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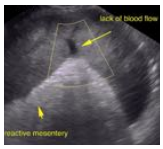
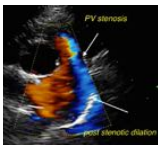
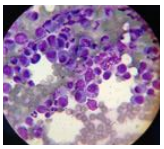
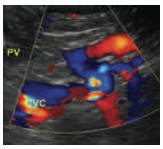

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1-800-838-4268 info@sonopath.com

PATIENT
Lulu Sabatino

SPECIES
Canine

BREED
Pug Cross

SEX
Spayed Female

AGE
11 years

WEIGHT
Not Given

INTERPRETED BY
Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY
Shari Reffi, CVT

HOSPITAL NAME
Newton VH

REFERRING VET
Dr. Wyman Greenwald

INVOICE
98123

DATE
4/7/22

PRESENTING CLINICAL SIGNS

History: Excessive urination, PU/PD. Hx of PLE. Current meds: Prednisone 20mg (tapering off), Thyro tabs 0.3mg.
Abnormal PE/Chem/CBC/UA Results: TP 4.3, ALB 2.5, AST 76, ALT 400, ALKP 3573, GGTP 12 (12 H), BUN/CREAT RATIO 38, TRIG 1080, PSL 187,WBC 29.6, PLT 807, LYMPH 4, EOS 1, ABS NEUT 26640, T4 0.5, U/A- Cloudy, USG 1.012, ph 7.5, Prot trace, Bld 3+, wbc 4-10, rbc 4-10, Coccobacilli <10

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 3.0 cm beyond the cystourethral junction. The ureters were not visible which is normal. The bladder revealed multiple calculi with suspended debris and mild apical ventral wall thickening. The largest calculus measured 1.1 cm. Grouping of calculi measured 4.0 cm. No evidence of inflammatory or neoplastic changes was noted. Ureteral papillae were normal.

The **kidneys** presented infarcts and irregular contour with mild, degenerative changes. The corticomedullary definition and the renal pelvises were normal. The left kidney measured 5.3 cm. The right kidney measured 5.6 cm. Blood flow to the kidneys appeared adequate.

Adrenal Glands

Both **adrenal glands** were normal in size, yet isoechoic to the surrounding fat. This is likely owing Prednisone suppression. The left adrenal gland measured 2.0 x 0.55 cm at the cranial pole and 0.5 cm at the caudal pole. The right adrenal gland measured 2.27 x 0.54 cm at the cranial pole and 0.56 cm at the caudal pole.

Spleen

The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes was noted.

Liver

The **liver** was uniformly swollen with minor, excessive gallbladder debris and over distension with dependent and suspended bile without evidence of overt mucocele formation. However, excessive sludge was present. The liver presented coarse architecture with mildly increased portal markings and subtle, mixed echogenic changes. This is consistent with vacuolar hepatopathy and some level of remodeling and history of inflammatory component. There was no overt suspicion of neoplasia.

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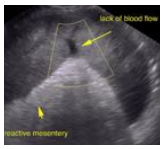
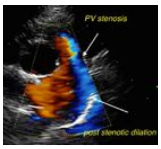
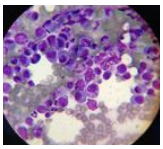
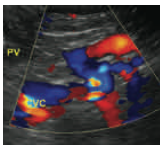

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Gastrointestinal

Examination of the **gastrointestinal tract** revealed areas of mucosal fogging in the intestinal tract with remodeled mesentery.

Pancreas

The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Some parenchymal remodeling, however, with mild deviation from curvilinear normalcy was observed. Pancreatic duct and capsular irregularities were present consistent with age related changes. If pain upon imaging (+ Murphy sign) was present or if the patient is focally painful in subxiphoid palpation then low-grade smoldering chronic pancreatitis should be suspected.

ULTRASONOGRAPHIC FINDINGS

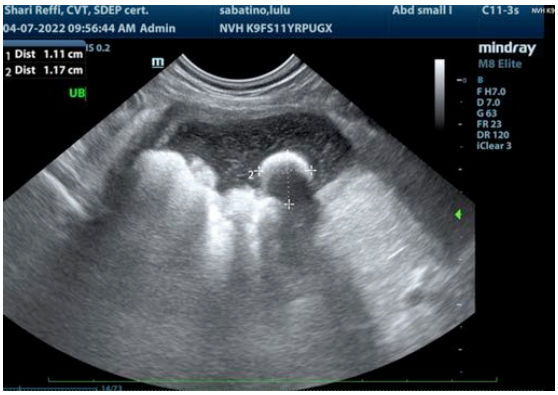
Multiple bladder calculi and chronic cystitis pattern.

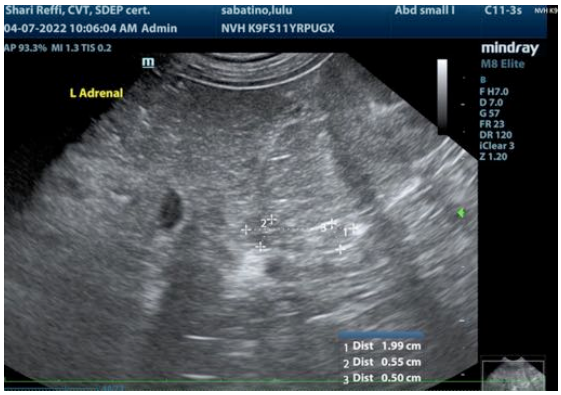
Cortical renal infarcts and mild degenerative changes.

Vacuolar hepatopathy with age related changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

I recommend a cystotomy, stone analysis and culture with 6 week antibiotic therapy based on the presentation. I recommend intestinal biopsies at the time of surgery for long term intestinal management. The areas of remodeled mesentery are good targets for intestinal biopsies. Protein losing enteropathy/lymphangectasia is suspected.





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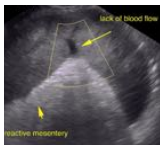
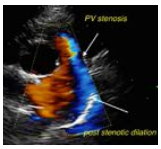
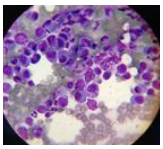
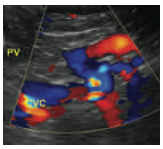

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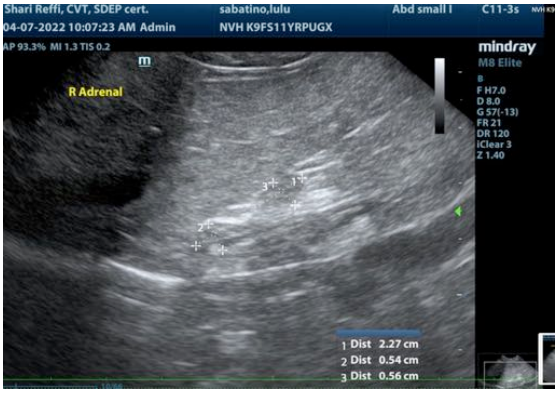

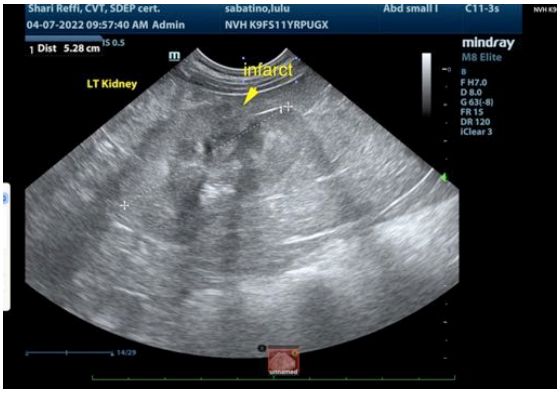

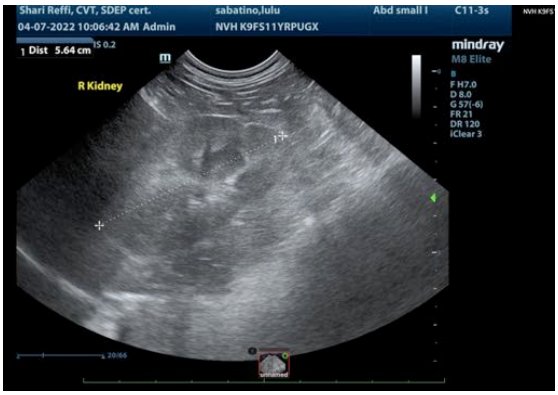

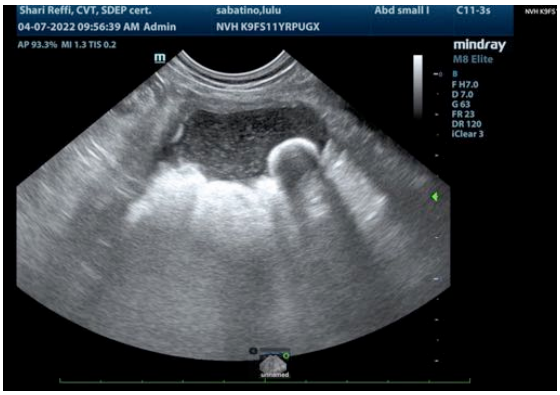

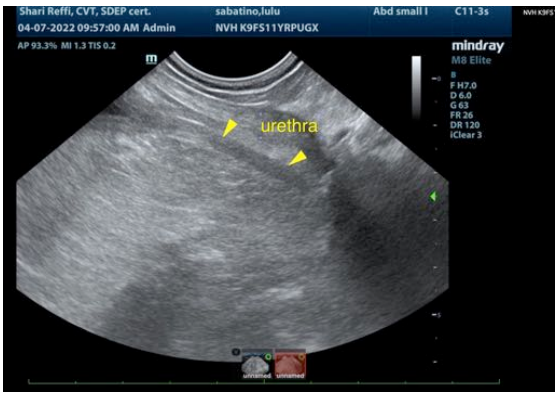

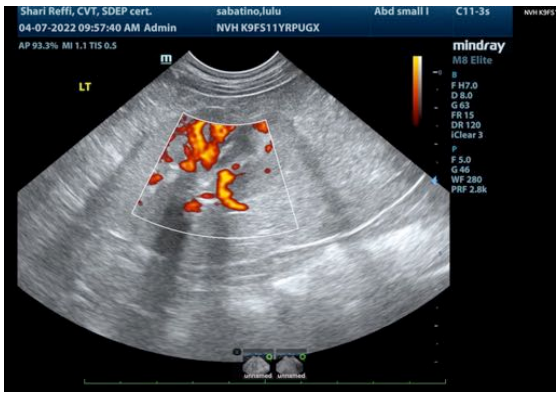

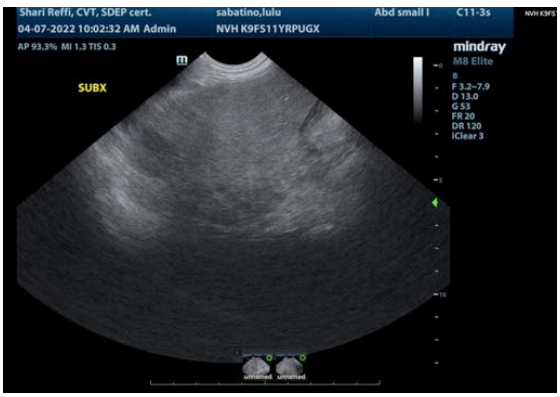

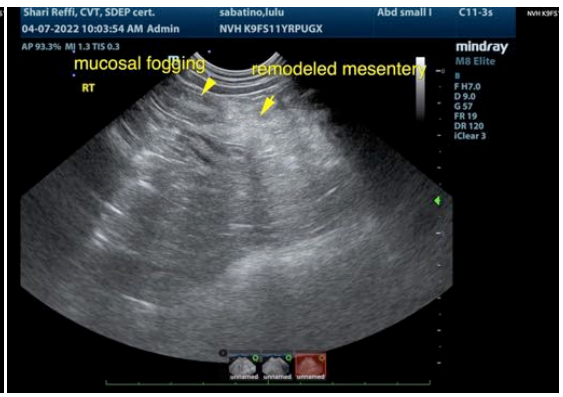

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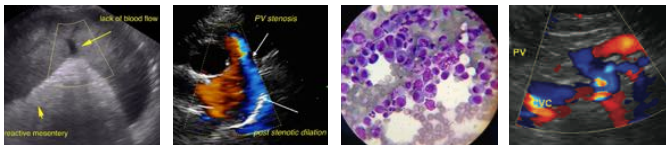

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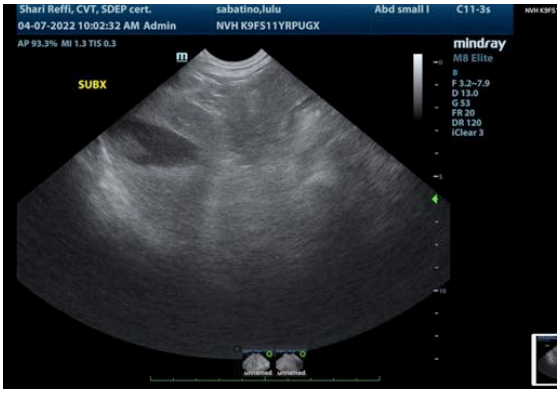

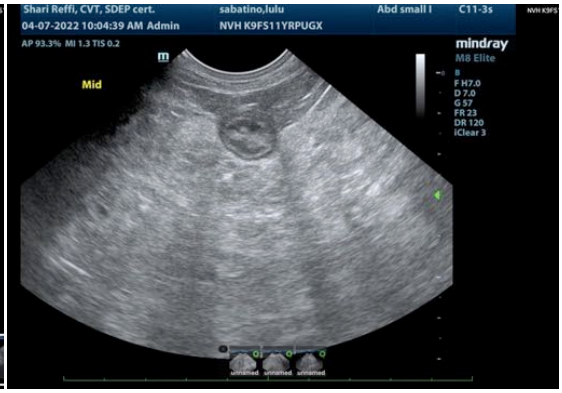

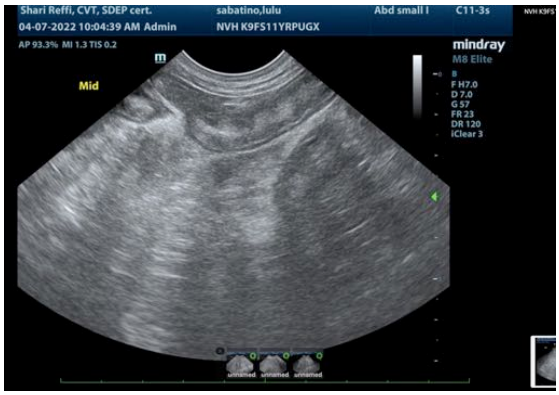

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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