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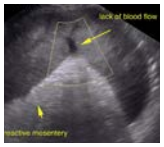
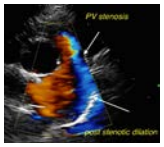
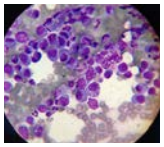
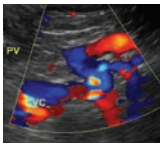
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

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

PATIENT

Joaquim Goncalves

SPECIES

Canine

BREED

Yorkie

SEX

Neutered Male

AGE

10 Years

WEIGHT

Not Provided

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Jessica Miller

HOSPITAL NAME

All Creatures Great & Small

REFERRING VET

Dr. Mitrovic

INVOICE

38672

DATE

6/14/22

PRESENTING CLINICAL SIGNS

Came for FHO sx, routine blood work showed ALK 3000, next day check ACTH 2hrs post 1 tab 22.7
Current meds: Gabapentin + tramadol
Abnormal PE/Chem/CBC/UA Results: AML 3064, GTP 17, Cortisol levels 2 hours pot 22.7

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, or masses. In the dependent portion of the urinary bladder, there are numerous hyperechoic shadowing mineralizations. Three such mineralizations are 0.68, 0.52, and 0.51 cm. Correlate these findings with abdominal radiographs. Findings are most consistent with cystic calculi.

The prostate is normal in size (0.61 cm) and shape for this neutered male dog. The parenchyma is homogenous and the external margins are smooth. The prostatic urethra appears normal with no evidence of irregularity, invasion, mass effect or calculi.

The left kidney has a normal shape and size (5.07 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.67 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal/borderline enlarged in size measuring 0.88 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

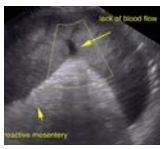
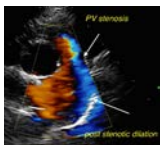
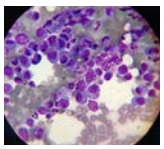
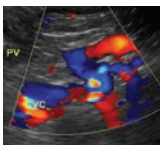
The right adrenal gland is normal/borderline plump in size measuring 0.60 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size, echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. There is a hyperechoic nodule visualized measuring 0.61 cm. This lesion is most consistent with a benign myelolipoma.

Liver

The liver is large in size, and normal in echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. There are numerous ill-defined, hyperechoic lesions within the parenchyma. Two such lesions measure at 0.93 cm and 0.97 cm.

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The gall bladder lumen is moderately distended. The wall of the gall bladder has irregular polypoid projections and there is a large amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.7cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. The duodenum measured as normal (between 0.3-0.5cm in wall thickness) and the jejunum measured as normal (between 0.2-0.47cm.) Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The pancreas is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

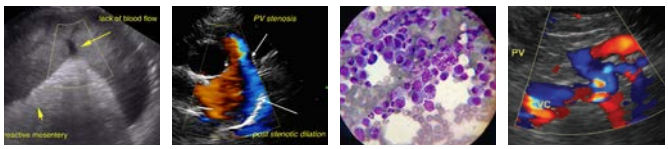
PRIMARY FINDINGS

- Borderline bilateral adrenomegaly – The bilateral adrenomegaly could be consistent with bilateral hyperplasia (e.g., secondary to pituitary-dependent hyperadrenocorticism), bilateral infiltrative neoplasia, inflammatory adrenal disease, other. Correlation with clinical findings is recommended.

- Numerous shadowing foci in the dependent portion of the urinary bladder – most consistent with numerous cystic calculi. Correlate with abdominal radiographs. Recommend urinalysis and culture.

- Large, heterogeneous liver with hyperechoic lesions – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy. The hyperechoic areas described are most consistent with benign lesions, although continued monitoring is warranted.

- Distended gallbladder with debris and gallbladder polyps – The gallbladder polyps and debris present could be consistent with an early mucocele, cholestasis or chronic inflammation.



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SECONDARY FINDINGS

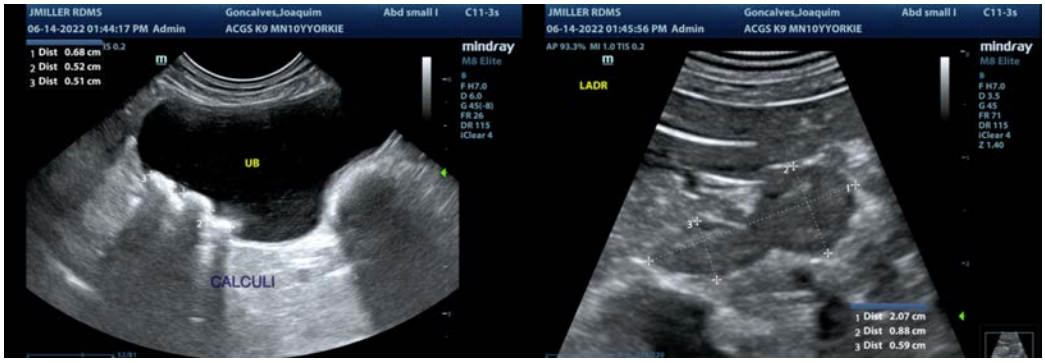
- Hyperechoic nodule visualized in the spleen – most consistent with a benign myelolipoma.

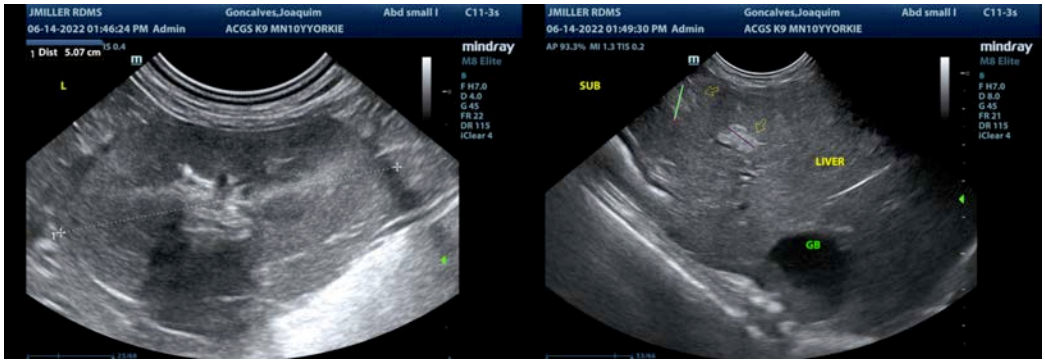
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The adrenal glands are slightly irregular, and both appear "plump". If clinical signs of Cushing's are present, treatment could be considered based on clinical judgement, or additional adrenal function testing could be considered.

No focal lesions are visualized in the liver, and the appearance could be consistent with a vacuolar/steroid hepatopathy, although the gallbladder polyps are fairly well defined. Based on the significant ALP elevation and the appearance of the gallbladder, I would consider starting Ursodiol and consider treatment for cholecystitis with continued monitoring of the gallbladder for possible development into a surgical lesion (does not appear surgical at this time).

There are numerous calculi within the urinary bladder. Correlate the size and number of stones present with abdominal radiographs. Recommend urinalysis and culture. If there is no infection evident, these are likely not struvite stones, and a cystotomy should be considered.





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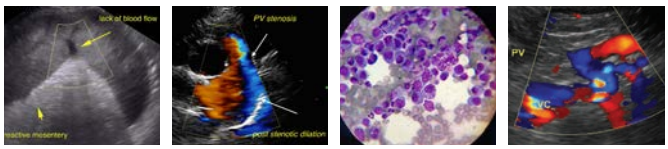

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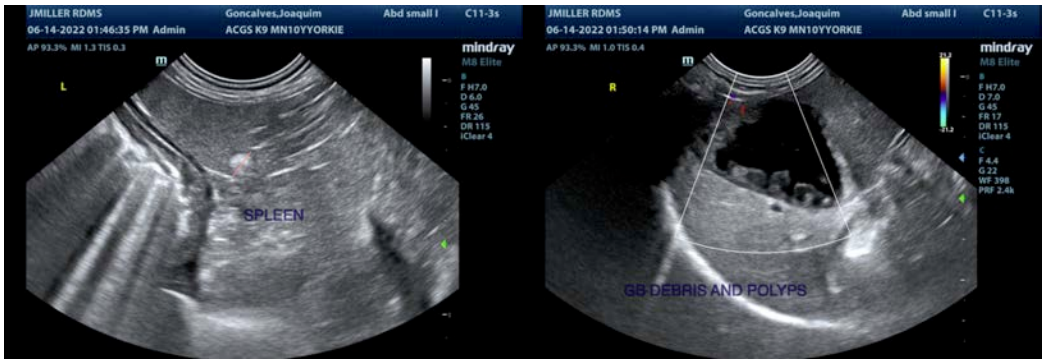

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)

kathleen.sennello@sonopath.com