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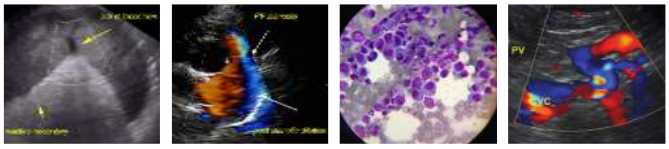

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Bizzy Menweg

SPECIES

Canine

BREED

Bichon

SEX

NM

AGE

14 years

WEIGHT

19.6 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Jasmine Palacios (SDEP Atendee)

HOSPITAL NAME

Rivers Edge PMC

REFERRING VET

Dr. Hollomon

INVOICE

12949

DATE

1/4/21

PRESENTING CLINICAL SIGNS

Recently ADR, diabetic x 7yrs. O noted seizure activity, p had 2 on 1/3/22. Seizures lasted about 5 minutes, convulsing/ lost control of body, difficulty walking/motor skills declined. P on insulin type N 4 U BID, glucosamine 1/2 BID with each meal, and pepcid ac 1/2 BID. P also on RC glyco balance. P currently hospitalized on IVF, Vit k and Cerenia administered in clinic. P not currently on insulin while in hospital
Abnormal PE/Chem/CBC/UA Results: Chem: anemic 34%, increased GGT, ALT and Alk Phos, Decreased BG (29), cPL abnormal, coags normal Radiographs: Potential prominent cardiac silhouette, loss of detail and slightly large liver

ALP >2,000, ALT 686, GGT 21, TBili 0.2, Snap cPL -abnormal

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 cm exhibited normal thickness and tone. Primarily anechoic urine was present in the lumen. Mild, nondependent, particulate sediment was present, likely indicative of minor cellular or crystalline debris without evidence of calculus formation. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural changes were noted.

The residual prostate was symmetrically normal in size with uniform parenchyma and slight coarse echotexture measuring 0.72 cm in diameter.

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 increased medullary echogenicity and moderate loss of corticomedullary symmetry and definition expected for the age of the patient. Mild bilateral pyelectasia was present. The left kidney measured 3.9 cm in length. The right kidney measured 4.6 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 0.36 cm width in the cranial pole and 0.47 cm width in the caudal pole. The right adrenal gland measured 0.60 cm width in the cranial pole and 0.42 cm width in the caudal pole.

Spleen

The spleen exhibited normal size and contour with generalized splenic parenchyma heterogeneity and discreet hypoechoic nodular to micronodular splenic parenchyma changes. No distinct splenic masses or nodules were noted.

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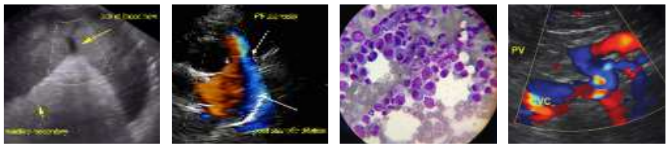

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Liver/ Gallbladder

The liver was subjectively normal in size, structure, and contour. The liver exhibited generalized mild parenchyma echogenicity with a moderate coarse echotexture and evidence of parenchymal remodeling. A solitary to intermittent, subtle hypoechoic parenchymal nodule was present. The hepatic and portal vasculature were normal in appearance without signs of congestion. Moderate gallbladder debris that appeared to be mildly congealed along the inner luminal surface primarily, was present with anechoic content noted in the central gallbladder. No evidence of gallbladder Inflammation or peripheral gallbladder inflammation was present. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact yet subjective mild prominent wall layering. The lumen of the stomach was empty with mild luminal gas. 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 ileus, obstruction, or foreign material. The jejunum wall width measured 0.45 cm.

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 pancreaticoduodenal lymph nodes were present adjacent to the right pancreatic limb. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). An example of the lymph node measured 0.48 cm diameter. No effusion was noted.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Bilateral moderate chronic renal changes with mild pyelectasia
- Discreet hypoechoic nodular to micronodular splenic parenchyma - likely consistent with age-related benign nodular hyperplasia, hematopoiesis, or potential splenitis, early neoplasia i.e., hemangiosarcoma, lymphoma, or mast cell neoplasia cannot be entirely ruled out
- Chronic hepatopathy exhibiting parenchymal remodeling and subtle hypoechoic parenchymal nodule - metabolic / vacuolar / reactive (diabetic) hepatopathy, cholangiohepatitis with areas of nodular to regenerative hyperplasia, hematopoiesis are possible, early hepatic neoplasia is considered less likely yet cannot be entirely ruled out
- Probable chronic to chronic active pancreatitis with associated benign minor pancreaticoduodenal lymphadenopathy
- Moderate gallbladder debris - potential early gallbladder mucocele

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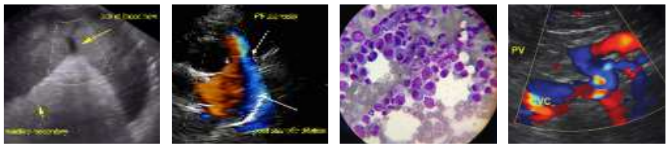

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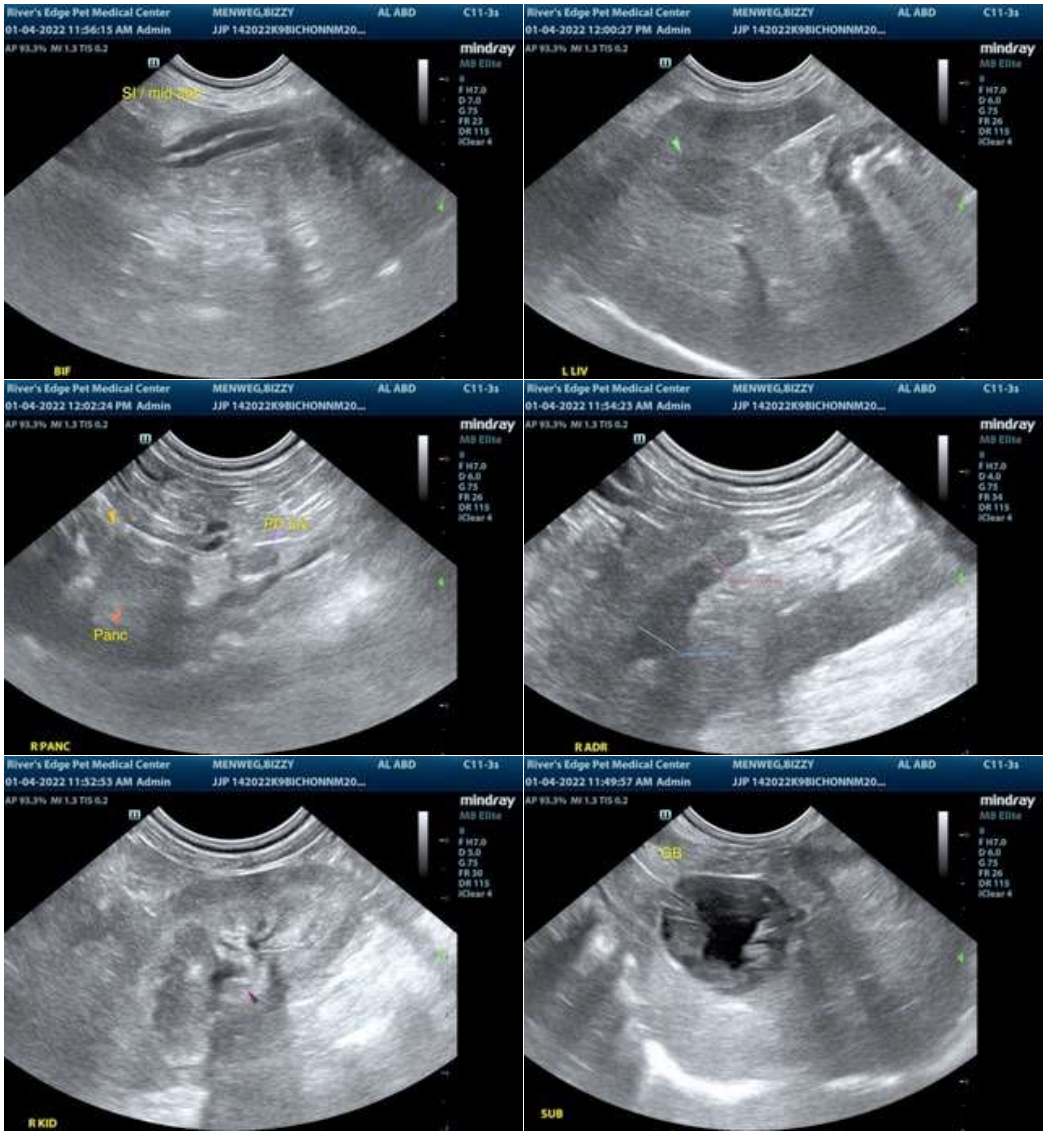
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The pyelectasia in both kidneys 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.

Assuming normal clotting status, hepatosplenic FNA could be considered for screening cytology primarily to ensure only benign changes are present. Hepatosupportive medications including Denamarin and Ursodiol are warranted.

Assuming no evidence of persistent hypoglycemia as a potential cause of the patient's seizures, neurological and/or Internal medicine consultation is recommended.



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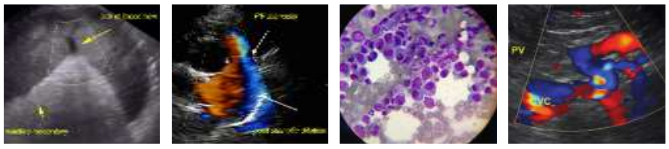

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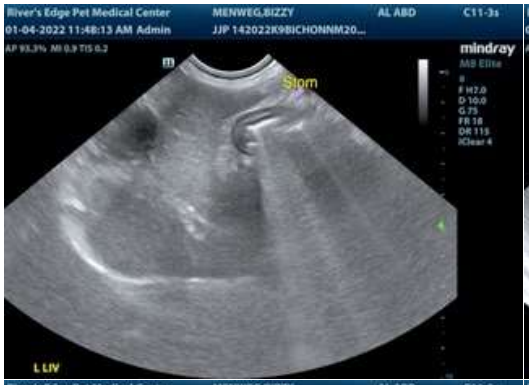

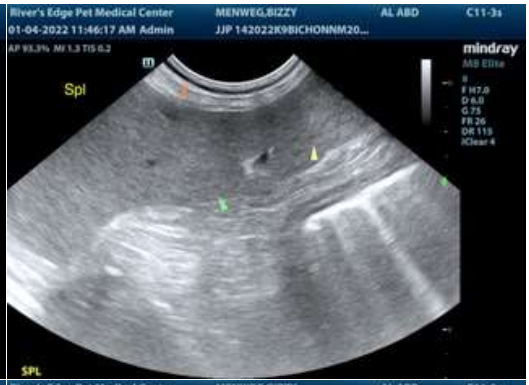

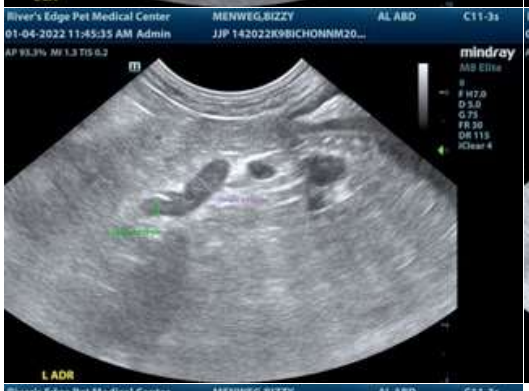

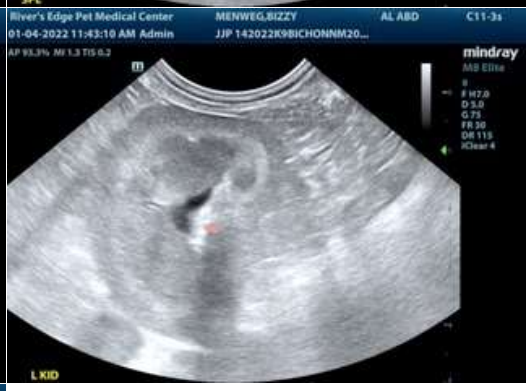

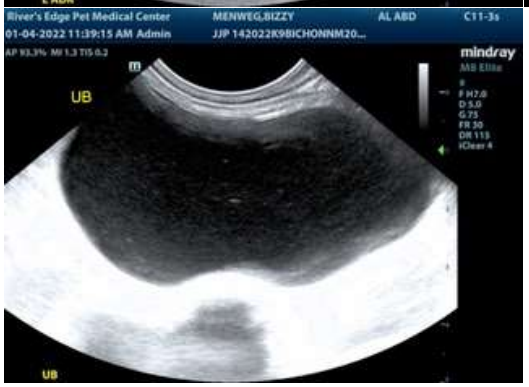

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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