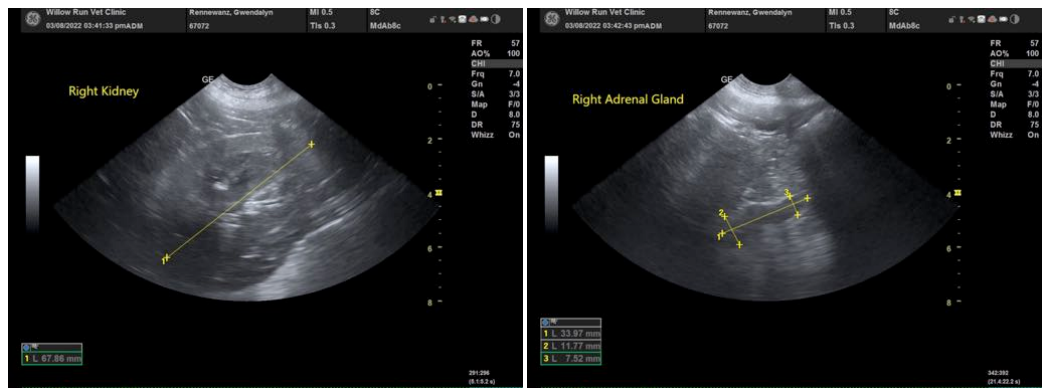
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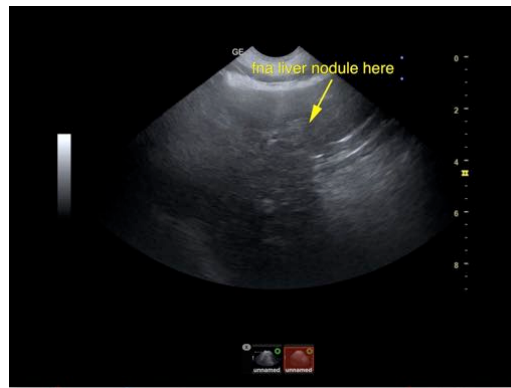
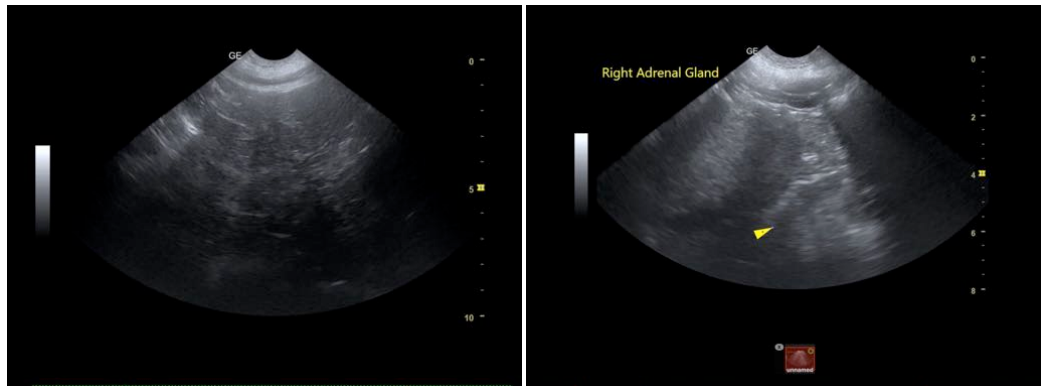
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

**IMAGING PERFORMED BY**

Dr. Reese

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

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