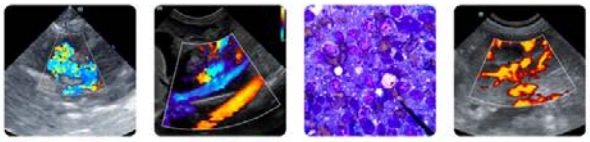

PATIENT

Lucky Gonzalez

SPECIES

Canine

BREED

Lab x

SEX

Neutered Male

AGE

10 Years

WEIGHT

67 lbs

INTERPRETED BY

Greg Kuhlman, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY

Julia Bakker, DVM

HOSPITAL NAME

Orange Blossom Veterinary Imaging

REFERRING VET

Dr. Paul

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PRESENTING CLINICAL SIGNS

Bloodwork: CBC: mild to moderate anemia, HCT 30.5 (N 37.3-61.7), normocytic, normochromic, r/o chronic dz vs slow bleed (ie spleen); elevated neutrophils 23.69 (N 2.95-11.64), elevated monocytes 2.13 (N 0.16-1.12), r/o chronic infection vs inflammation vs neoplasia. Platelets normal. Chem: BG normal, renal values normal, electrolytes normal. Moderately elevated ALP 638 (N 23-212), mildly elevated ALT 251 (N 10-125), mildly elevated GGT 15 (N 0-11), Bilirubin normal. r/o Cushings, liver dz Did not run pancreas as no vomiting, and no elevation of amylase (actually low), or lipase. Also did not run T4 as currently sick so might not be accurate, would be good idea to run in future as obese. If has Cushings, could also lower T4 level. In-house urine SG and dipstick: SG low (1.012), normal pH, 7.0, small amount of protein (+30), can be from Cushings, all else normal; negative glucose, ketones, rbc's, wbc's, bili, etc. Radiographs: chest: Abdomen: on lateral view, hepatomegaly, and spleen has "lumpy" appearance, looks more normal on VD view. A: extremely pu/pd for a few months, panting heavily, elevated ALP, distended abdomen: possible Cushings

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder contains a moderate amount of suspended echogenic debris. Diffusely, the urinary bladder wall is mildly thickened at 4.4 mm in width.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. The left kidney measured 6.9 cm. Non-obstructive linear multifocal hyperechoic diverticular foci with acoustic shadowing are noted in the right kidney. The right kidney measured 7.4 cm.

Adrenal Glands

The right adrenal gland is not seen.

The caudal pole of the left adrenal gland appears mildly enlarged at 10.1 mm. The cranial pole is normal at 6.3 mm.

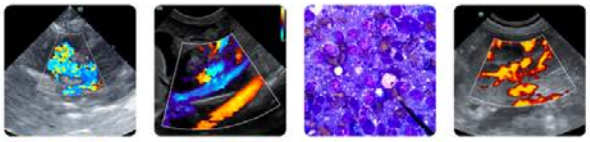
Spleen

The spleen has several isoechoic ill-defined lesions present throughout that are not capsule displacing. Two of these lesions are measured and found to be 8.3 mm in diameter and 12.8 mm in diameter. The spleen otherwise appears normal with normal blood flow.

Liver

Liver is subjectively enlarged (swollen contour) without disruption of architecture. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen and falciform fat. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

The gallbladder contains a moderate amount of aggregating hyperechoic debris, some of which is adhered to the luminal margin. The gallbladder does not appear obstructed at this time. No free fluid surrounding the gallbladder.



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Gastrointestinal

The stomach and intestines have normal wall layering and thickness. Colon contains normal contents with normal wall thickness.

Pancreas

The visible pancreas is normal in size with normal echogenic parenchyma and surrounded by normal peri-pancreatic mesentery.

Free Abdomen

There are no enlarged abdominal lymph nodes seen on this exam. No free abdominal fluid is seen.

ULTRASONOGRAPHIC FINDINGS

- Urinary bladder debris.
- Age related renal changes.
- Mildly enlarged caudal pole left adrenal gland.
- Ill-defined splenic lesions.
- Hyperechoic hepatomegaly.
- Gallbladder debris.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The splenic lesions are likely benign extramedullary hematopoiesis, unlikely to be neoplasia. However, recommend fine needle aspirate to rule out neoplastic cause.

The gallbladder findings may be clinically incidental. However, given the appearance of the debris it is possibly concerning for disease such as bacterial cholangitis. Recommend bile aspirate for aerobic and anaerobic culture and a cytology. If owners not to pursue this procedure, treat with Ursodiol and an antibiotic such as Amoxicillin for 4-6 weeks, and then recheck the appearance of the gallbladder via ultrasound.

If no cause is identified for patient's dilute urine such as hyperadrenocorticism, consider possible primary renal disease as cause. Recommend rechecking urine specific gravity first thing in the morning several times. If patient has dilute urine consistently after not drinking overnight, then consider full staging, monitoring and managing per IRIS guidelines to determine if chronic kidney disease may be present.

The urinary bladder changes may be indicative of a urinary tract infection. Recommend urinalysis if not already performed and submission of urine culture if active urine sediment is present.

The appearance of the liver is most likely due to benign vacuolar hepatopathy caused by secondary disease, not primary hepatic disease. As discussed, screen for hyperadrenocorticism. If ruled out, then consider screening for other diseases such as Leptospirosis if the patient is not vaccinated for this disease. Also recommend screening for hypertriglyceridemia, hypothyroidism, and occult pancreatic or occult GI disease.

No obvious cause for the patient's anemia seen on this exam. Given the degree of anemia and that it is normochromic and normocytic, suspect anemia of chronic inflammation. Consider more global workup of the patient ot possibly identify a cause of chronic inflammation.

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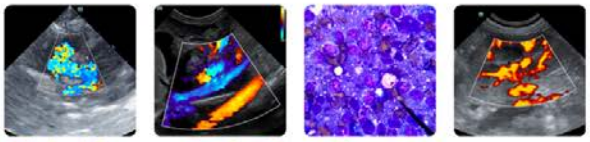

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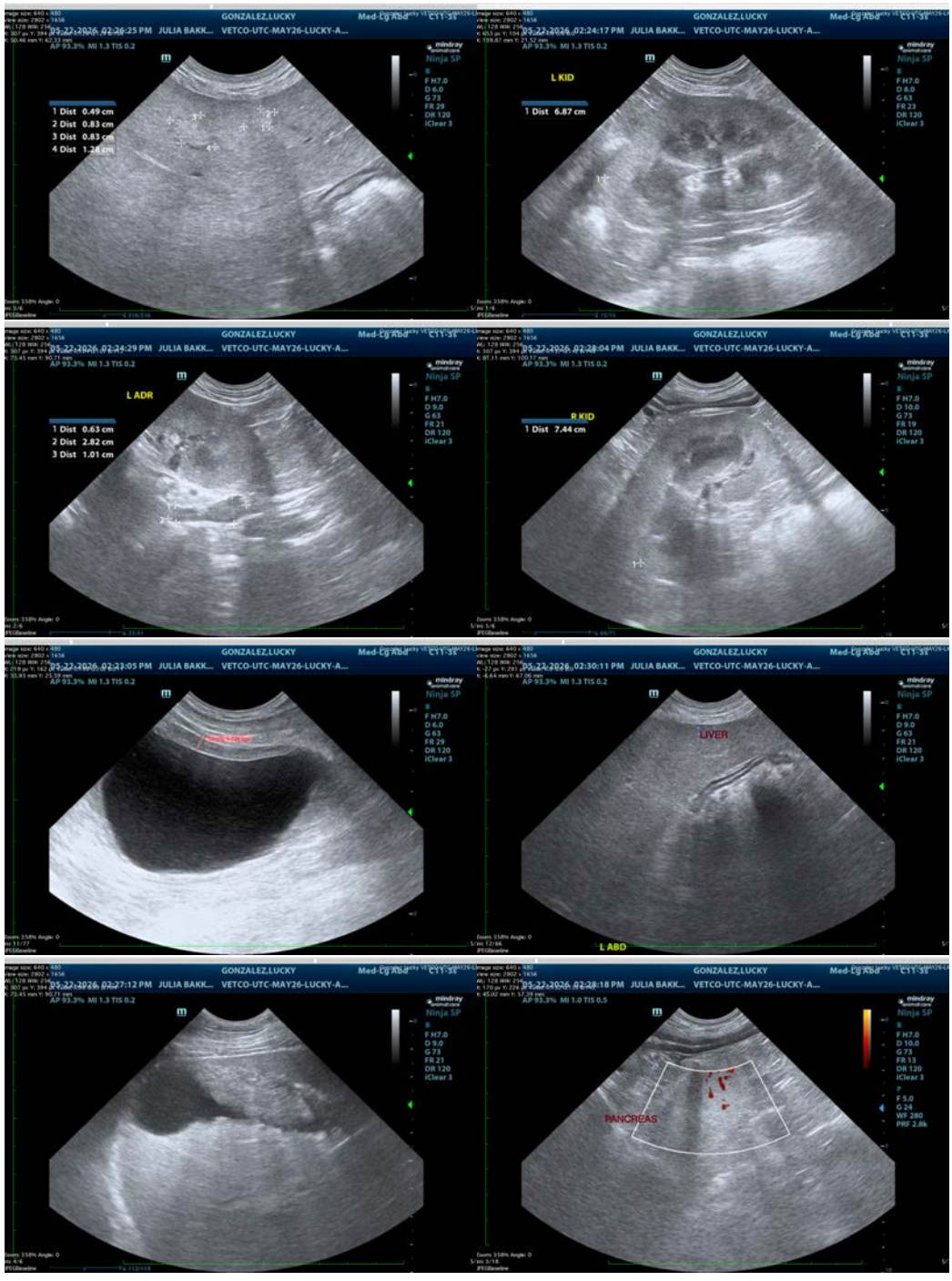

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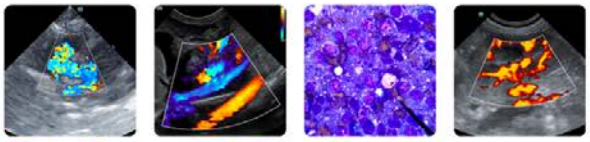

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Greg Kuhlman, DVM, DACVIM (SAIM)

Veterinary Internal Medicine Specialist
info@SonoPath.com