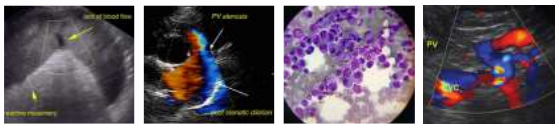

PATIENT

Hanne Hyde

SPECIES

Canine

BREED

Dachshund

SEX

FS

AGE

10 years

WEIGHT

13.5

INTERPRETED BY

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

IMAGING PERFORMED BY

Jenna Walsh, CVT

HOSPITAL NAME

Ark AH

REFERRING VET

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12425

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10/21/21

PRESENTING CLINICAL SIGNS

Weight loss, vomiting - has always been sensitive, but last 2 weeks vomits most of what she eats, usually several hours after eating (but is having normal BM's, just less frequent). Was at Daughter's for 6 weeks while O was away, busy house, 3 year old was very fond of Hanne. She doesn't usually eat things, but worried she may have. Normal PE other than 2# weight loss over the last 3 months. Bright and active most of the time per O. R/O Gastritis, GI ulcer, Gastric FB, Neoplasia/IBD, Pancreatitis - - Episode of vomiting/Diarrhea after dental in July also that took almost 4 weeks to resolve. Current Medications Cerenia/SQ fluids Tuesday, May repeat Cerenia Wednesday if helps
Abnormal PE/Chem/CBC/UA Results: No recent labs, July Labs slightly elevated ALkPhos, rest WNL

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra exhibited normal tone. Mild nonuniform thickening of the urinary bladder wall was present. Moderate, nondependent to mildly congealed particulate sediment was present. Hyperechoic focal echogenicities with distal acoustic shadowing were present in the dependent lumen. An example of urinary bladder calculus measured 1.1 cm 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 some increased echogenicity and mild to moderate loss of corticomedullary symmetry and definition expected for the age of the patient. Nonobstructive medullary mineral was present in both kidneys. No evidence of pelvic dilation was present. The left kidney measured 5.8 cm in length.

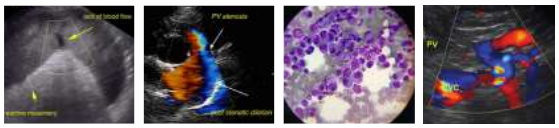
Adrenal Glands

A well-defined, hyperechoic 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 1.8 cm x 1.58 cm. The overall left adrenal gland measured 2.9 cm length x 1.58 cm width at the caudal pole. The nodule in the left adrenal gland was more pronounced.

A well-defined, hyperechoic nodule was also present in the mid to cranial right adrenal gland with mild associated symmetrical capsule expansion. The nodule did not exhibit signs of mineralization or vascular invasion. The nodule measured 0.94 cm x 0.71 cm. The overall right adrenal gland measured 2.2 cm length x 0.42 cm width in 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



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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/ Gallbladder

The liver presented mildly enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with mild gallbladder debris. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. Minor retained chyme was present in the stomach. No evidence of gastric foreign material or mechanical pyloric outflow obstruction was noted. The gastric body wall width measured 0.34 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 duodenum wall width measured 0.36 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.

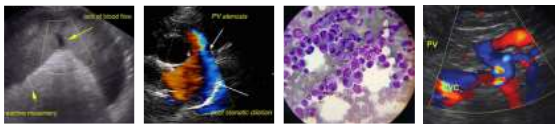
Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Urinary bladder calculi with moderate nondependent to congealed particulate sediment
- Bilateral chronic renal changes with nonobstructive medullary mineral
- Bilateral nodular adrenal glands - adenomas, benign hyperplasia, or potential emerging neoplasia such as adenocarcinoma or pheochromocytoma or other possible
- Mild gallbladder debris (non-mucocele)
- Probable inflammatory gastroenteropathy, potential IBD



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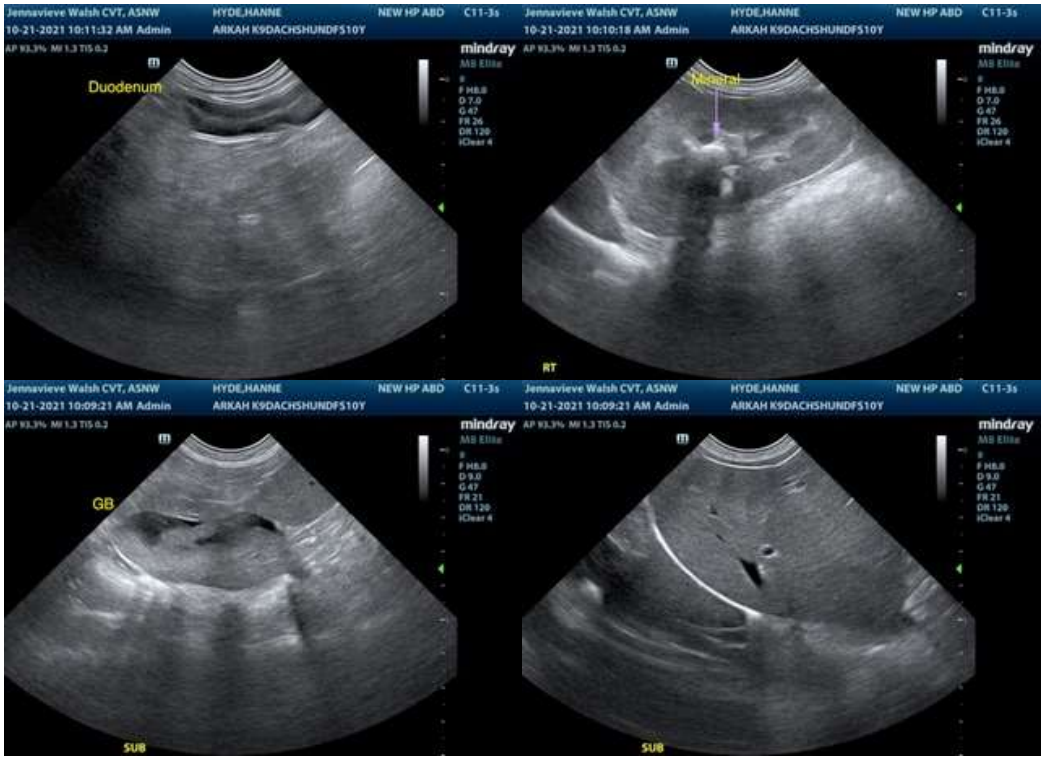
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Screening blood pressure to assess for evidence of hypertension is recommended. If clinical concern for pheochromocytoma, urine catecholamine levels could be considered. Ideally, serial sonographic monitoring of the adrenal nodules with initial recheck in 4 weeks to assess for evidence of progression is suggested.

A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. Empirically, a limited antigen or hydrolyzed diet trial, broad-spectrum deworming i.e., Panacur 50 mg/kg PO SID for at least 5 consecutive days even if fecal testing Is negative and as-needed GI support are recommended. Urine culture and sensitivity on a sterile urine sample to rule out underlying infection Is recommended. Eventual cystotomy may be required and if elected, gastrointestinal biopsies could be considered at time of surgery.



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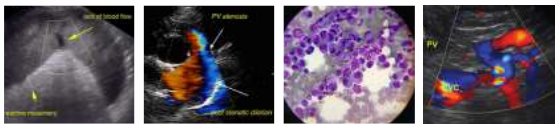

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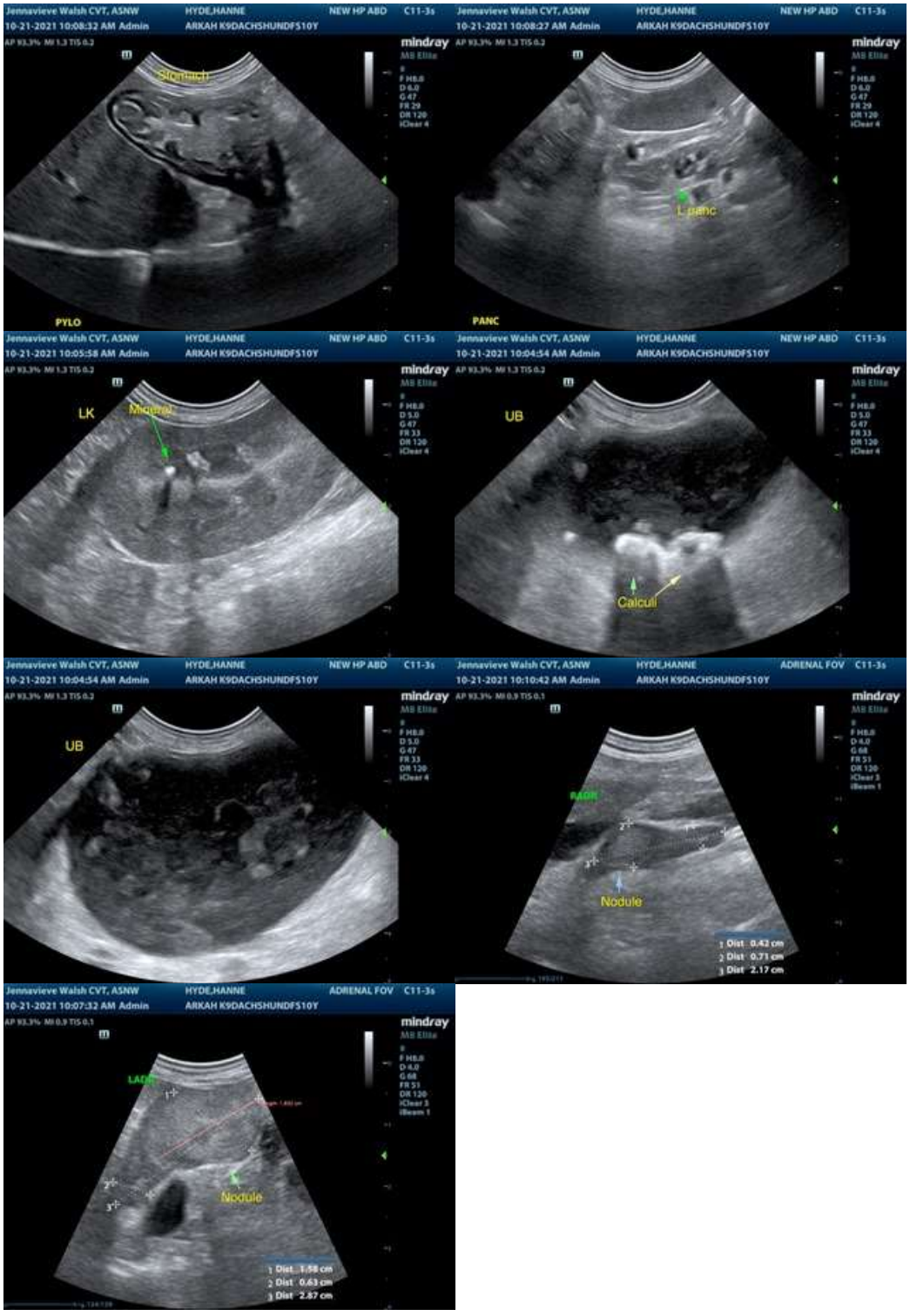

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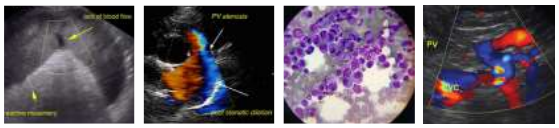

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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