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Clinical Sonography & Telecytology
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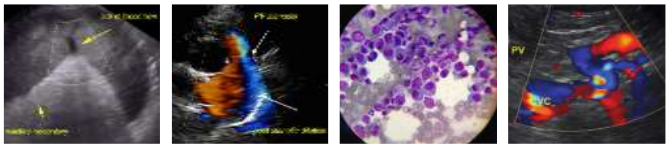

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Bella Aragon

SPECIES

Canine

BREED

Dachsund Mix

SEX

FS

AGE

12 years

WEIGHT

24.1 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Focused Ultrasound Resources

HOSPITAL NAME

Focused Ultrasound Resources

REFERRING VET

Dugan's VH

INVOICE

12670

DATE

11/26/21

PRESENTING CLINICAL SIGNS

Wt loss w/ muscle wasting Anorexia, alopecia, dehydration, dull coat, ADR, hypothyroid, renal insuff
Abnormal PE/Chem/CBC/UA Results: SDMA - 36 BUN - 38 ALT - 579 ALKP > 2000 GGT - 158 AMYL - 497

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder was normal in size and tone. Anechoic urine was present in the bladder with no sediment or calculi. Focal area of primarily symmetrical mural hypertrophy was noted in the dorsal urinary bladder wall extending mildly into the lumen, measuring 1.4 cm x 0.5 cm. No evidence of mineralization associated with the focal mural hypertrophy was noted. The urethra exhibited normal structure and tone to a depth of 3.0 cm.

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 moderate loss of corticomedullary symmetry and definition expected for the age of the patient. Multifocal cortical cysts were present along with hyperechoic cortical foci, suggestive of pinpoint areas of cortical fibrosis, microinfarction, or mineralization. Mild dystrophic medullary mineralization was present. No evidence of pelvic dilation was present. The left kidney measured 6.5 cm in length. The right kidney measured 7.1 cm in length.

Adrenal Glands

Bilateral symmetrical adrenal gland enlargement with uniformly hypoechoic parenchyma was present. The left adrenal gland measured 0.92 cm width at the caudal pole and 0.99 cm width at the cranial pole. The right adrenal gland measured 0.98 cm width at the caudal pole and 1.1 cm width at the cranial 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 exhibited generalized enlargement with overall mild increased parenchymal echogenicity exhibiting moderate coarse echotexture and generalized parenchyma remodeling. No distinct hepatic masses or nodules were noted. The gallbladder was non-distended containing a solitary cholelith, along with nondependent mineralized sediment. The cholelith measured approximately 2.7 cm in diameter. No evidence of gallbladder or peripheral inflammation was noted.

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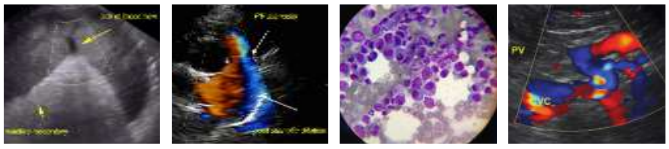

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Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained mild, echogenic ingesta exhibiting progressive distal acoustic shadowing. The pylorus wall width measured 0.52 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 0.52 cm. The jejunum wall width measured 0.3 cm.

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

Pancreas

The parenchyma of the pancreas was mildly echogenic to nonuniform, with diffuse parenchyma remodeling. The capsule of the pancreas was mildly asymmetrical in contour without evidence of peripancreatic inflammation. These changes may suggest chronic inflammation, fibrosis, or saponification if previous history of pancreatitis. No overt signs of pancreatic neoplasia.

Free Abdomen

Subtle evidence of generalized echogenic mesentery was present. No overt lymphadenopathy or peritoneal free fluid was noted.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Focal dorsal urinary bladder mural hypertrophy - nonspecific, focal cystitis, atypical polyp, emerging neoplasia cannot be excluded
- Bilateral moderate chronic renal changes with multifocal cortical cyst and dystrophic medullary mineralization
- Chronic hepatopathy - metabolic, vacuolar, steroid, or inflammatory hepatopathy possible, potential for hepatic neoplasia thought less likely although cannot be definitively excluded
- Nonobstructive cholelithiasis and mineralized gallbladder sediment
- Bilateral prominent adrenal glands
- Probable mild chronic pancreatitis
- Mild retained gastric ingesta

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Full adrenal workup with LDDST is recommended, although the overall clinical signs exhibited by this patient were not overtly consistent with hyperadrenocorticism.

Ultrasound-guided FNA of the liver, assuming normal clotting status, could be considered.

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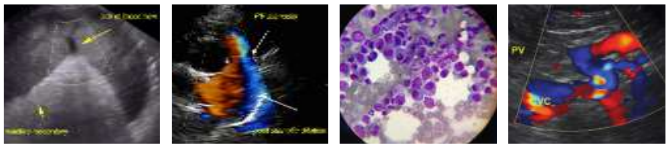

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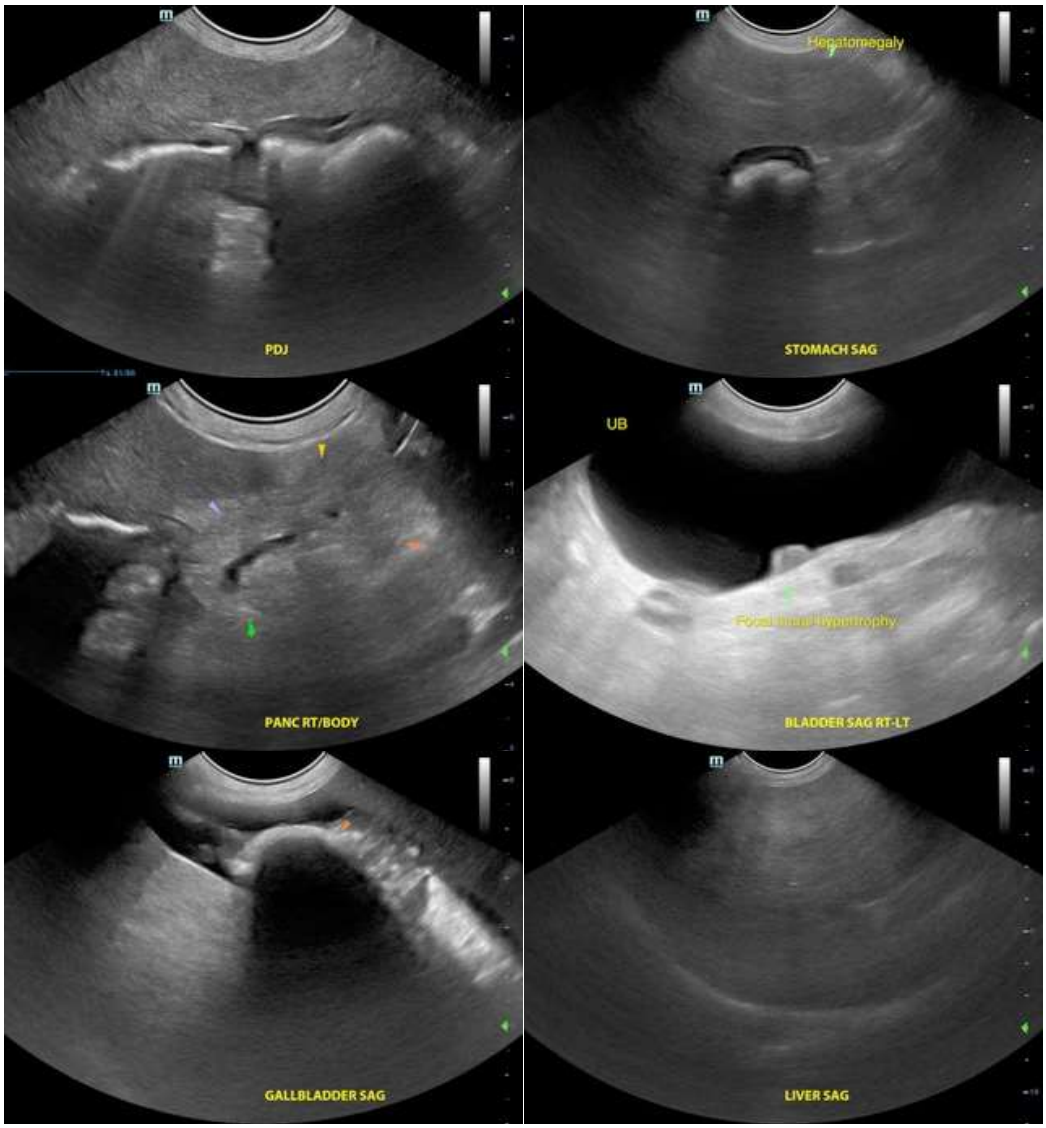
Further renal staging to include urine C/S and protein: creatinine ratio on sterile urine sample may be considered. Sonographic monitoring of the focal urinary mural hypertrophy for evidence of progression +/- screening BRAF assay would be appropriate.

Overt evidence of post-hepatic obstruction was not overtly evident likewise, the appearance of the gallbladder was not overtly consistent with an active gallbladder mucocele. However, sonographic reassessment of the gallbladder and common bile duct is suggested if increasing evidence of cholestasis or cranial abdominal/ subxiphoid pain in palpation.

Potential for mild gastric stasis Is possible If documented NPO and in light of the patient's anorexia.

The ingesta was suggestive of food without overt obstructive foreign material. A GI panel to include PLI/TLI/Cobalamin/Folate as well as three view chest radiographs and neurological / musculoskeletal examination are recommended to assess for or rule out occult disease which may cause weight loss.



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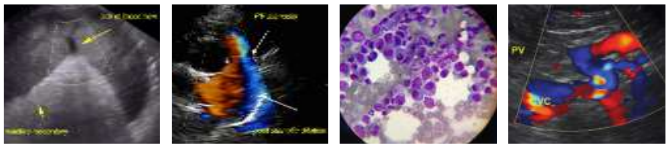

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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