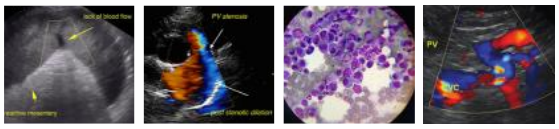

PATIENT

Bevmo Garrett

SPECIES

Canine

BREED

Mini Pinscher

SEX

FS

AGE

12 years

WEIGHT

26 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Jenna Walsh, CVT

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PRESENTING CLINICAL SIGNS

Early mucocele initially documented 5/2020. Chronic/recurrent intermittent GI signs such as vomiting, diarrhea, colitis. 10/15/22 presentation with mucoid diarrhea and abdominal tensing. Chronic AP elevation since 4/2020 (values 950-1631 IU/L since that time). History of proteinuria without urogenital cause identified on workup; attributed to hepatopathy. Proteinuria only partially managed with enalapril (0.8 mg/kg BID). Most recent pooled UPC=3.9 (10/2/22). Clinically compensated mitral region 3/6 systolic murmur. Multiple sc lipoma like masses. Current Medications Cosequin, Fish Oil, Enalapril 10 mg BID, Ursodiol 75 mg qd, Denamarin Primary Question/Differential to Be Answered in This Exam Status of mucocele; this vs other identifiable cause of GI patterns.

Abnormal PE/Chem/CBC/UA Results: 10/15/22: AP 1017 (20-150 normal range), ALT 143 (10-118 normal range). Marginal anemia PCV=39% with otherwise normal CBC. 10/2/22: UPC (pooled) 3.9 with USG 1.025 See email for newest and most recent comparative diagnostics. Last formal AUS study report of 9/9/2020 attached.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra exhibited normal tone to a depth of 3.0 cm. Mild nonuniform thickening of the urinary bladder wall was present. A solitary hyperechoic focal echogenicity with distal acoustic shadowing was present in the dependent lumen measuring 0.74 cm in diameter. The bladder was otherwise normal containing primarily anechoic urine without evidence of inflammatory mural changes.

The area of the aortic trifurcation was free of pathology.

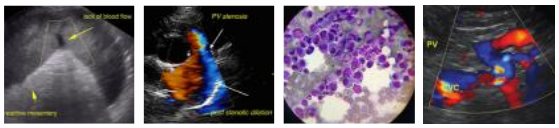
Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. Pinpoint to focal nonobstructive medullary mineral noted in both kidneys. No evidence of pyelectasia was present. The left kidney measured 5.7 cm in length. The right kidney measured 6.0 cm in length.

Adrenal Glands

The left adrenal gland was mildly prominent in size based on caudal pole width measurement in light of body weight. The right adrenal gland was normal in size. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The left adrenal gland measured 2.4 cm length x 0.78 cm width at the caudal pole. The right adrenal gland measured 2.3 cm length x 0.48 cm width 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



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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 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 echogenic, nonmineralized, non dependent biliary sludge. The biliary sludge was non organized with a hypoechoic to anechoic, irregular to interrupted rim visible between the nondependent sludge and inner wall. No evidence of inflammatory gallbladder or peripheral gallbladder changes was noted. The common bile duct was normal.

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.

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

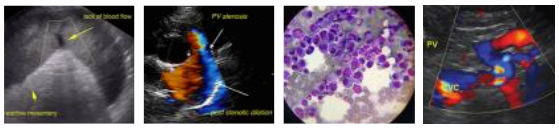
The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Cystic calculus
- Mild chronic renal changes with static medullary mineral
- Mildly prominent left adrenal gland - nonspecific without evidence of neoplastic criteria
- Benign hepatopathy - vacuolar hepatopathy, nonobstructive cholestasis, inflammatory / immune-mediated disease, hyperplasia, hematopoiesis, or other hepatopathy possible, no evidence of hepatic neoplastic criteria
- Stable, non-inflamed, partial gallbladder mucocele
- Sonographically unremarkable gastrointestinal tract



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- Minor pancreatic remodeling - age related / patient variant, remodeling owing to previous inflammation, mild chronic pancreatitis possible
- Sonographically unremarkable gastrointestinal tract

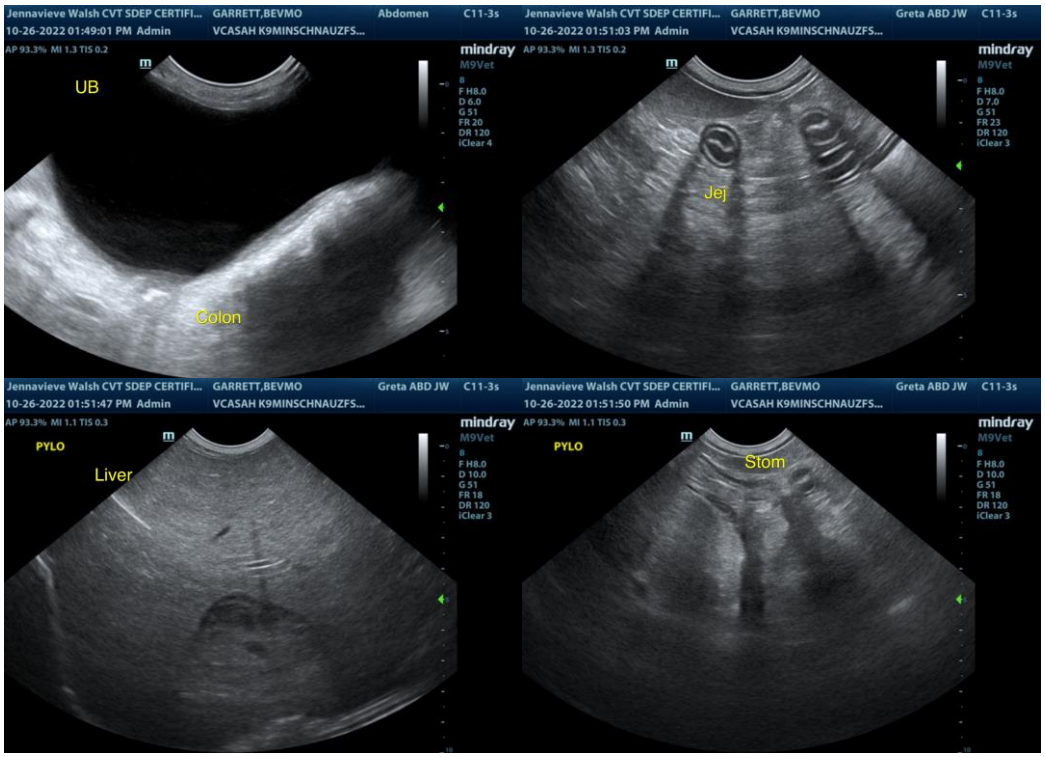
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Urine C/S on sterile urine sample to rule out underlying infection, given the presence of the cystic calculus, may be considered if clinically indicated.

Although no reported clinical signs i.e., PU/PD, polyphagia, etc., a full adrenal workup could be considered if suspicion for Cushing's Syndrome.

Subjectively, the partial gallbladder mucocele appears to be mildly progressive based on the sonographic appearance of gallbladder debris, although no evidence of current inflammation. No indication for immediate cholecystectomy, yet continued sonographic monitoring as well as monitoring for evidence of increasing cholestasis, and cranial abdominal / subxiphoid discomfort on palpation is advised. Continued hepatosupportive medications are recommended.

Mild to low-grade inflammatory gastroenterocolonopathy or low-grade to chronic pancreatitis may potentially be contributing factors to the recurrent GI signs. A GI panel to include PLI/TLI/Cobalamin/Folate could be considered. As-needed GI support, which may include hydrolyzed diet trial and high colony count probiotic may prove beneficial.



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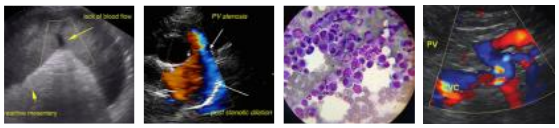

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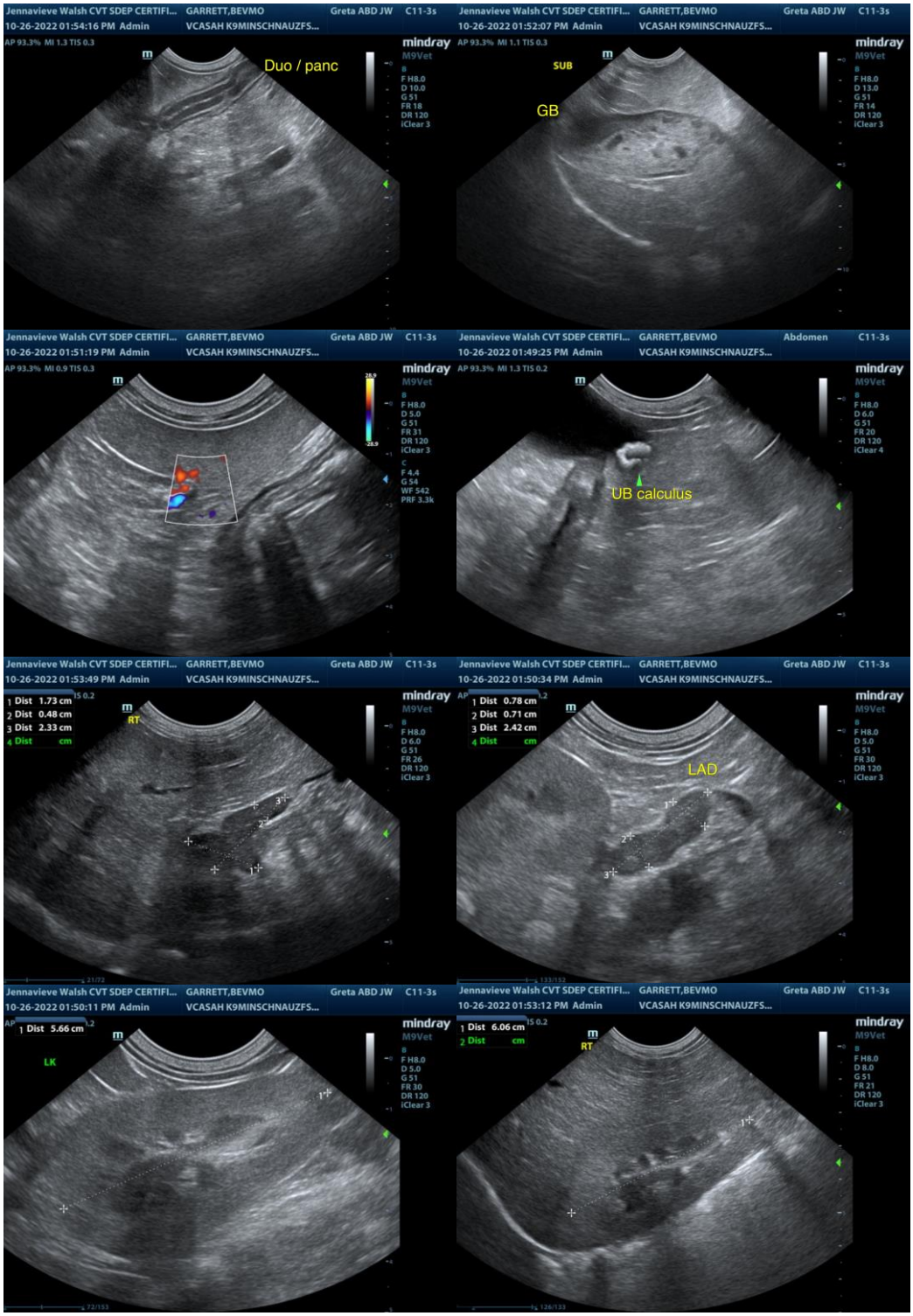

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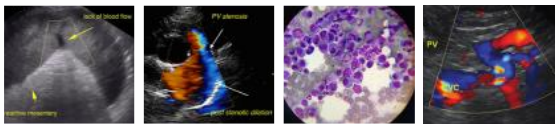

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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