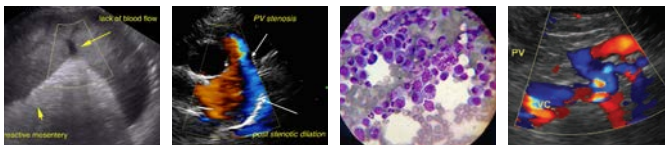
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Molly Imbriani

SPECIES
Canine

BREED
Poodle X

SEX
Spayed Female

AGE
13 Years

WEIGHT
10 kg

INTERPRETED BY
Jessica Midence, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY
Dr. Van Nieuwal

HOSPITAL NAME
Animal Emergency Hospital Deland

REFERRING VET
Dr. Van Nieuwal

INVOICE
45049

DATE
2/10/23

PRESENTING CLINICAL SIGNS

Came in this AM for having collapsed, known diabetic. 10 units SQ BID. Known heart disease and pulmonary hypertension. Owners gave insulin 7AM, collapsed shortly after insulin given. BG on presentation 166 mg/dL.

Abnormal PE/Chem/CBC/UA Results: CPLi: strong positive UA: mild UTI Slight BUN elevation, lipase >1000 (1244 with 10x dilution), ALP 224

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder mucosa, trigone, and visible urethra are normal in thickness and there is no evidence of mucosal irregularities. The bladder lumen is distended with a large volume anechoic urine and bladder thickness is considered normal for volume of urine. No masses, inflammatory changes or calculi are observed.

The left kidney is normal in size and shape with slightly irregular contour, consistent with a prior infarct. The kidney measures 5.5 cm. There is normal corticomedullary distinction and the cortex is hyperechoic with pinpoint hyperechoic speckling and subtle hyperechoic striations that are typical of diabetic animals (this is considered clinically insignificant). There is 3.0 mm of pyelectasia with a suspected m mildly dilated proximal ureter that tapers quickly.

The right kidney is normal in size, shape and architecture with smooth peripheral margins and measures 5.3 cm. There is normal corticomedullary distinction and the cortex is hyperechoic with pinpoint hyperechoic speckling and subtle hyperechoic striations that are normal with diabetic animals (this is considered clinically insignificant). There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is mildly enlarged for this size of a dog, with the caudal pole measuring 0.68 cm and the cranial pole measuring 0.47 cm. The left adrenal gland has normal shape and it is normal in appearance and echogenicity.

The right adrenal gland is normal in size (0.50 cm). The right adrenal gland has normal shape and it is normal in appearance and echogenicity.

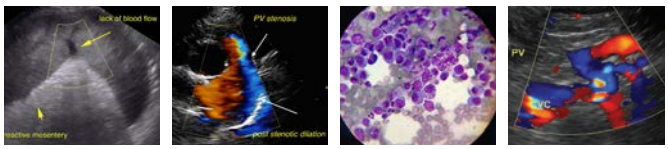
Spleen

The splenic echotexture is homogeneous with parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule is smooth with no irregularities. There are hyperechoic speckles, considered benign. The splenic vasculature is normal without signs of congestion or thrombosis.

Liver

The liver is subjectively enlarged with rounded borders and is hyperechoic, which is consistent with the reported diabetes. The visible portions of the vasculature and biliary tract appear normal. No pathological hepatic lymphadenopathy observed.

The gallbladder lumen is distended. The wall is a normal thickness and smooth. A moderate amount of dependent debris is noted that has a centrally hyperechoic aggregate that casts a scant shadow. A small amount of cystic mucinous hyperplasia was present. The cystic and common bile ducts are normal/not visible. No signs of inflammation.



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Gastrointestinal

The gastric lumen is empty. The stomach wall is of normal wall thickness with some variability due to rugal folds. There is normal gastric wall layering. There are no masses or focal lesions observed and the pyloric outflow tract appears patent.

The visualized areas of duodenum, jejunum and ileum appear normal in thickness. The duodenum measures normal with distinct wall layering. The remainder of the small intestines also measures normal with normal wall layering. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material. No focal lesions observed.

Sections of colon are visualized with formed fecal material and gas shadowing distally. The colon measures normal. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The pancreas measures normal, but the left pancreas is mildly hypoechoic, consistent with mild pancreatitis. There is also a small pancreatic nodule measuring 0.50 cm x 0.60 cm. This nodule is isoechoic to the rest of the pancreas, though there is a distinct hyperechoic border surrounding.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The omentum is of normal uniform echogenicity.

PRIMARY FINDINGS

- Mild pancreatitis of the left pancreas
- Gallbladder sludge with central aggregate of mineralization
- Left renal pyelectasia and suspected dilated proximal ureter – consistent with pyelonephritis, intravenous fluid therapy, or polydipsia, as would be expected with diabetes.

SECONDARY FINDINGS

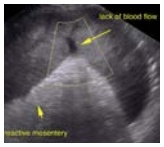
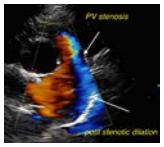
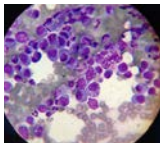
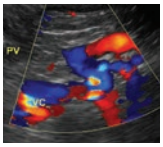
- Changes to both kidneys – consistent with diabetes.
- Left-sided adrenomegaly – could be consistent with chronic physiologic stress or adrenal hyperplasia (e.g., emerging hyperadrenocorticism).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes to the left pancreas are subtle, but the mildly hypoechoic changes support pancreatitis. There is also a pancreatic nodule that is likely benign hyperplastic change. The left kidney does have pyelectasia with a proximal dilated ureter. This is consistent with pyelonephritis, particularly given the reported urinary tract infection and BUN increase, though there were no other signs of renal inflammation, and this could also be consistent with polydipsia expected in a diabetic, or intravenous fluid therapy if that applies to this patient.

The left adrenomegaly is likely incidental to the presenting complaint of this patient, though if there is adrenal hyperfunction, that could predispose to thromboembolic disease as the cause of collapse. This can be evaluated further in the future if the patient develops overt symptoms of hyperadrenocorticism or the diabetes becomes difficult to control.

The gallbladder sludge is aggregated and quite hyperechoic. Consider Ursodiol therapy. If the patient fails to respond to supportive care, further investigation of the gallbladder changes could be considered,

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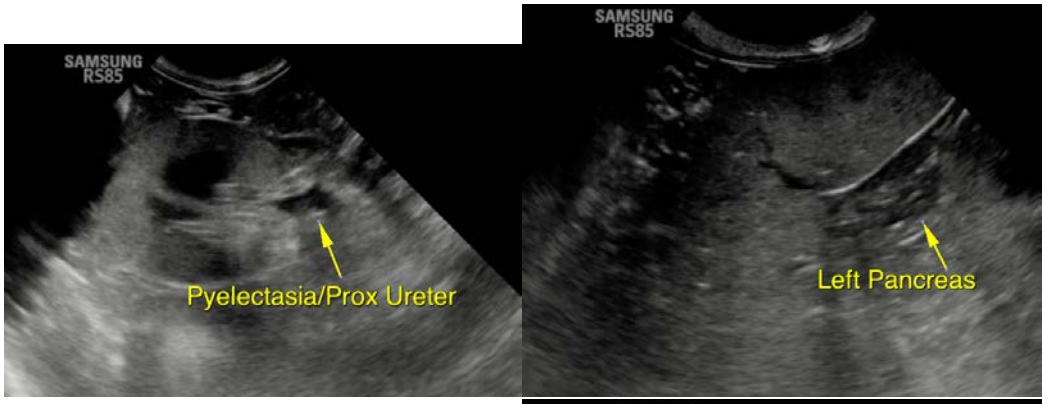
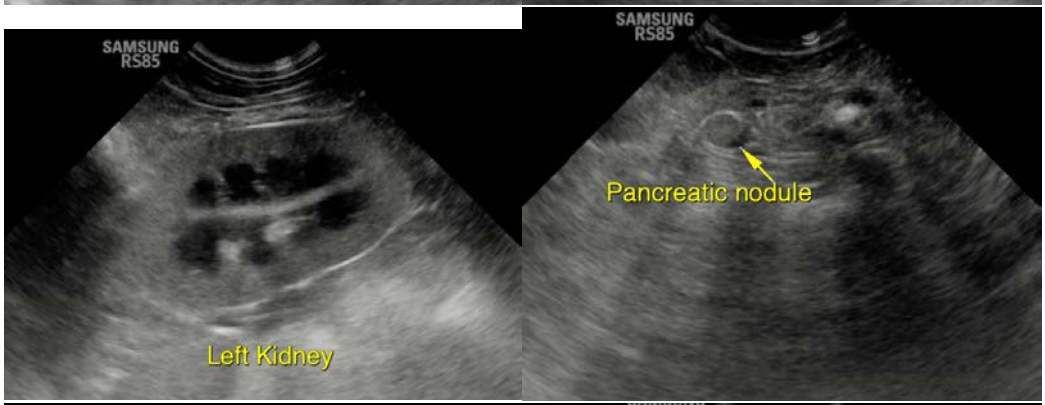
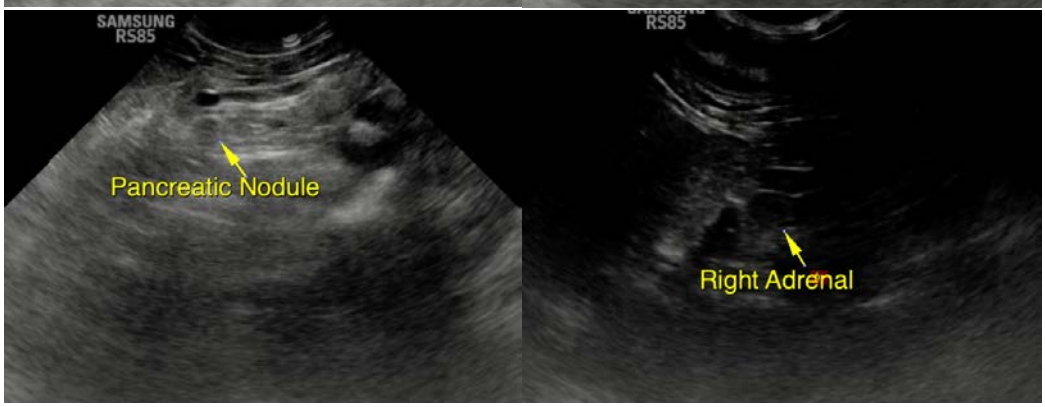
such as a cholecystocentesis for cytology and culture. Continue to treat for urinary tract infections, supportive care for the diabetes and pancreatitis. Also consideration should be given to the pulmonary hypertension as the cause for collapse, as well as hypoglycemia prior to presentation with a rebound normoglycemia at presentation.







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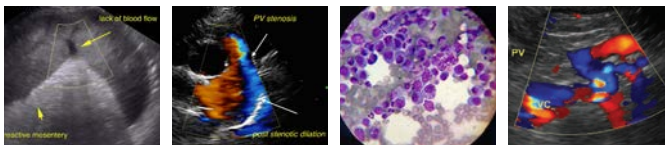

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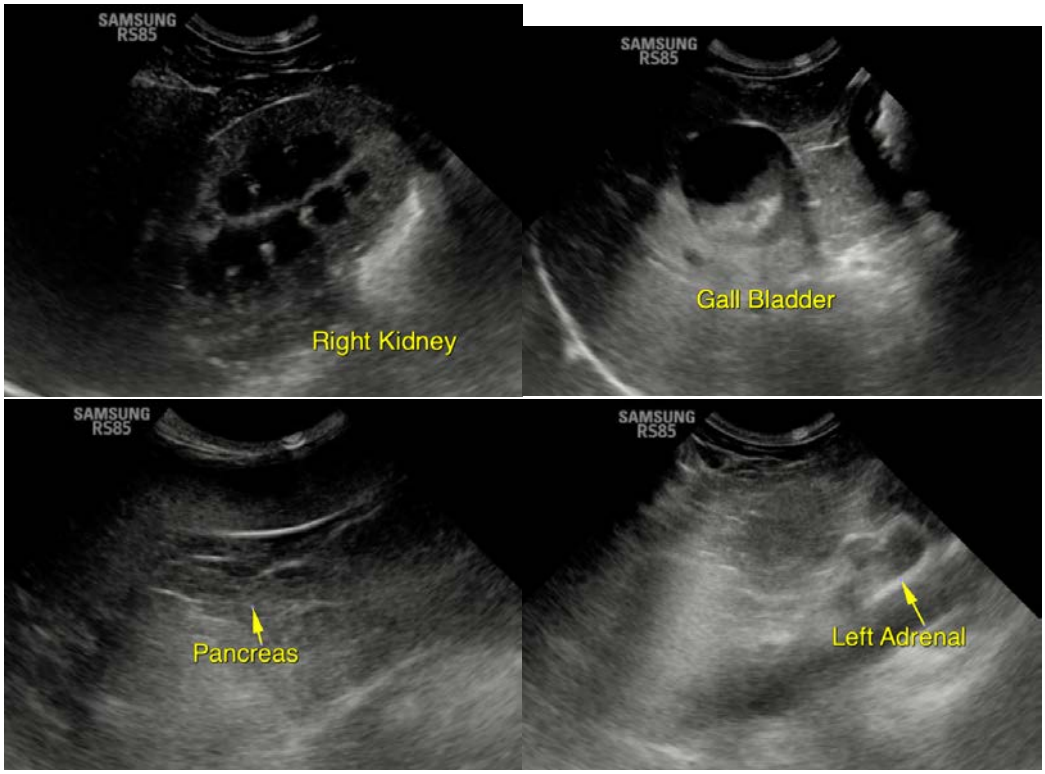

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Jessica Midence, DVM, DACVIM (SAIM)

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