

PATIENT

Raylan Enger

SPECIES

Canine

BREED

Labrador Retriever

SEX

M/N

AGE

8 years

WEIGHT

38 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dave Stasiuk RDMS,
RDMS

HOSPITAL NAME

Alpine 24/7

REFERRING VET

Alpine 24/7

INVOICE

20914

DATE

2/1/23

PRESENTING CLINICAL SIGNS

DKA. Lethargic. Severe PU/PD. Tense abdomen. Elevated SDMA, Glucose, ALT and ALP. Dog received butorphenol prior to scan.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 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 was noted.

The residual prostate was free of pathology.

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 loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pyelectasia was present. The left kidney measured 7.5 cm in length. The right kidney measured 7.8 cm in length. Pinpoint dystrophic medullary mineral was present.

Adrenal Glands

Both adrenal glands were borderline to mildly prominent in size, exhibiting mild nonhomogenous to discretely nodular parenchyma. No adrenal tumors were noted. The left adrenal gland measured 1.2 cm width at the caudal pole and 0.91 cm width at the cranial pole. The right adrenal gland measured 0.87 cm width at the caudal pole and 0.86 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.

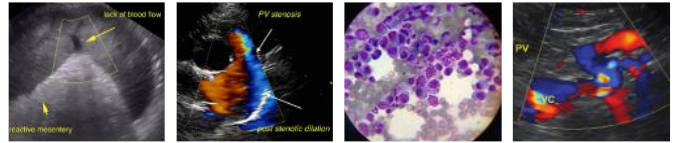
Liver/ Gallbladder

The liver was mildly enlarged and rounded with regionally asymmetrical hepatic capsule contour. Generalized hyperechoic nonuniform omentum was present. The liver exhibited moderate coarse echotexture. Intermittent discrete nondisruptive hypoechoic nodules were present, an example measured 2.0 cm in diameter.

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 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.



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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.

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

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Pancreas

The left limb, right limb, and base of the pancreas presented hypoechoic to heterogeneous echogenicity compared to adjacent omental fat. Mild asymmetrical capsule margination was present with mild regional peripancreatic to cranial abdominal hyperechoic omentum. No overt evidence of neoplasia.

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Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

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ULTRASONOGRAPHIC FINDINGS

- Mild chronic renal changes with pinpoint dystrophic medullary mineral- no evidence of pyelonephritis
- Bilateral prominent nonhomogenous discretely nodular adrenal glands
- Low grade to chronic active pancreatitis pattern
- Diabetic hepatopathy- subjectively benign

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Urine culture and sensitivity are recommended on sterile urine sample, especially if evidence of glucosuria. Full adrenal work up and assessment of systemic BP, especially if strong clinical concern for Cushings syndrome, is recommended (ACTH stimulation test is advised given the presence of diabetes, if adrenal testing is elected). Empirical therapy for pancreatitis and diabetic ketoacidosis, with as needed hepatogastrointestinal support, would be reasonable with close monitoring of serum glucose levels.

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RDCS

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Potential Causes of Diabetic Dysregulation

This is a suggestive checkoff list when faced with an unregulated diabetic patient:

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UTI

Dietary indiscretion/intolerance

Pancreatitis

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Hyperthyroidism/hypothyroidism

Exogenous steroids (including topical eye meds)

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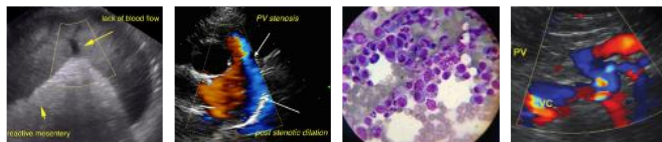
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Cushing's

Acromegaly

Owner compliance

Insulin quality issues



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Antibodies to insulin

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Underlying Neoplasia

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For an additional charge, internal medicine consult can be utilized through SonoPath.com. You can select the internal medicine drop down at <http://spa.sonopath.com/>.

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One of the world's top internists & SonoPath associate Dr. Remo Lobetti BVSc, MMedVet, PhD, DECVIM can evaluate your case through SonoPath. <https://sonopath.com/resources/sonopath-services/internal-medicine-teleconsultation-services>

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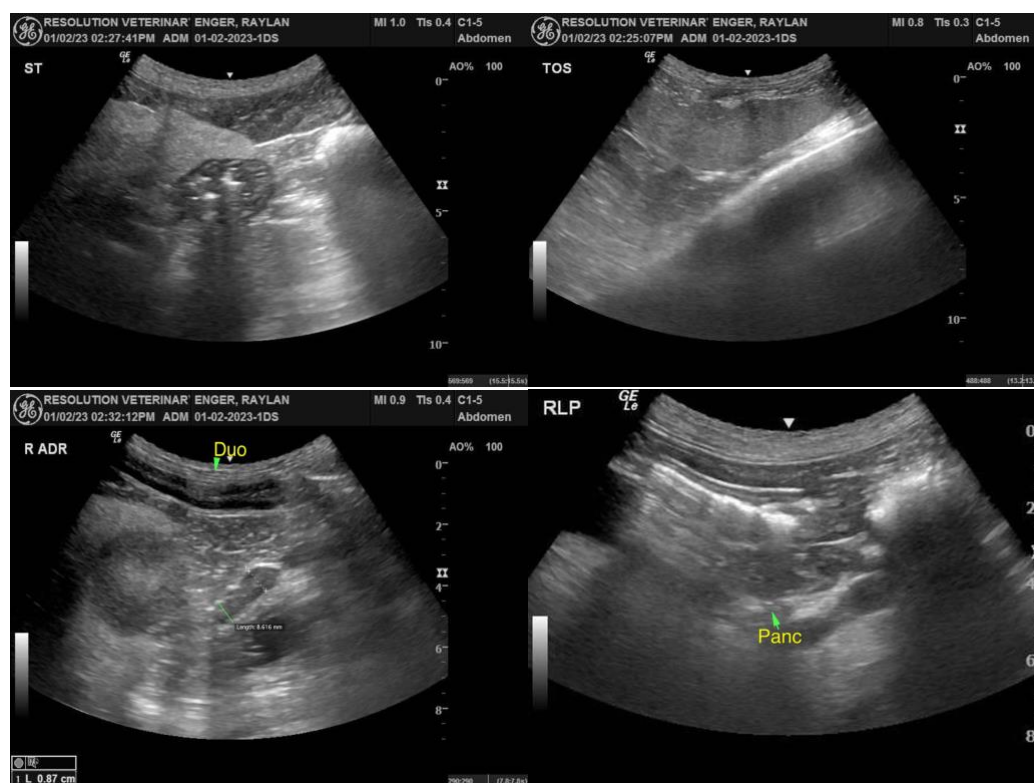
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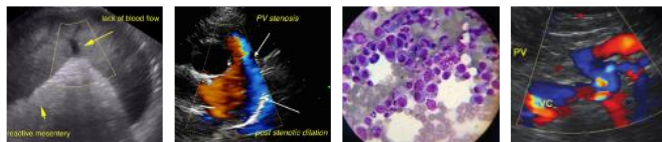
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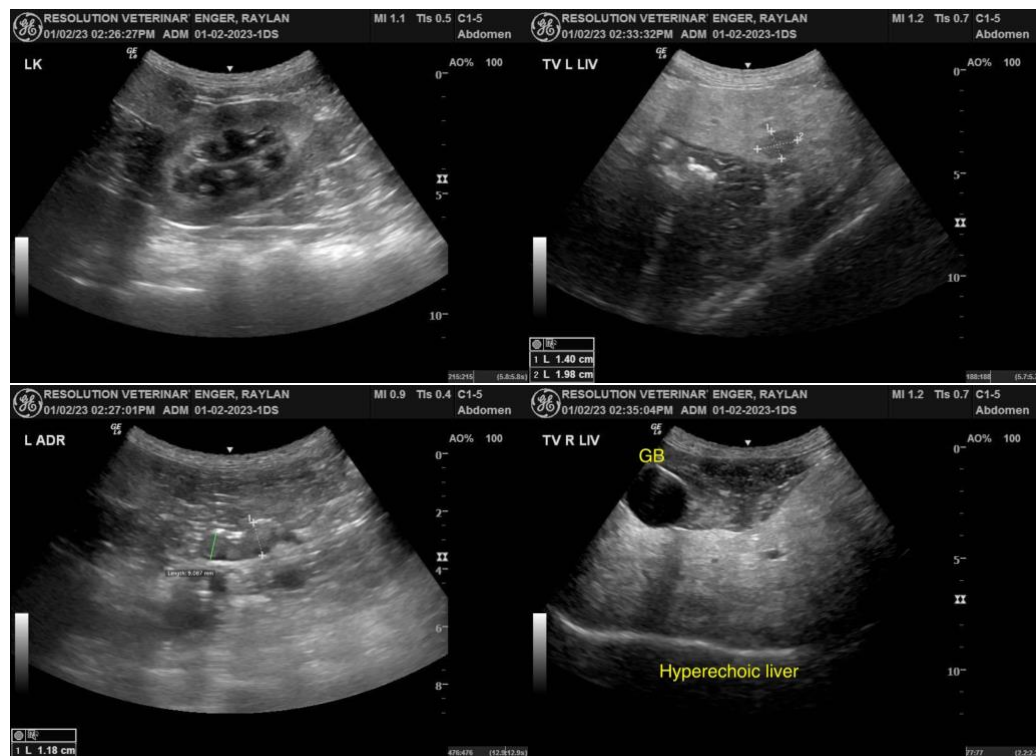
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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