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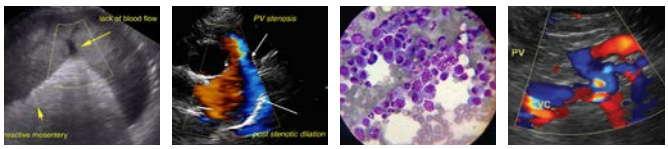


PATIENT
Ginger Courney

SPECIES
Canine

BREED
Mix

SEX
Spayed Female

AGE
12 Years

WEIGHT
30 Pounds

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

IMAGING PERFORMED BY
Dr. Hannah Fearing

HOSPITAL NAME
Lanier AH

REFERRING VET
Dr. Hannah Fearing

INVOICE
26336

DATE
10/15/21

PRESENTING CLINICAL SIGNS

Hx of mildly elevated ALP (last check was 215) for ~1-2 years. Has been on ursodiol 250 mg PO SID since 2018 due to gallbladder debris seen on previous ultrasound. Intermittent mild diarrhea +/- vomiting suspect somewhat anxiety-related.
Abnormal PE/Chem/CBC/UA Results: 9/4/2021 CBC/Chem: mildly elevated ALP (215) similar to previous; otherwise NSF T4: WNL UA: RBCs and epithelial cells - suspect artifact from cysto Fecal: NADx3 4Dx: BDLx4

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder was normal in size and tone with regionally thickened apical to ventral apical urinary bladder wall exhibiting similar echogenicity and echotexture compared to adjacent apical and ventral urinary bladder wall without evidence of mural mineralization. The ventral apical urinary bladder wall measured 0.92 cm in width. Anechoic urine was present. No sediment or calculi noted. The urethra was normal to a depth of 3.0 cm.

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 loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 4.9 cm. The right kidney measured 4.5 cm.

The area of the aortic trifurcation was free of pathology.

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 0.45 cm at the cranial pole and 0.62 cm at the caudal pole. The right adrenal gland measured 0.81 cm at the cranial pole and 0.72 cm at the caudal pole.

Spleen

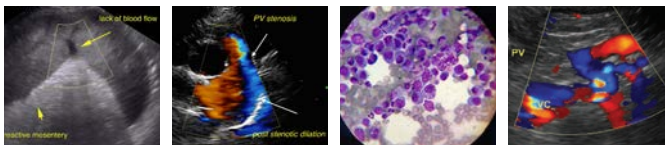
The spleen exhibited primarily finely textured parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Mild generalized parenchyma heterogeneity was present without evidence of nodular changes. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. The parenchymal heterogeneity is likely consistent with benign changes such as extramedullary hematopoiesis or age related remodeling with minor potential for inflammatory or neoplastic disease.

Liver

The liver exhibited generalized mild enlargement with maintained symmetrical capsule contour. Sugtly echogenic generalized hepatic parenchyma was noted with moderate coarse echotexture and evidence of parenchymal remodeling along with multifocal variably sized hypoechoic to heterogeneous parenchymal nodules. Example of liver nodule measured 0.97 cm in diameter. The nodules were non-expansive without distortion of the hepatic capsule. The gallbladder was non distended in size with moderate, non-dependent, non-organized, subjectively mobile debris. The cystic duct and common bile ducts were normal without evidence of dilation.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material. Pylorus wall measured 0.42 cm.



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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. Jejunum wall measured 0.37 cm.

Normal visible colon wall layers were present with subjective semiformed to soft feces.

Pancreas

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

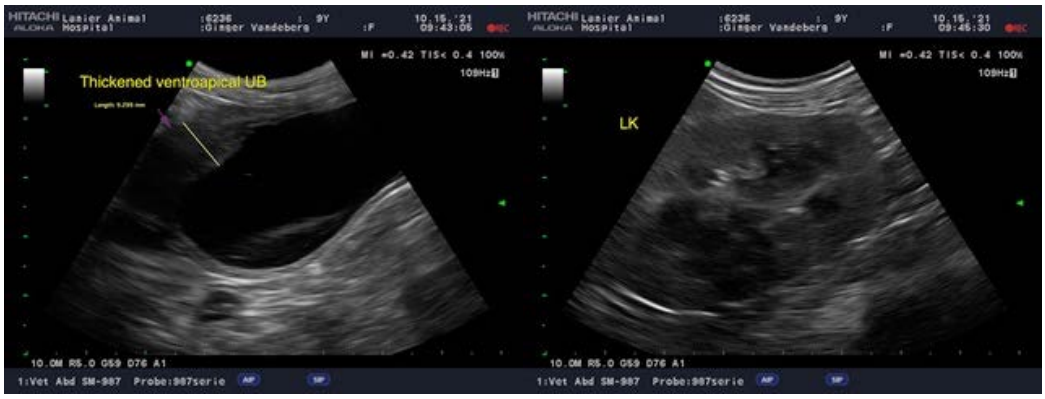
ULTRASONOGRAPHIC FINDINGS

- Mildly thickened ventral apical urinary bladder wall
- Mild hepatomegaly with parenchymal remodeling and multifocal variably sized non-expansive, hypoechoic to heterogeneous parenchymal nodules
- Moderate gallbladder debris (non-mucocele)
- Sonographically unremarkable gastrointestinal tract/colon
- Age related kidneys

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Ventral apical cystitis with potential for emerging neoplasia such as transitional cell carcinoma possible. Screening BRAF assay as well as cytospin cytology of free catch urine sample with submission of epithelial cells for pathological review may be considered. However, if negative, biopsy of the urinary bladder wall may be required for definitive diagnosis. Sonographic monitoring with initial recheck in 4 weeks for evidence of progression would be a more conservative approach. Urine culture and sensitivity is recommended if clinically indicated.

Vacuolar hepatitis or non-specific hepatitis/cholangiohepatitis (given the presence of gallbladder debris and cholestasis) possible. Potential for neoplasia cannot be definitively excluded, yet the nodules may indicate areas of nodular to regenerative hyperplasia or hematopoiesis. If a hepatic nodule is accessible for FNA, and assuming normal clotting status, cytology is suggested. Continued Ursodiol along with Denamarin and as-needed gastrointestinal support would be appropriate. Recheck of the hepatic nodules for evidence of progression or other changes could also be done at the time of sonographic reassessment of the ventral apical urinary bladder.



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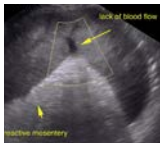
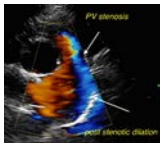
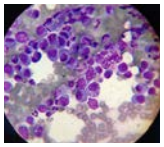
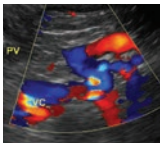

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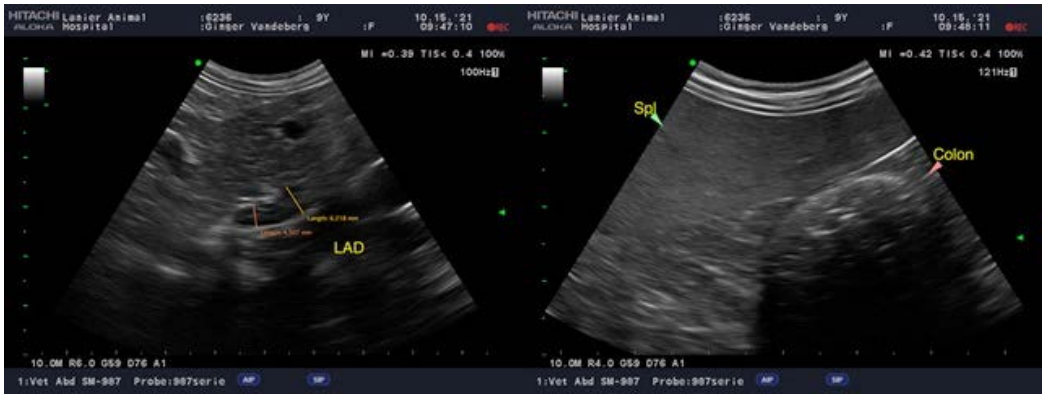

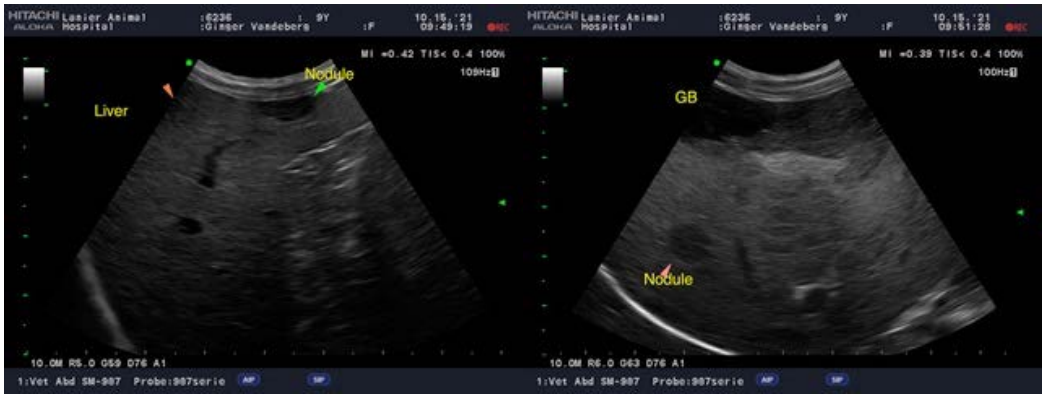

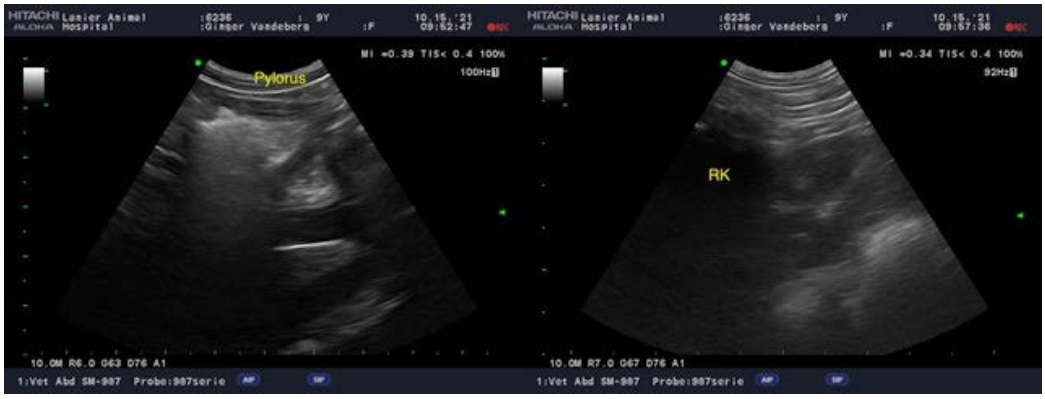

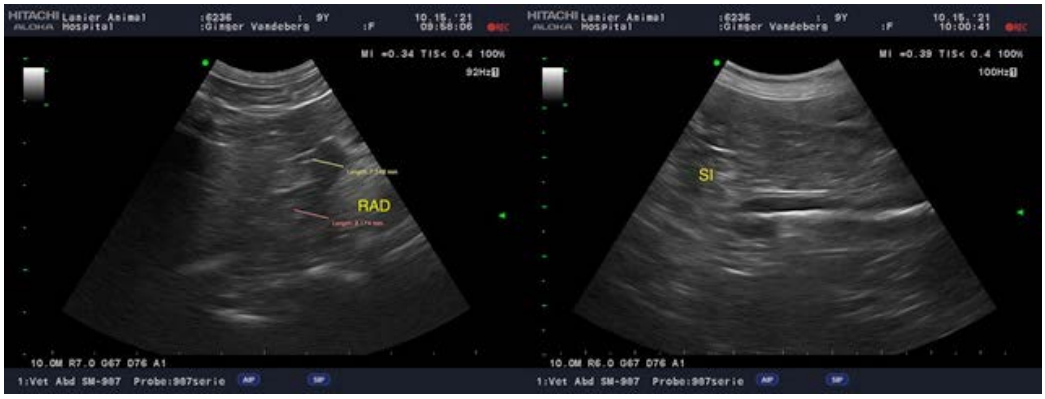

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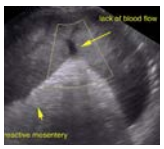
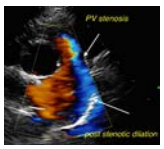
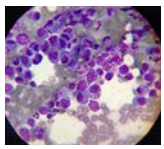
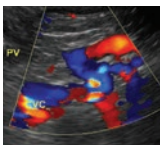

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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