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Clinical Sonography & Telecytology
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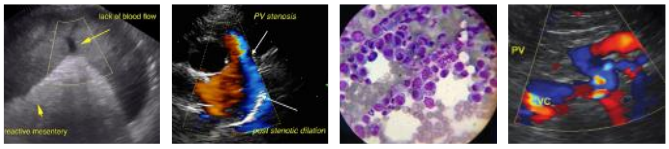

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Penny Smith

SPECIES

Canine

BREED

Labrador Retriever

SEX

FS

AGE

11 years 8 months

WEIGHT

70 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Karen Ebersole, DVM, DABVP (Canine and Feline)

HOSPITAL NAME

Scanvet

REFERRING VET

Dr. Goodman

INVOICE

16026

DATE

1/31/23

PRESENTING CLINICAL SIGNS

Vomiting and hyporexia since mid-December. Was seen at E clinic for vomiting on 12/25, BW, UA and Rads from then. Treated with Cerenia and SQ fluids. AUS recommended as next step.

Abnormal PE/Chem/CBC/UA Results: UA (12/25): SG 1.018, Prot ++, Bld +. Sed: WBC 10/HPF, RBC few, Transitional cells 1-4/HPF. BW (12/25): BUN 24, Creat 2.0, ALP 243, Amylase 2,018. RADS (thorax and abd): NSF.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 4.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic 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 mild loss of corticomedullary symmetry and definition expected for the age of the patient. Mild bilateral pyelectasia was present. The left kidney measured 7.4 cm in length. The right kidney measured 7.1 cm in length.

Adrenal Glands

The bilateral adrenal glands were normal in size. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The left adrenal gland measured 2.7 cm length x 0.54 cm width at the caudal pole. The right adrenal gland measured 1.7 cm length x 0.57 cm width at the caudal pole.

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not 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. The gallbladder was non-distended in size containing primarily anechoic content with mild, nonorganized, echogenic gallbladder debris. No evidence of gallbladder or peripheral gallbladder inflammatory criteria was noted. The cystic and common bile ducts were normal.

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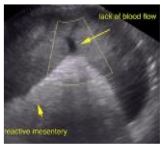

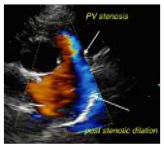

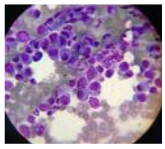
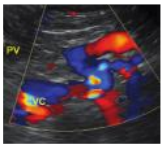

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Gastrointestinal

The stomach presented regionally to mildly prominent to thickened walls exhibiting subjective indistinct wall layer detail in the subjective ventral mid to left gastric body or possible fundus. The gastric body wall width measured up to 1.0 cm. The stomach was empty with mild luminal gas. No evidence of retained ingesta, fluid, or foreign material was noted. By comparison, discernable intact gastric wall width measured 0.40 cm. No evidence of mechanical pyloric outflow obstructive criteria or obstructive pyloric mural pathology. The pylorus wall width measured 0.48 cm.

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 mechanical / metabolic ileus, obstruction, or foreign material.

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

Pancreas

The pancreas was normal to mildly prominent in size with symmetrical capsule contour and isoechoic to mildly heterogeneous parenchyma compared to the adjacent omentum. Subjective minor pancreatic duct dilation was present.

Free Abdomen

Suspect cystic aortic or renal lymph nodes were noted adjacent and slightly caudal to the right kidney. These suspected lymph nodes did not pick up blood flow on power doppler assessment and not consistent with pathological criteria. No evidence of omental masses or evidence of peritoneal effusion were noted.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Mild chronic renal changes with mild bilateral pyelectasia
- Regional mildly prominent to thickened gastric walls, sonographically unremarkable small bowel
- Mild heterogeneous pancreas - age/patient variant, potential for low-grade inflammation possible
- Mild gallbladder debris (non-mucocele)
- Sonographically normal urinary bladder

Secondary Findings

- Suspect cystic aortic / renal lymph nodes adjacent to the right kidney - incidental

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The mildly prominent to thickened gastric walls were nonspecific and sonographically may suggest gastritis. Potential for emerging infiltrative gastric neoplasia cannot be definitively excluded. Spec cPL is warranted to assess for evidence of low-grade pancreatitis as a contributing factor.

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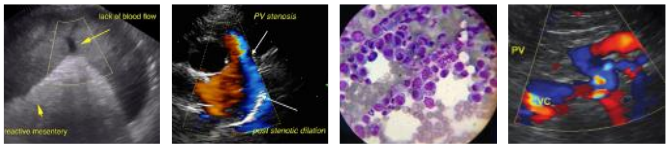

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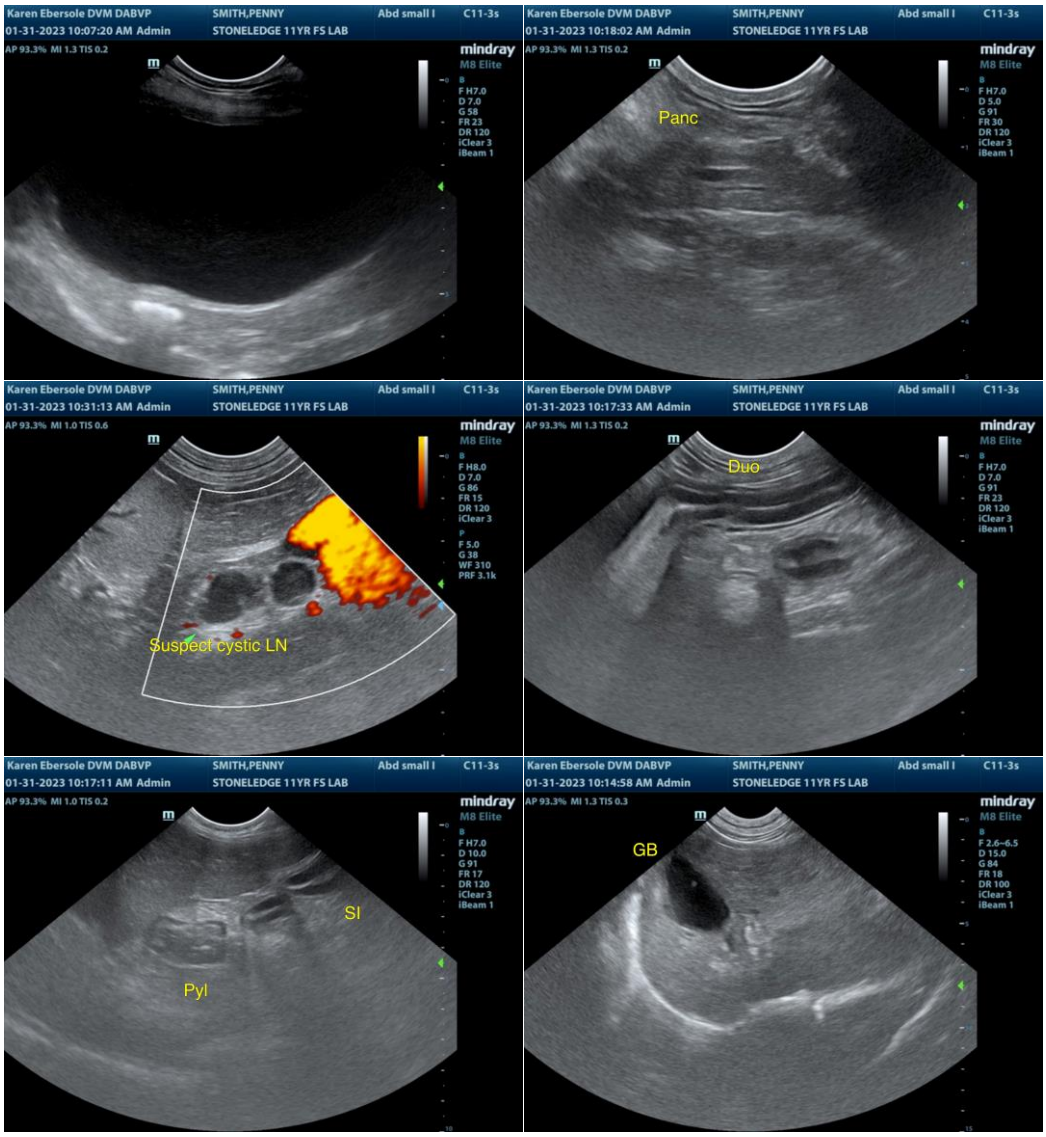
Empirically, gastritis protocol +/- coverage for helicobacter and sonographic reassessment of the gastric walls in 3-4 weeks would be reasonable. Gastric endoscopy with potential for biopsies is likely ideal given this presentation. A resting cortisol level to rule out occult Addison's Disease is suggested, yet the adrenal glands were overtly normal in presentation.

The bilateral pyelectasia may be owing to chronic renal changes, potential pelvic scarring possibly owing to previous calculi passage, IV fluid therapy (if applicable). Urine C/S and protein: creatinine ratio on sterile urine sample is recommended.



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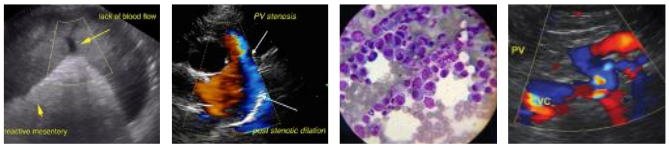

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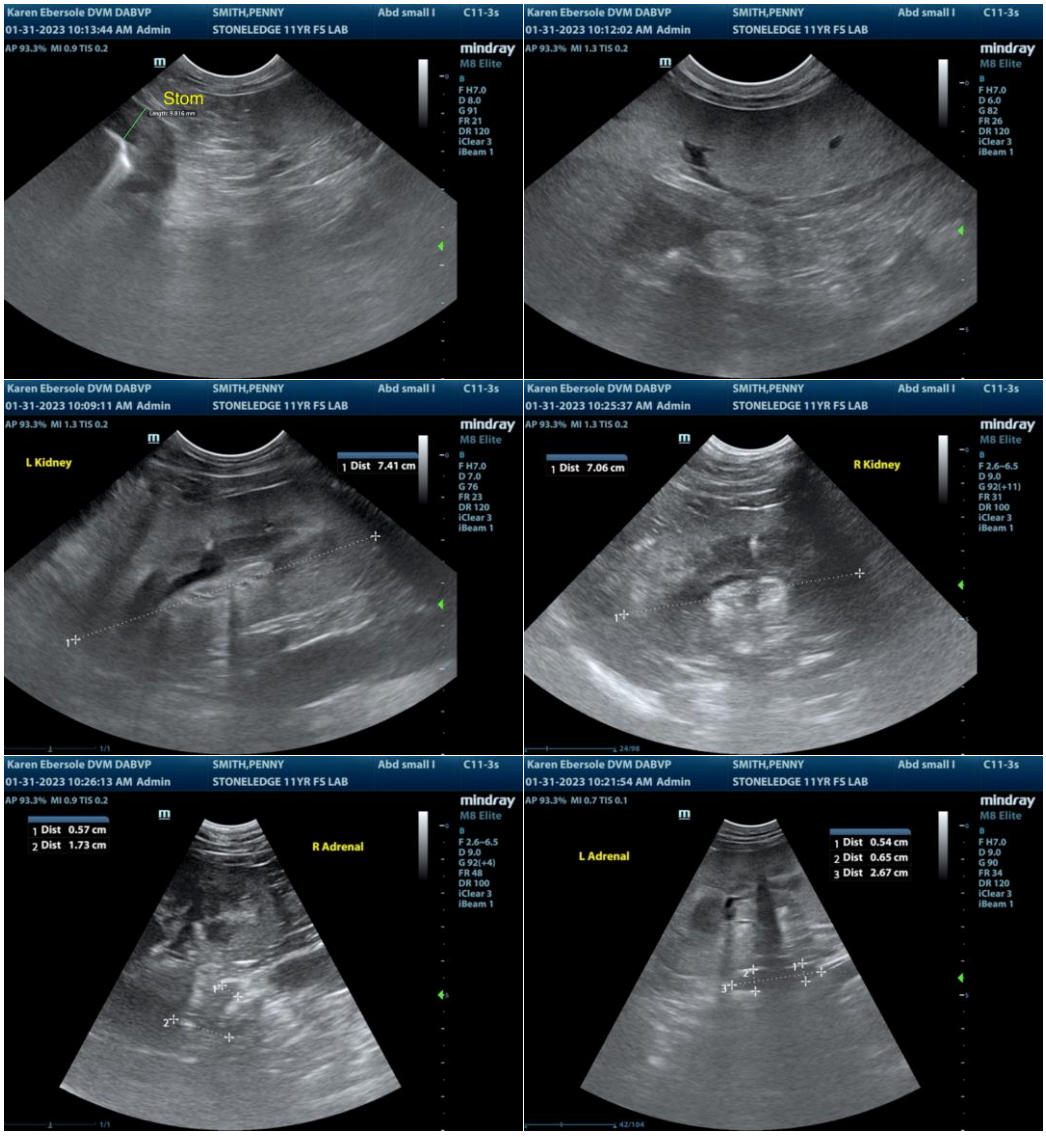

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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