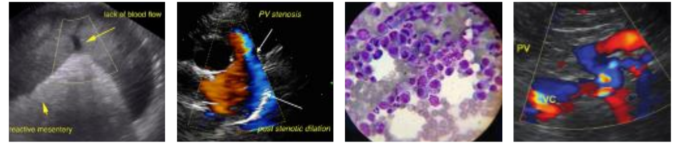
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Holly Weimer

SPECIES

Canine

BREED

Maltese

SEX

FS

AGE

9 years

WEIGHT

21 lbs.

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY

Dr. Mack

HOSPITAL NAME

Northside VC

REFERRING VET

Dr. Mack

INVOICE

15931

DATE

1/25/23

PRESENTING CLINICAL SIGNS

anorexia reported for 3 days and vomiting bladder infection diagnosed today with U/A
Abnormal PE/Chem/CBC/UA Results: Alt- too high to read Alkp - 1754

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no sediment or calculi. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory / neoplastic mural changes was noted.

The area of the aortic trifurcation was free of pathology.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and minor loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation or left or right pyelectasia was present. The left kidney measured 4.8 cm in length. The right kidney measured 4.9 cm in length.

Adrenal Glands

A well-defined, nonmineralized nodule was present in the caudal left adrenal gland with mild associated symmetrical capsule expansion. The nodule did not exhibit signs of mineralization or vascular invasion. The nodule measured 1.4 cm x 1.2 cm in. The overall left adrenal gland measured 0.6 cm width at the cranial pole and 1.2 cm width at the caudal pole.

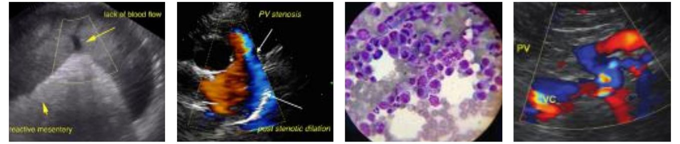
The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.46 cm width at the cranial pole and 0.52 cm width at the caudal pole.

Spleen

The spleen exhibited subjective mild to variable enlargement with mildly rounded yet symmetrical splenic capsule contour with mild splenic parenchyma heterogeneity. No masses or nodules were noted. Normal splenic vascularity was noted.

Liver/ Gallbladder

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to benign parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion. Adequate hepatic vascular volume was present. No overt evidence of a portosystemic shunt. The gallbladder was non-distended in size with anechoic content. The gallbladder wall was minor thickened in appearance consisting of an echogenic double rim corresponding to the inner and outer portions of the wall. This is consistent with minor gallbladder wall edema. Possible causes may include acute inflammation, edema, and anaphylaxis. The cystic and common bile ducts were normal.



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Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained mild, nonshadowing ingesta / chyme with luminal gas without signs of obstruction or foreign material.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction, or foreign material.

Normal visible colon wall layers were present with apparent formed feces in lumen.

Pancreas

The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

Free Abdomen

Intermittent, mildly prominent, hepatic lymph nodes were present adjacent to the portal vein. The lymph node was essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). No evidence of additional intraabdominal lymphadenopathy. No evidence of peritoneal effusion was noted.

ULTRASONOGRAPHIC FINDINGS

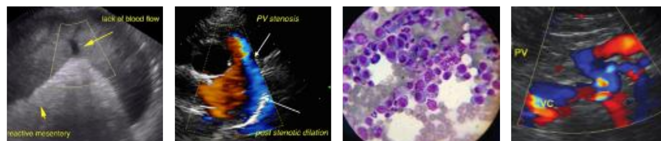
- Hepatopathy
- Minor concurrent hepatic lymphadenopathy
- Minor gallbladder wall edema
- Heterogeneous pancreas
- Structurally normal gastrointestinal tract with mild gastric ingesta / chyme
- Mild splenomegaly exhibiting nonhomogeneous parenchyma
- Caudal left adrenal nodule - suspect adenoma

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The suspected etiologies for the hepatopathy and minor gallbladder wall edema would be acute nonspecific hepatitis (viral, bacterial, Leptospirosis, toxin), with potential for concurrent vacuolar hepatic changes, nonobstructive cholestasis, reactive hepatopathy, less likely mild anaphylaxis, or infiltrative neoplasia.

The splenic presentation may indicate incidental splenitis, hyperplasia, or hematopoiesis, while the possibility of early infiltrative splenic neoplasia, although thought less likely, cannot be excluded. Further assessment may include hepatosplenic FNA cytology using a 25-gauge needle and assuming normal clotting status, as well as Leptospirosis titers / PCR.

Suspect mild metabolic gastric stasis without evidence of a gastrointestinal obstructive pattern. Spec cPL could be considered to assess for low-grade / chronic pancreatitis as a contributing factor.



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Empirically, hospitalization with IV fluids, hepato-protectants, +/- antibiotic trial to cover for nonspecific hepatitis, and as-needed gastrointestinal support with clinical reassessment would be reasonable. Screening blood pressure is recommended to assess for evidence of hypertension which may allude to a more aggressive emerging left adrenal pathology i.e., pheochromocytoma. Ideally, sonographic monitoring of the left adrenal gland for evidence of progression with initial recheck in 2-3 months is recommended.

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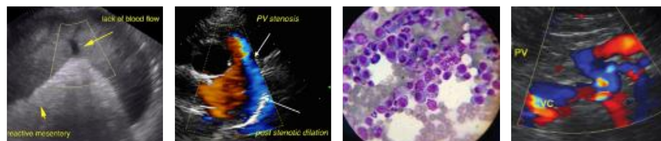

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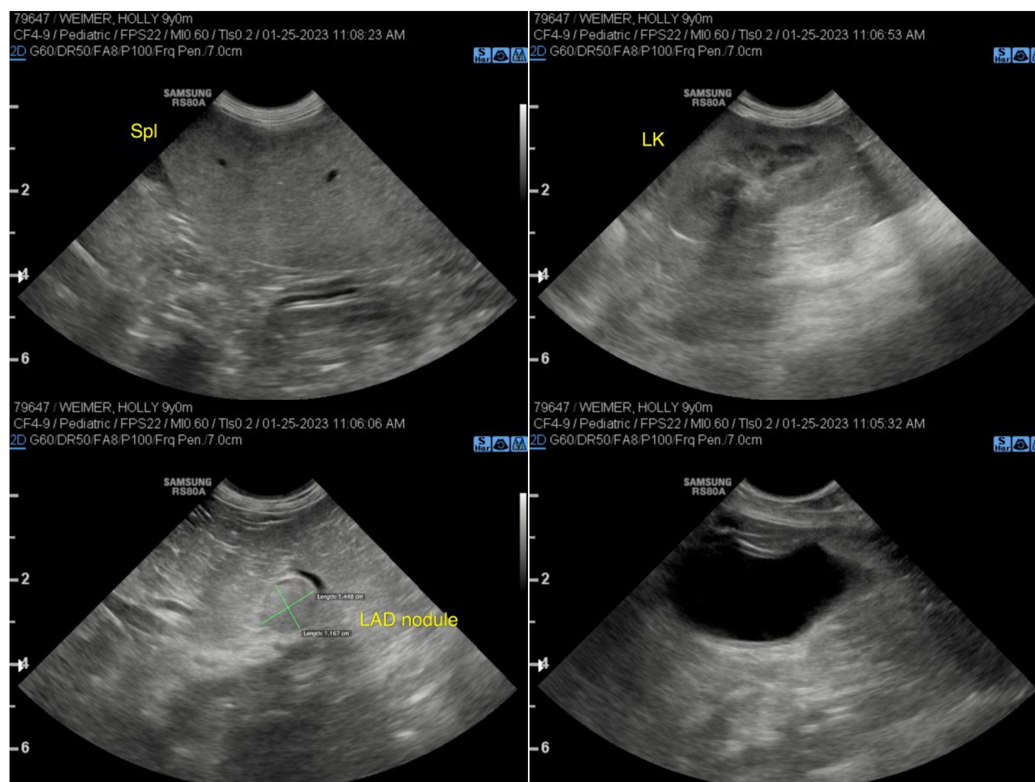

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)
info@SonoPath.com