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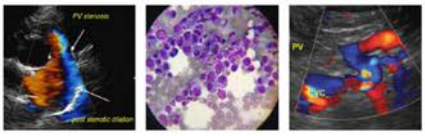

SonoPath
Clinical Sonography & Telecytology
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PATIENT

Lola Harper

SPECIES

Canine

BREED

Golden Retriever

SEX

Spayed Female

AGE

4 Years

WEIGHT

45 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Amy Mayhew, LVT

HOSPITAL NAME

SVS Imaging MI

REFERRING VET

Family Pet Practice

INVOICE

39571

DATE

7/15/22

PRESENTING CLINICAL SIGNS

weight loss chronic issue-weight has fluctuated over the last year. no vomiting/diarrhea. doesn't always finish food-prefers canned over dry. has been separating other pet during feeding. urine/BM normal. rec CHP to check where liver values are. discussed maldigestion profile. repeat AUS. also discussed RC HP diet as previously discussed to rule out allergy component. explained would need 12 hr fast for maldigestion profile. em Last AUS done IH 7/20/21 - BW has shown elevated liver values off/onsince. Abnormal PE/Chem/CBC/UA Results: Abnormal Examination Findings: Presented for decreased appetite and wt loss. P had similar episodes last summer (July 2021) and again Dec 2021. At that time, was dx and treated for hepatitis and wt had maintained. Unclear if wt was put back on after last visit in December or if P has been slowly losing more since then. BAR- jumping on you in the room, playful, active. Per O, still active at home, goes swimming in pool regularly, plays with kids/other dog. Poss pyrexia. Temp is generally high end of normal while here. 5. minimal tartar 7. panting during exam. O did note more panting yesterday/today. 8. mildly coarse coat, but overall not pruritic (last year was more suspicious of pruritus/allergies). 9. tense on ab palpation, intestines feel possibly thickened. Fine on bladder palpation. P did vomit up food last week when O gave her a high protein Purina canned food. No vomiting since. 13. thin- can see ribs. lowest weight we have for P (down 7lbs from 7mo ago). Some muscle mass still present. Discussed diet- prefers to eat canned food over kibble, but O has not increased canned food offered. Reviewed based on current diet, if canned only, would feed 2-2.5cans/day, but canned alone could cause D+. Unclear how much kibble P actually eats. Per O, P is very interested in their food. O approves IH BW to start: CBC- leukocytosis with neutrophilia, confirmed with blood smear Chem- hyperglobulins, ALT (315), AST (131), ALP (620), GGT (16). Normal Tbili UA- occ rbc/wbc *no glucose noted (results were imported incorrectly), new- numerous bilirubin crystals Expressed concern that liver values are elevated again (worse than prev) and now poss infection/severe inflammation. Concern for primary hepatic disease (infectious hepatitis?, lepto?), poss cholangiohepatitis or cholecystitis. Have prev discussed potential inflammatory disease as P has always improved with steroid therapy- rule out food allergy/sensitivity, maldigestion disorders, EPI? Reviewed potential zoonotic risk with some infections and strongly rec further testing. Can not rule out toxin, fb ingestion. Suspect P is feeling more painful despite her regular play/exercise. -rec imaging, lepto titers, fasted maldigestion panel -discussed abx therapy- o cautious with this due to P having vomiting with amoxi when attempted last year. Plan to start with further dx and will monitor temp when here tomorrow with poss sedation. **Please see attached labs and previous AUS report from last year.

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. There is a moderate amount of echogenic debris in the dependent portion of the urinary bladder. Some of this debris is hyperechoic and shadowing, most consistent with mineralized sandy debris.

The left kidney has a normal shape and size (7.01 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 (7.09 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.

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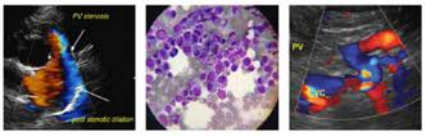

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Adrenal Glands

The left adrenal gland is normal in size measuring 0.46 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 in size measuring 0.81 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. No focal parenchymal abnormalities are visualized.

Liver

The liver is large, hypoechoic and irregular. The visible portions of the vasculature and biliary tract appear normal. The liver is very irregular and consists of numerous coalescing nodules that disrupt the hepatic margins.

The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are primarily anechoic. 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. Duodenum wall measured 0.55 cm. Jejunum wall measured 0.42 cm. 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.

ULTRASONOGRAPHIC FINDINGS

- Echogenic sandy debris within the urinary bladder – correlate findings with abdominal radiographs and recommend urinalysis and culture.

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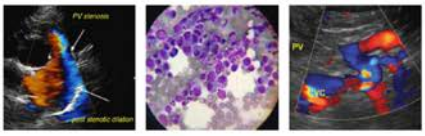

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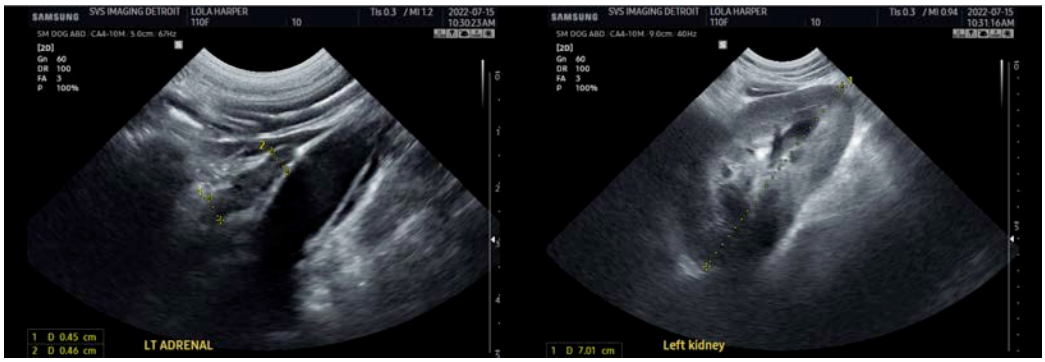
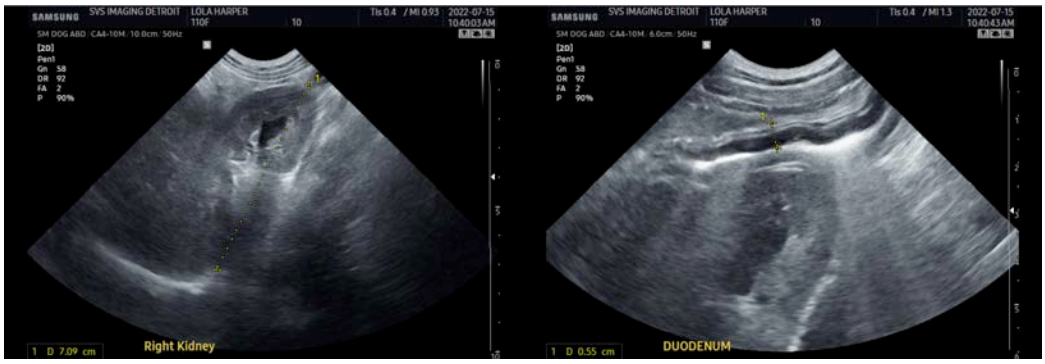
- Large, irregular, diffusely nodular liver – These lesions could be a cluster of benign regenerative nodules, or a diffuse neoplastic process.

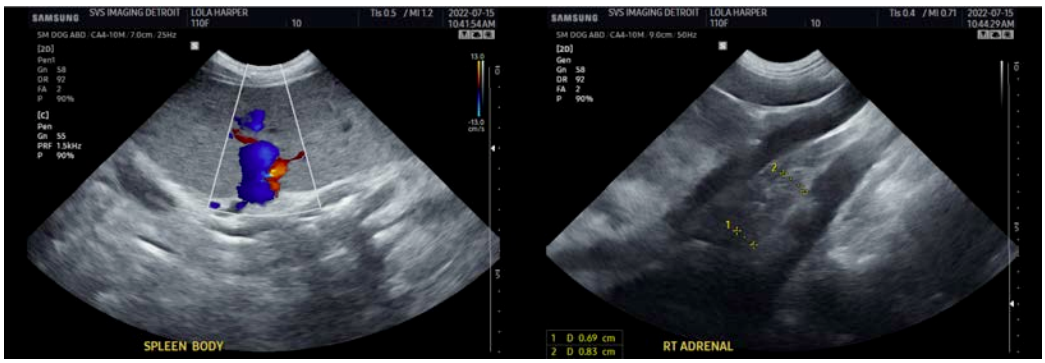
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Per the history, this patient has a chronic history of liver issues. Based on that information, it is possible that the diffuse nodules visualized in the liver are regenerative nodules. Based on the age of this patient and the chronicity, it is possible to have a chronic inflammatory hepatitis that eventually proceeds to cirrhosis and regenerative nodules. This type of diagnosis would require a biopsy. Strongly recommend a surgical biopsy of the liver with histopathology, copper levels, aerobic and anaerobic cultures, as well as a liver function test and evaluation of coagulation parameters. There is concern that this liver process could proceed to liver failure.

Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.







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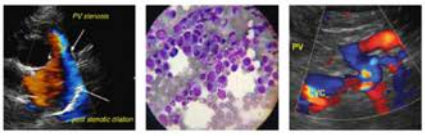

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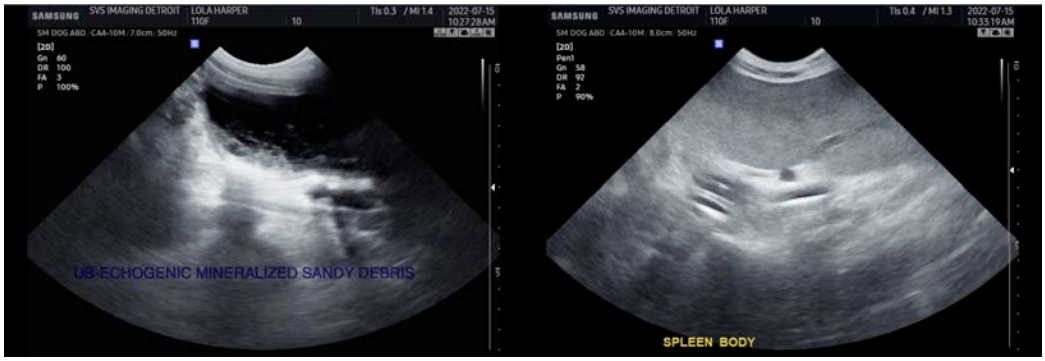

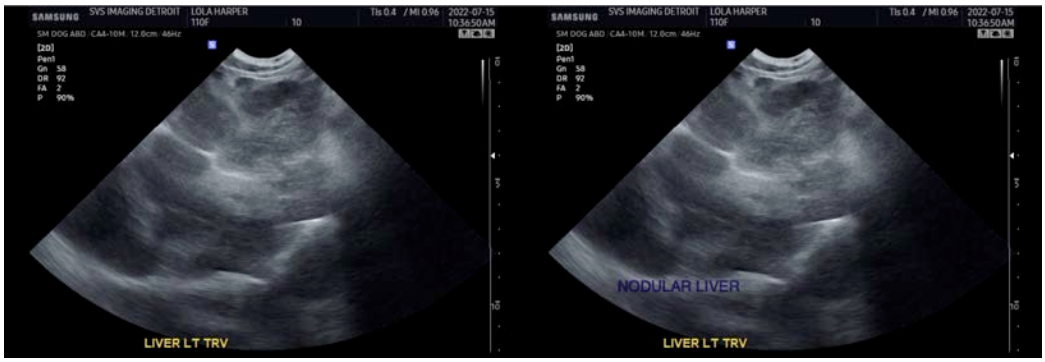

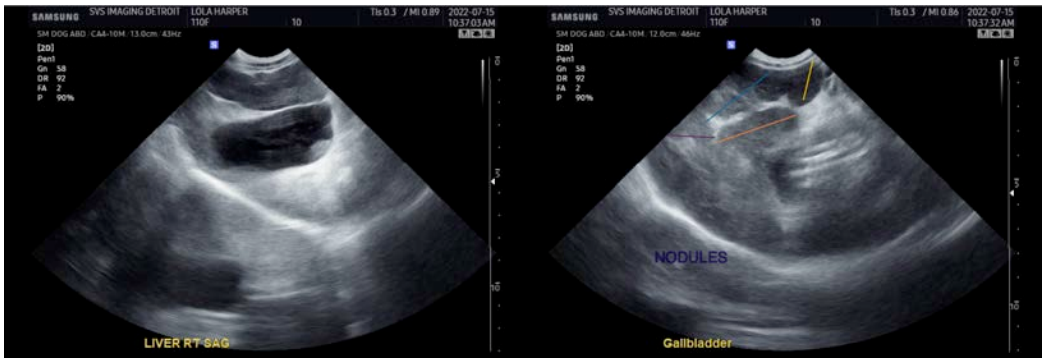

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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