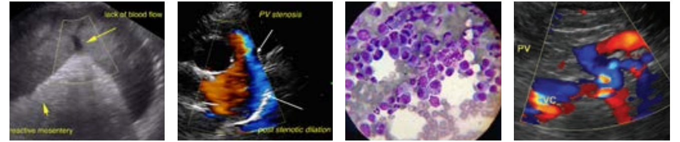
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Quincy Beamer

SPECIES
Canine

BREED
Yorkshire Terrier

SEX
Neutered Male

AGE
14 Years

WEIGHT
2.7 kg

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

IMAGING PERFORMED BY
Patti Mayfield, DVM

HOSPITAL NAME
Emergency Vet Hospital

REFERRING VET
Patti Mayfield, DVM

INVOICE
42581

DATE
11/6/22

PRESENTING CLINICAL SIGNS

Patient presented to EVH on 11/6/2022 at ~ 6 am with following Hx: -- o woke up this am, found breathting heavily, recumbent. -- pool of drool noted on floor. -- o rpeorts that p was noted to be normal Saturday (yesterday) Hx: seizures noted over the last few yrs. -- last seizure noted prior to starting medications 6-8 mos. unknown medication. -- o also reports weakness in hind limbs recently. Treatments at time of triage: NSR bolus 80 mL IV, then NSR 14 mL/hr IV - methadone 0.27 mg IV. - admin dextrose 25% 0.7 g IV Attemped AUS without sedation due to critical nature, however patient was vocal and intermittently flailing. Administered Butorphanol 0.2 mg/kg + Midazolam, 0.1 mg/kg (mixed) IV. Patient was far more compliant for remainder of imaging (following left kidney). Patient became hypothermic and remained hypoglycemic despite 5% dextrose CRI

Abnormal PE/Chem/CBC/UA Results: PE: - mild pyrexia, 103.2 F - 7-8% dehydrated - painful abdomen, tense - recumbent chem17/CBC: - glu 39, - BUN 50 otherwise unremarkable 3 view whole body rads: - lung fields claer. moderate tracheal collapse. heart WNL. extrathoracic structures WNL. ABDO: - marked gas distension of SI. no foreign material noted. approrpatie serosal detail review pending.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 1.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

No overt pathology in the area of the residual prostate.

The area of the aortic trifurcation was free of pathology.

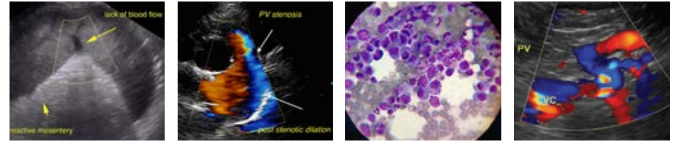
Normal renal size with asymmetrical margination was present in both kidneys. The renal cortex presented uniformly increased in echogenicity with uniform echotexture. The renal cortex appeared to be hypertrophied resulting in an altered cortex: medulla ratio. Marked loss of corticomedullary distinction was also present. The renal medullary volume was subjectively reduced. Pinpoint areas of medullary mineral noted in both kidneys. Small cortical cysts noted in both kidneys. Mild to moderate pyelectasia noted in the left kidney without overt evidence of left hydroureter. The right kidney measured 3.4 cm. The left kidney measured 3.3 cm.

Adrenal Glands

The bilateral adrenal glands were mildly prominent in size in light of patient body weight. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The right adrenal gland measured 1.7 cm length x 0.61 cm at the caudal pole. The left adrenal gland measured 1.4 cm length x 0.67 cm at the caudal 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.



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Liver

The liver exhibited subjective mild enlargement. Primarily maintained symmetrical capsule contour. Regional non-uniform hyperechoic to nodular parenchyma noted in the ventral liver measuring approximately 5-6 cm in diameter. A separate mildly expansive, non-homogeneous, hyperechoic intraparenchymal nodule was seen caudal to the gallbladder, measuring 2.8 cm in diameter. This nodule mildly distorts the hepatic capsule. Generalized hepatic parenchymal remodeling noted. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented wall thickening secondary to echogenic mucosa hypertrophy. Intact yet subjectively mild prominent wall layering noted. The stomach contained a mild amount of retained anechoic fluid.

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 omental masses, lymphadenopathy, or evidence of peritoneal free fluid.

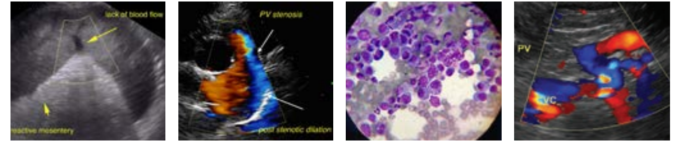
ULTRASONOGRAPHIC FINDINGS

- Bilateral marked chronic degenerative kidneys with cortical cysts
- Mild medullary mineral and left kidney pyelectasia
- Regional non-uniform hyperechoic to nodular ventral hepatic parenchyma with concurrent separate mildly expansive intraparenchymal macronodule – Inflammation, fibrosis, nodular hyperplasia, hematopoiesis, likely granuloma, neoplasia all potentials.
- Heterogeneous pancreas – Age related/patient variant, minor remodeling owing to potential previous inflammatory episode, chronic pancreatitis all potentials. No overt evidence of pancreatic neoplastic criteria, although insulinoma may be difficult to visualize sonographically.
- Subjective minor gastritis pattern, sonographically unremarkable small bowel

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The pyelectasia 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, screening hepatic FNA cytology in the area of the non-uniform to nodular hepatic parenchyma +/- separate hepatic nodule could be considered for further clarification.



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Insulin level on same serum samples warranted, if persistent hypoglycemia. Potentially, the persistent hypoglycemia may also be secondary to hepatic pathology.

Given the overall clinical presentation in combination with sonographic abnormalities, very guarded to unfavorable prognosis likely indicated.

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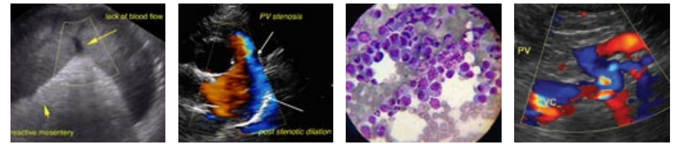

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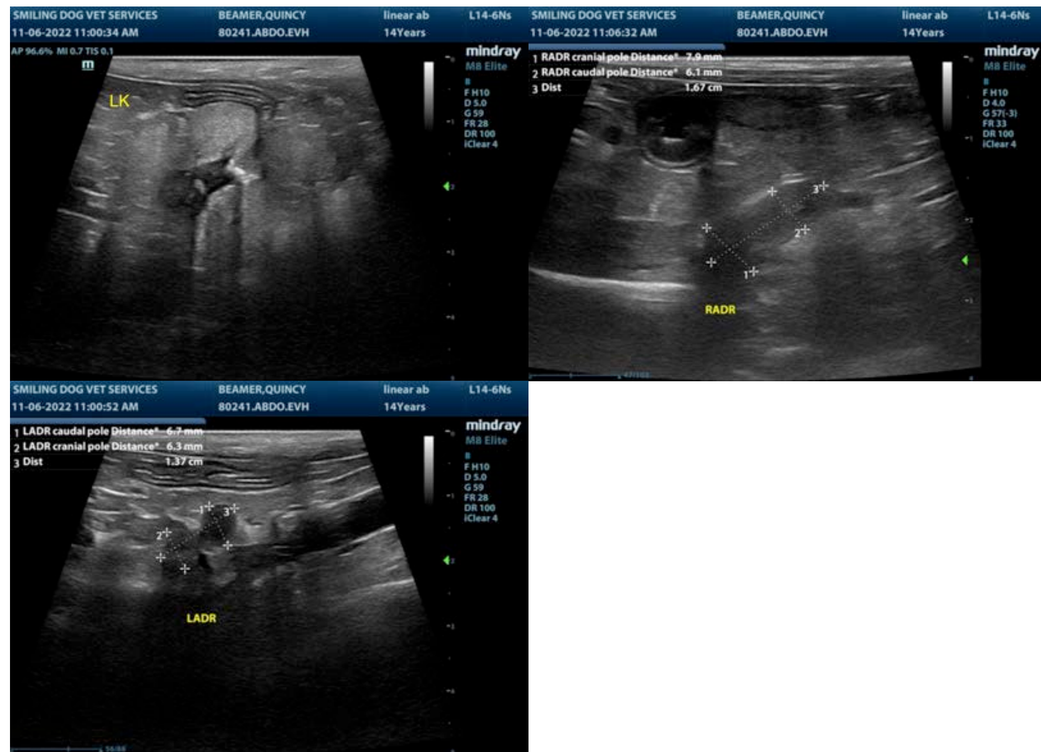

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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