**PATIENT**

Maggie Stoffer

SPECIES

Canine

BREED

Vizsla

SEX

Spayed Female

AGE

12 Years

WEIGHT

56 Pounds

INTERPRETED BYLisa Carioto, DVM,
DVSc, Diplomate
ACVIM**IMAGING
PERFORMED BY**

Sarah Pender, CVT

HOSPITAL NAME

SVS Imaging QC

REFERRING VET

Dr. Hartmann

INVOICE

39955

DATE

7/28/22

PRESENTING CLINICAL SIGNS

Poor appetite since yesterday. No Vomit or diarrhea. Did eat i/d this morning at the clinic.
Abnormal PE/Chem/CBC/UA Results: CBC unremarkable TBIL 3.6, chol 376, Amylase 1604, ALT 3514, ALP 3558 4DX test negative. Is current on leptovaccine

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**Urinary System**

The **urinary bladder** is well distended with anechoic contents. The wall is smooth and regular. No abnormalities are noted with the trigone or proximal urethra, and there is no evidence of sediment, cystoliths, polyps or a mass.

Kidneys

The **left kidney** measures 7.11 cm. The capsule is smooth. The cortex is mildly hyperechoic and thickened (0.75 cm). A mild loss of the normal definition of the cortico-medullary junction is present. An anechoic, 2 mm x 2 mm, structure is present at the mesenteric border. It is most consistent with a benign cyst. There are no signs of nephroliths or pyelectasia. The surrounding mesentery is not hyperechoic.

The **right kidney** measures 6.57 cm. The capsule is smooth. The cortex is mildly hyperechoic and thickened (0.85 cm). A mild loss of the normal definition of the cortico-medullary junction is present. Occasional mineralizations of the diverticulae and pelvis are present, without evidence of nephroliths or pyelectasia. The surrounding mesentery is not hyperechoic.

Aortic bifurcation/trifurcation No abnormalities observed.

Adrenal Glands

The **left adrenal gland** measures 0.86 cm at the cranial pole, 0.88 cm at the caudal pole and 2.75 cm in length. Both poles are enlarged and plump, however there are no signs of a mass or a nodule. No abnormalities are noted with the gland's overall architecture, echogenicity or echotexture. The phrenico-abdominal vein and surrounding vasculature and mesentery are unremarkable.

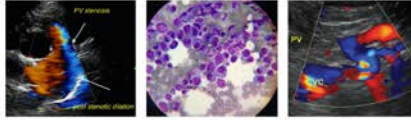
The **right adrenal gland** measures 0.59 cm at the cranial pole, 0.81 cm at the caudal pole. The gland does not have the normal "peanut shape". Occasional hypoechoic nodules of variable size, likely due to age-related nodular hyperplasia, are noted. The phrenico-abdominal vein and surrounding vasculature and mesentery are unremarkable.

Spleen

Splenomegaly with a smooth, curvilinear capsule. The spleen is within normal limits in echotexture and echogenicity. Perivascular cuffing, consistent with myelolipomas is observed; these are not considered clinically significant. No abnormalities are observed with its vasculature, i.e. congestion and thrombi are not identified.

Liver

Hepatomegaly is present. The liver is hyperechoic, i.e., it is isoechoic to the spleen and heterogeneous with multiple hypoechoic nodules scattered throughout the parenchyma. Examples of two nodules: 0.55 cm in diameter x 0.68 cm in length, and 0.75 cm in diameter x 1.03 cm in length. The latter may be due to nodular hyperplasia or regeneration. However, concomitant neoplasia, hepatitis or a hepatopathy, cannot be excluded. No abnormalities are observed with the hepatic vessels visualized.

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The **gallbladder (GB)** is moderately distended with a marked amount of free floating, gravity-dependent and inspissated echogenic material (sludge). A large proportion of the inspissated material appears immobile. Choleliths are also present. The GB wall is within normal limits in thickness. Certain areas of the wall are hyperechoic. The GB appears to have lost its normal shape and appears “deflated” with irregular borders towards the centre and neck. There is no evidence of free fluid in the surrounding area to suggest a recent rent or rupture. The cystic duct is dilated at 0.6 cm. The common bile duct is not visualized.

Gastrointestinal

The gastric wall is within normal limits in thickness and the wall layers are well defined. No obvious abnormalities are observed with its peristalsis.

Jejunum: Wall thickness and definition are within normal limits, however, diffuse fogging and stippling of the mucosa are present.

Gas is present in the transverse colon. The colonic wall is not thickened and mural detail is considered normal.

Pancreas

The pancreas has a mildly coarse echotexture, which is considered secondary to age related changes, however, previous episodes of pancreatitis cannot be excluded. There are no signs of active pancreatitis or neoplasia.

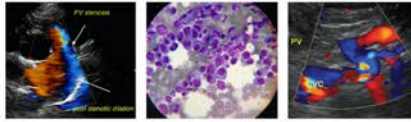
Other**Lymph nodes**

Hepatic lymph node: Mildly enlarged (0.91 cm x 0.78 cm), with smooth borders and hypoechoic.

Abdominal effusion is not visualized.

ULTRASONOGRAPHIC FINDINGS

- **Liver:** Vacuolar and reactive hepatopathies are suspected, in addition to age-related nodular hyperplasia. However, concomitant neoplasia, hepatitis or a hepatopathy, cannot be excluded without pursuing further diagnostics.
- **Gallbladder (GB):** abnormalities suggestive of chronic cholecystitis and fibrosis of the GB wall. The body with the inspissated bile has characteristics of a mucocoele, although not classical. There is no evidence of a rent or rupture, however, if a positive Murphy sign (abdominal pain) was appreciated during the ultrasound or during the physical exam, a cholecystectomy is suggested.
- **Kidneys:** Age related changes are possible causes, however, glomerulonephritis or interstitial nephritis must be considered. Pyelonephritis cannot be excluded despite the absence of classical sonographic signs.
- **Spleen:** Splenomegaly with preservation of the normal architecture. Differential diagnoses include splenitis, extramedullary hematopoiesis, and reactive hyperplasia. Neoplasia, such as lymphoma, or other round cell tumour, is less likely, but cannot be excluded. A fine needle aspirate would be required to obtain a definitive diagnosis.

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- **Gastrointestinal tract:** Very subtle signs of inflammation of the small intestinal tract, i.e., a chronic enteropathy cannot be excluded.
- **Adrenal glands:** Bilateral adrenomegaly is most likely due to hyperplasia secondary to stress and illness. Pituitary-dependent hyperadrenocorticism is considered less likely.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A cholecystectomy is suggested if Maggie is demonstrating or has demonstrated previous episodes pain, as well as gastroesophageal reflux disease (GERD).

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A hepatic biopsy, fine needle aspirate of the spleen and hepatic lymph node could also be performed during surgery. Culture of the bile is also recommended.

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If surgery is not an option, the following are suggested

Analgesia and intravenous fluids

A urinalysis and urine culture and sensitivity (renal changes)

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If the culture is negative, a urine protein: creatinine ratio is suggested

An arterial blood pressure, in the presence of the client

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Intravenous broad spectrum antibiotics during hospitalization (ampicillin or ticarcillin and enrofloxacin), followed by oral administration (4-8 weeks' duration depending on clinical status and liver enzymes, including GGT).

Vitamin K (0.5 mg/kg SQ q8-12h for 1-3 doses), due to cholestasis

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Fasting triglycerides are suggested to exclude hypertriglyceridemia as a predisposing cause of gallbladder sludge.

Diet change if hypertriglyceridemia identified

Small frequent meals

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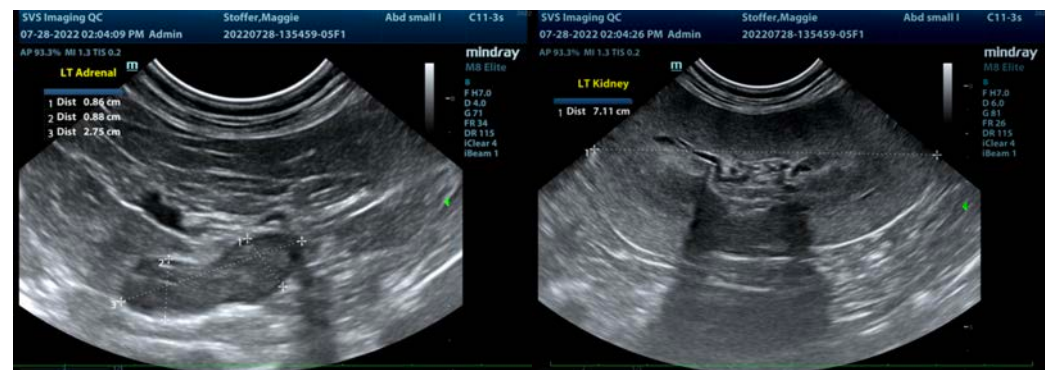
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Analgesia (gabapentin, +/- methadone) at home

A consultation with an internist may be considered due to Maggie's multiple co-morbidities.

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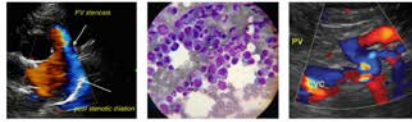
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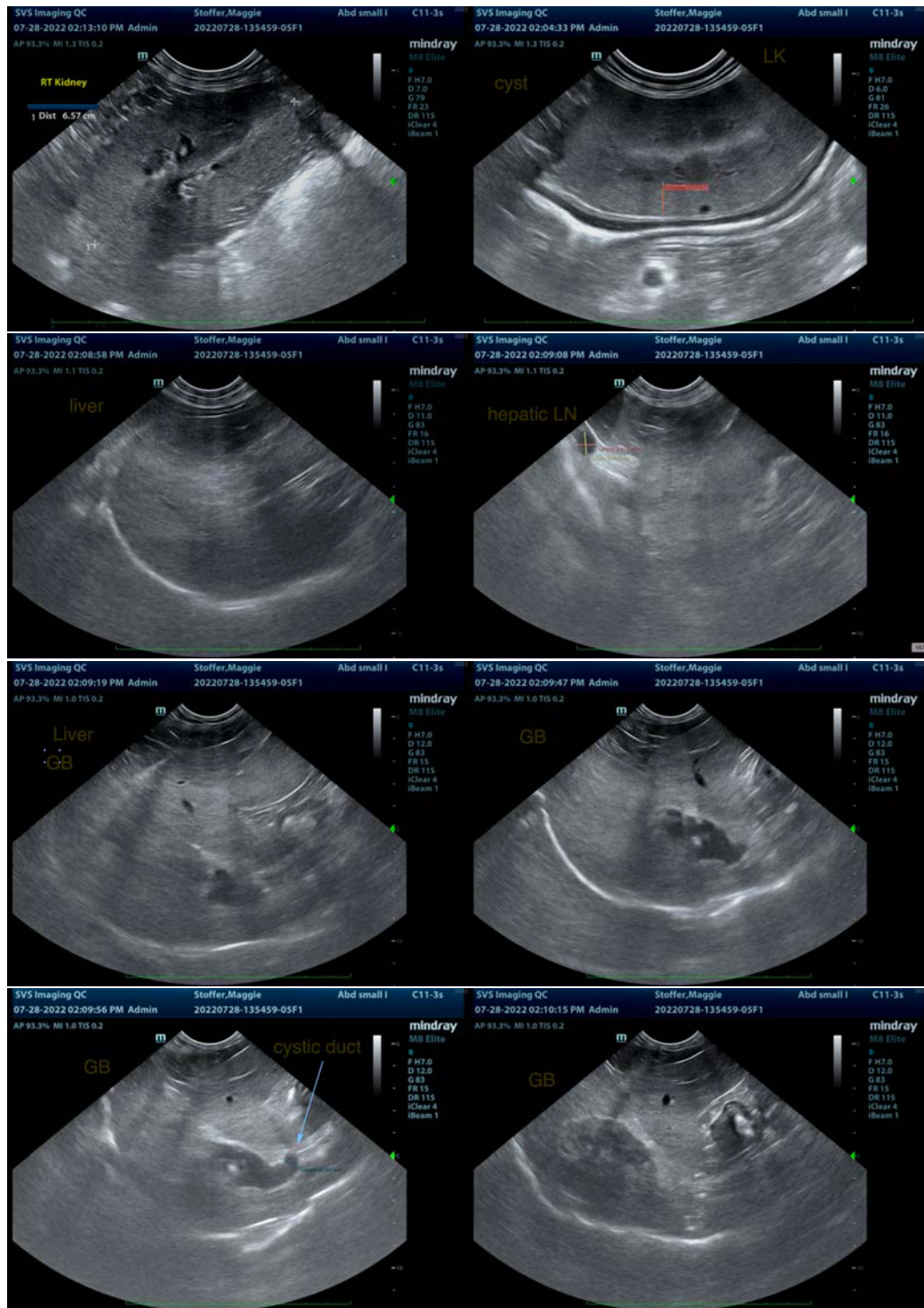
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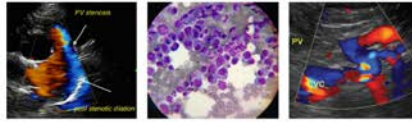


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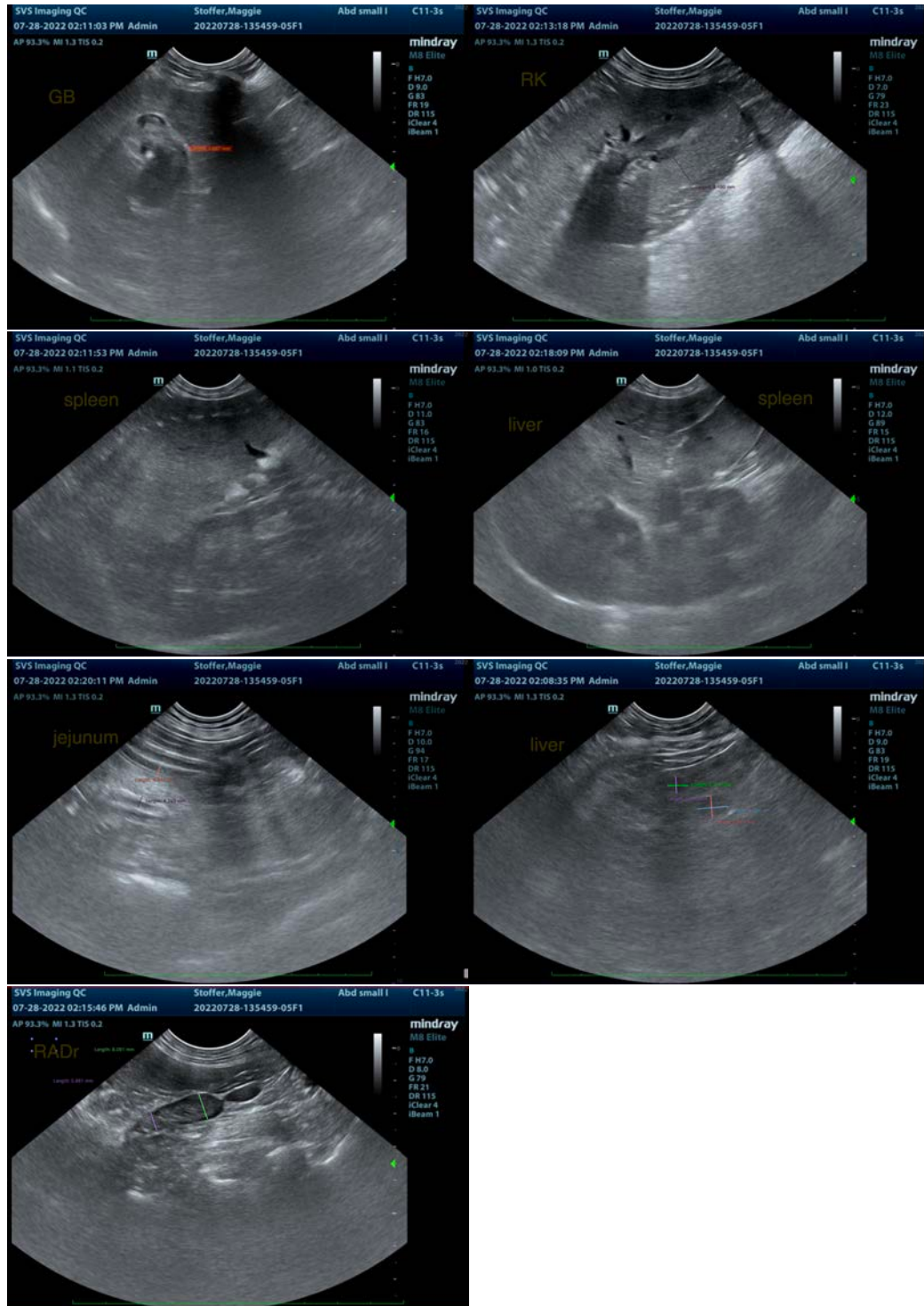
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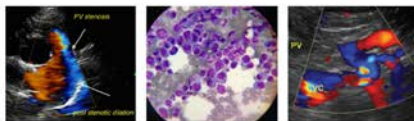
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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.

Lisa Carioto, DVM, DVSc, Diplomate ACVIM

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