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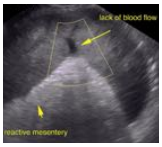

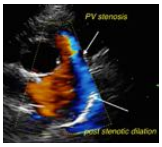

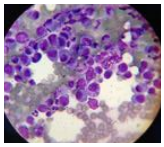
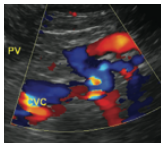

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1-800-838-4268 info@sonopath.com

PATIENT

Whiskey Glebe

SPECIES

Canine

BREED

Bichon Frise Cross

SEX

Neutered male

AGE

13 years

WEIGHT

7.5 kg

INTERPRETED BY

Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Biederbeck

HOSPITAL NAME

Lomsnes VH

REFERRING VET

Dr. Biederbeck

INVOICE

31692

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PRESENTING CLINICAL SIGNS

Barely eating for weeks, has lost 0.4kg since last week, 1.2kg in the past month. No vomiting. Had soft stools, resolved with metronidazole. Prev urinary crystals Ultrasound had been done last June due to severe chronic liver enz elevation : "Geriatric abdomen with minor renal mineralization. Hepatic remodeling with occasional hyperechoic nodular change. This is likely lipogranuloma with a minor potential for carcinoma. Mild to moderate degenerative renal changes"
Abnormal PE/Chem/CBC/UA Results: pale mm on exam, otherwise nsf Abdomen comfortable on exam and when u/s pancreas Hct dropping significantly- Hct-22.5% today, was 35.1% on June 22nd. Mild monocytosis today as well- 1.32 (0.16-1.12). PBS-no signs of regeneration PBS - anemic - very few large/hypochromatic RBCs seen. Only one NRBC seen. Couple larger RBCs with Howell-Jolly bodies. A number of smaller RBCs had many dark purple inclusions in them (artifact? diffuse Howell-jolly bodies?) >50% of the RBCs have large central Parlor, but the cell itself is otherwise normal chromic. No ghost cells seen. Autoagglutination test was completed just a drop of whole blood and NaCl - no agglutination noted. Platelets - seem slightly large in size, but normal quantity WBC - 2 basophils seen, and one toxic lymphocyte seen Chem done June 22nd: Moderate to severely Increased ALT. Severely elevated ALKP - both historically elevated for many years. ALKP improved today 1983 (23-212) prev >2000. ALT increased 785 (10-125) prev 215. ELEC: wnl

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** presented a relatively uniform thickening of the cranioventral and craniodorsal mucosae with micropolypoid mucosal changes without involvement of the submucosae. The urine presented some echogenicity consistent with suspended debris. No evidence of urethral pathology was present. This presentation is most consistent with chronic cystitis. Technically transitional cell carcinoma cannot be ruled out with=out histopathological review but is not overtly suspected based on this pattern. Cystocentesis and urine culture +/- pathological review of urine cytology would be warranted. No overt calculi were present at this time.

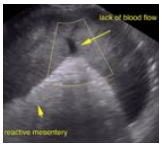
The **kidneys** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some age-related loss of curvilinear patterns regarding the capsule and C/M junction. The cortices presented largely uniform texture with some increased echogenicity expected for his age patient. Medullary structure differed distinctly from that of the cortex. Pelvic mineralization was noted along with cortical cysts.

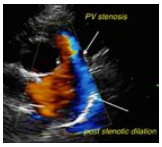
Adrenal Glands

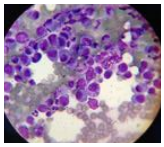
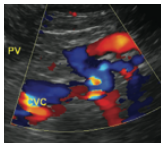
Both **adrenal glands** were visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The left adrenal gland measured 0.5 cm. The right adrenal gland measured 0.5 cm.

Spleen

The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. Occasional, hyperechoic lipogranuloma was noted. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature





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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** revealed coarse architecture with increased portal markings. The gallbladder and common bile duct were unremarkable.

Gastrointestinal

There was some residual chyme and gas was noted in the **stomach**, yet not pathological. This is consistent with end post prandial presentation. Transit of chyme into the small intestine was normal. Curvilinear patterns were maintained throughout the GI tract. No evidence of pathology. 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.

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 subxyphoid palpation then low-grade smoldering chronic pancreatitis should be suspected.

ULTRASONOGRAPHIC FINDINGS

Geriatric abdomen.

Mild to moderate degenerative renal changes.

Age related pancreatic and hepatic changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There was no evidence of pathology that would be responsible for the clinical history other than inflammatory hepatopathy. Urinary work up is warranted. CBC path review +/- bone marrow aspirate is recommended. GI blood loss is technically a potential; however, structurally appears unremarkable.

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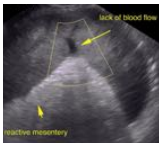
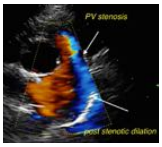
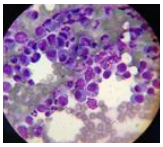
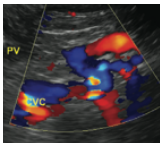

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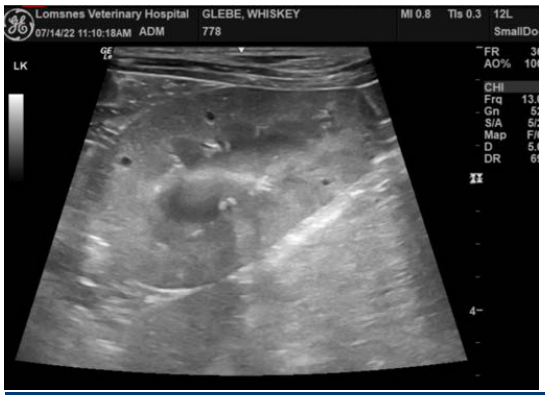

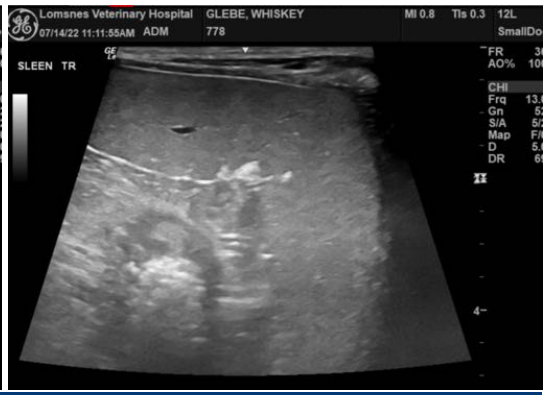

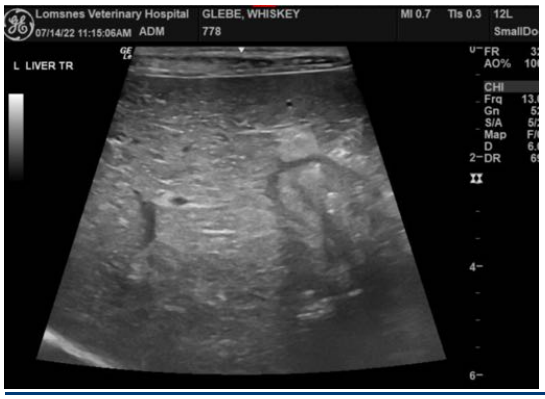

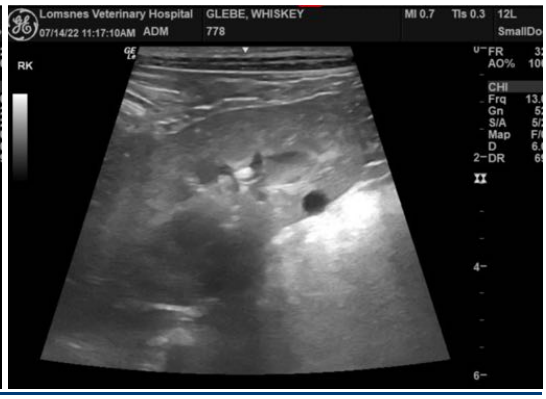

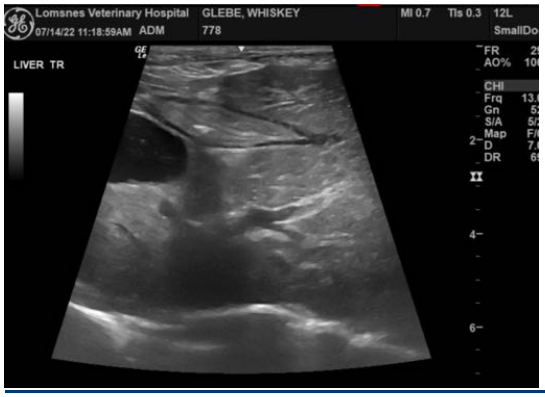

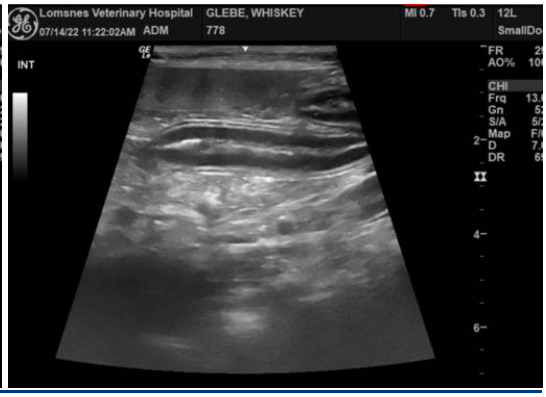

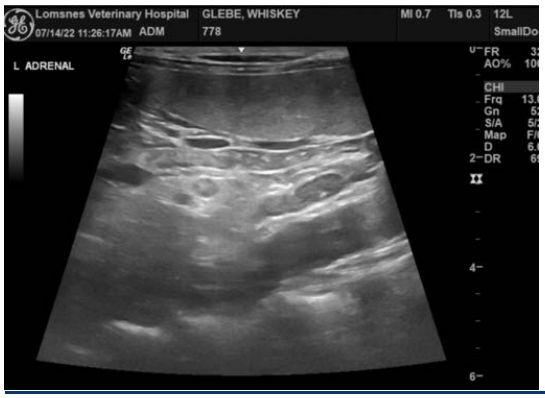

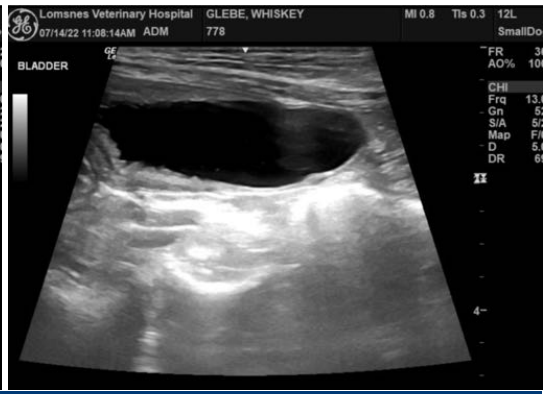

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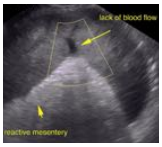

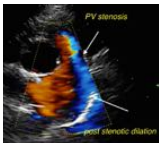

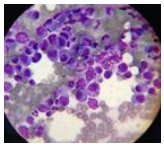
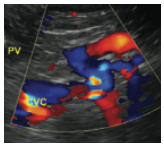

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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