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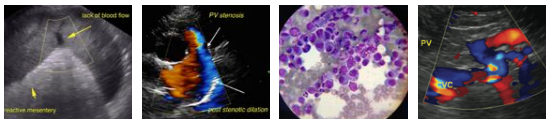

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IMAGING PERFORMED BY
dbimaginesound@gmail.com 917-64

PATIENT

Shirley Mobley

SPECIES

Canine

BREED

Pitbull

SEX

Spayed female

AGE

12 years

WEIGHT

66 lbs

INTERPRETED BY

Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Denise Bruno LVT, RDMS

HOSPITAL NAME

Ideal Pet VC

REFERRING VET

Dr. Kolta

INVOICE

32747

DATE

9/6/22

PRESENTING CLINICAL SIGNS

History: Cushing's, diabetic, hypothyroidism. Blood in urine. Calcinosis cutis. Medications: Minocycline 100mg 4 tabs Bid; L Thyroxine 0.4mg Bid, Vetsuline 13 U every 12 hours, Vetoryl 60mg Sid. Labs attached.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** presented apical ventral wall thickening. This appears resectable. The urine presented some echogenicity consistent with suspended debris. Sand was also noted and measured as a grouping 1.5 cm. The urethra, cystourethral junction and ureteral papilla were all free of evident pathology. 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. Slight pyelectasia was noted likely owing to UTI/low-grade pyelonephritis. The right kidney measured 7.26 cm. The left kidney measured 7.14 cm.

Adrenal Glands

The **adrenal glands** appeared slightly enlarged and swollen. No evidence of focal capsular expansion or invasion into the phrenic veins was noted. No overt suspicion of neoplasia was noted. This is considered likely a hyperplastic change associated with stress or adrenal endocrinopathy (PDH). If isosthenuria is persistently present and the patient morphologically suggests Cushing's disease then ACTH testing would be indicated. The right adrenal gland measured 3.6 x 1.02 cm at the cranial pole and 1.19 cm at the caudal pole. The left adrenal gland was mineralized and irregular with phrenic vein occupation and measured 3.59 x 1.33 cm at the caudal pole and 1.05 cm at the cranial pole.

Spleen

The **spleen** was largely smooth with subtle heterogeneous parenchymal changes while maintaining normal echogenic relationship to the liver and kidney. These changes are consistent with normal age-related alteration. The capsule was smooth without noticeable impingement from within the spleen or from pathology in the adjacent abdomen. The splenic vasculature demonstrated normal volume without signs of congestion or significant contraction. No evidence of active acute or chronic inflammatory, neoplastic, or infarctual changes was noted.

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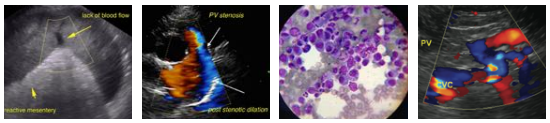

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Liver

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.

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. 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

Severe chronic cystitis pattern with sand. Mild potential for transitional cell carcinoma.

Benign hepatopathy.

Age related renal changes with slight pyelectasia.

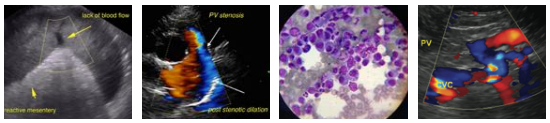
Bilateral adrenal enlargement, strongly consistent with pituitary dependent hyperadrenocorticism. Phrenic vein occupation may be thrombosis or invasive neoplasia. This should be monitored or removed.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Resection of the cranial half of the bladder is recommended. PDH with left adrenal carcinoma is a strong potential in this case versus bilateral hyperplasia and phrenic vein thrombosis. I recommend 6-8 week antibiotic therapy based on culture results is recommended. However, long term management of UTI may necessitate pulse antibiotic therapy. Predisposing issues such as recessed vulva and urine pooling should be considered. Blood pressure measurements are warranted if not already performed.

Canine Chronic UTI Protocol

I recommend **Enrofloxacin** (5-10 mg/kg SID PO) (In patients > 1 year of age) in late pm after urination to maximize urinary concentrations overnight. This assumes that culture supports this use. Repeat **culture** at 3-4 weeks and continue treatment at least 7-10 days post negative urinary sediment and negative culture. *Note: Negative culture does not necessarily mean lack of UTI.* Other favorite antibiotics for chronic UTI include third generation Cefa (Ceftiafur or similar s.i.d. injectable) or



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Clavamox. If suspicion of occult urinary incontinence is present then **phenylpropanolamine (PPA)** (1-2 mg/kg BID) can be employed long term to enhance urethral tone.

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

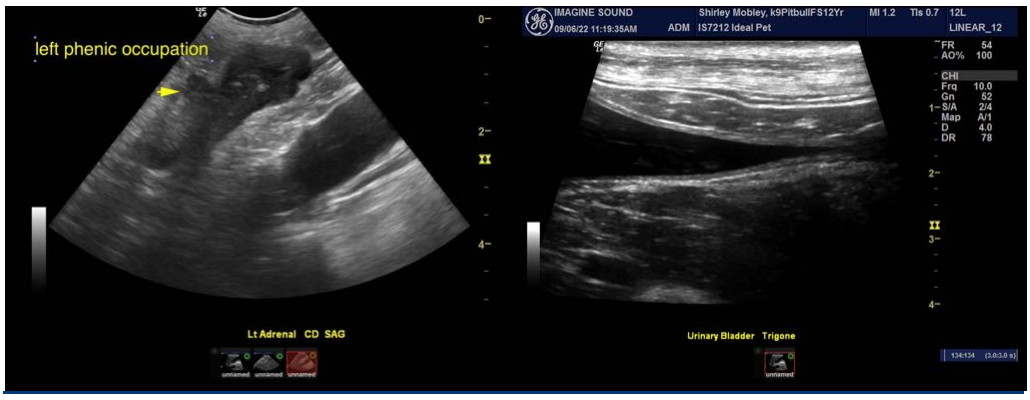
Owner compliance

Insulin quality issues

Antibodies to insulin

Underlying Neoplasia

Diffuse liver disease



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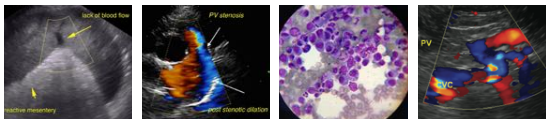

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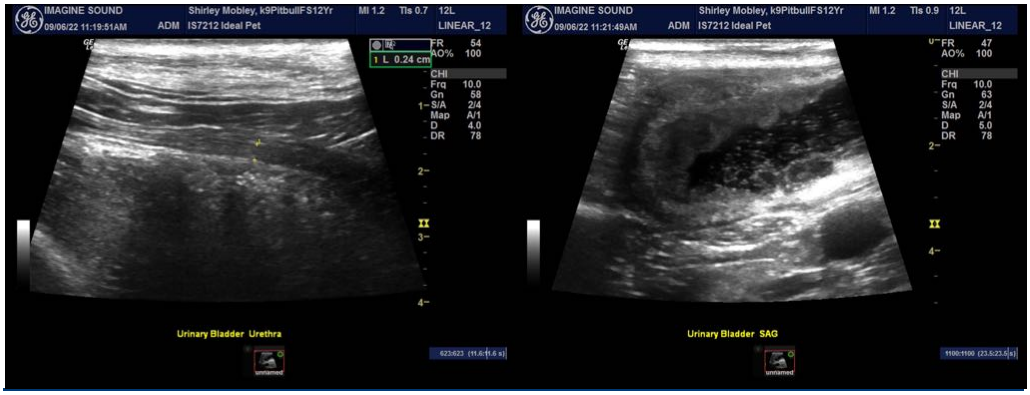

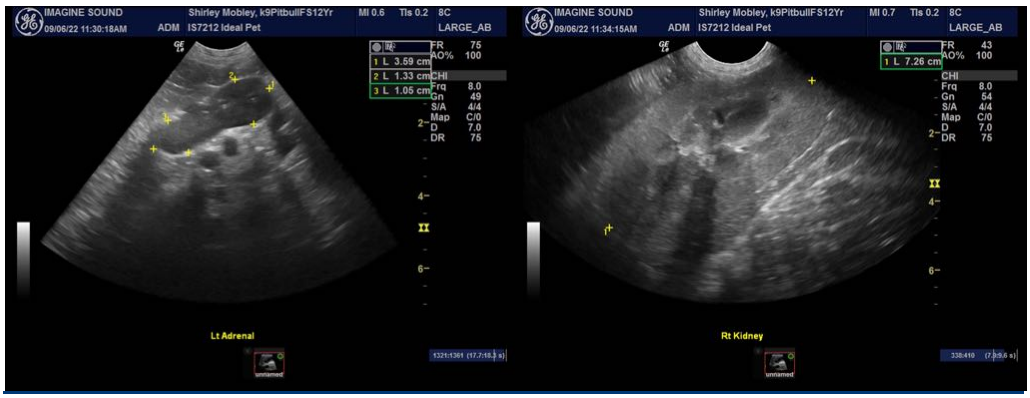

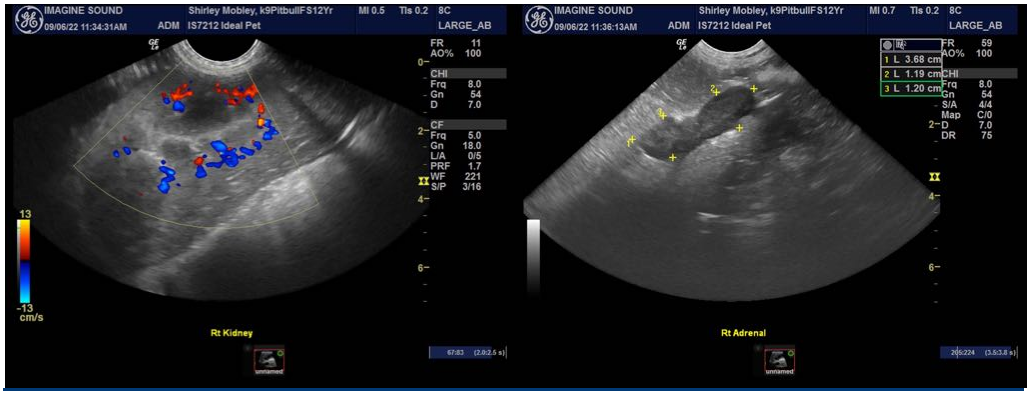

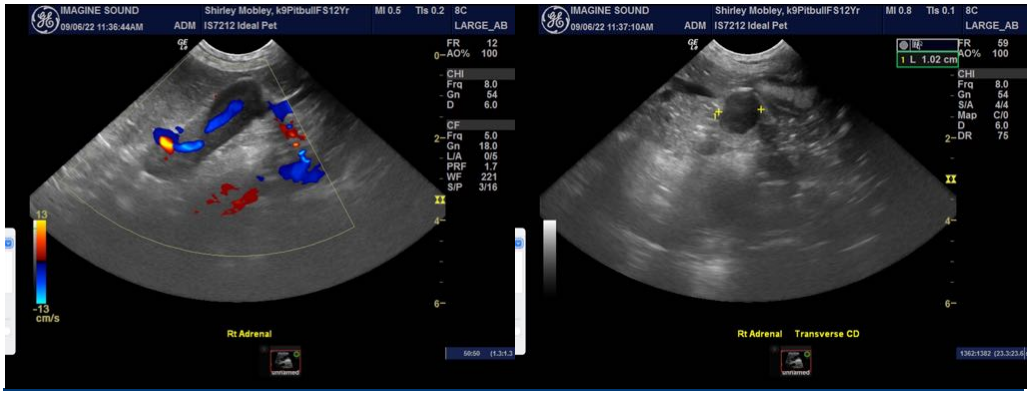

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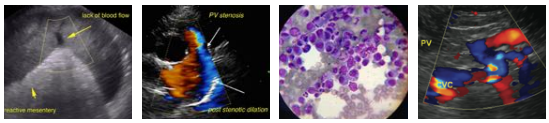

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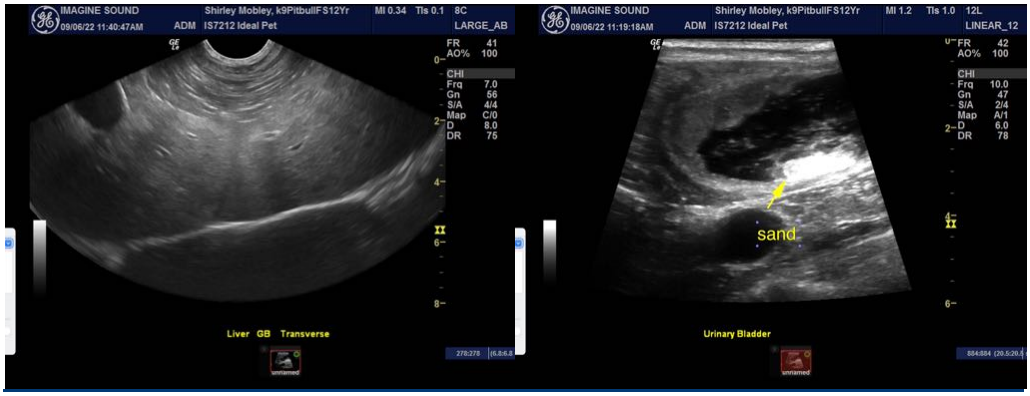

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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