IMAGING PERFORMED BY

SVS Mobile Imaging KC 816 - 401 - 5010

svsimagingkc@gmail.com

SonoPath

Clinical Sonography & Telecytology

EDUCATIONAL TELECONSULTATION SERVICES™

1-800-836-4266 info@sonopath.com SonoPath.com

PATIENT

Dozer Abbott

SPECIES

Canine

BREED

Minature Schnauzer

SEX

MN

AGE

7 years

WEIGHT

19 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Rachel Runnells, RVT

HOSPITAL NAME

SVS Imaging KC

REFERRING VET

Dr. Michelle Hall

INVOICE

13325

DATE

2/11/22

PRESENTING CLINICAL SIGNS

P presented for second opinion. Has had the gall bladder removed, after that p got SARDs. Since then P has been pot bellied. Rads were sent off -Consideration would be given to cranial organomegaly and intra-abdominal fat. Low dose dex was done at rDVM and came back WNL.
Abnormal PE/Chem/CBC/UA Results: Blind, pot bellied appearance that is tight during palpation. BW was sent off: Mild anemia, SDMA elevation 15, phos elevated 6.6, potassium elevated 5.5, ALP high 2,314, Amylase and lipase are elevated as well. T4 is at 0.7.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 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.

No overt pathology was noted in the area of the residual prostate.

The area of the aortic trifurcation was free of pathology.

Normal size and margination were present in the kidneys. Mild altered cortex / medulla ratio owing to subjective mild generalized cortex hypertrophy with mild uniform increased cortex echogenicity was present in both kidneys. Pinpoint areas of medullary mineral were present in both kidneys. The left kidney measured 5.7 cm in length. The right kidney measured 5.6 cm in length. No evidence of retroperitoneal inflammation or effusion was noted.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.61 cm width at the caudal pole and 0.61 cm width at the cranial pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.49 cm width at the caudal pole and 0.54 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. The spleen exhibited mild generalized enlargement.

Liver/ Gallbladder

The liver presented moderately enlarged in size. The parenchyma of the liver exhibited mild uniform increased echogenicity compared to the spleen and renal cortices. The echotexture of the liver parenchyma was uniform with a mild coarse echotexture. The capsule of the liver was symmetrical in margination. The hepatic and portal vasculature were normal in appearance without signs of

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congestion. The gallbladder was not present owing to a previous cholecystectomy. No overt pathology was noted in the aera of the previous gallbladder or in the area of the common bile duct.

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. The duodenum wall width measured 0.45 cm.

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

Pancreas

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

Free Abdomen

No overt lymphadenopathy was present. Small pockets of very scant peritoneal free fluid were noted. The omentum was of uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Nonspecific chronic renal changes with pinpoint medullary mineral
- Splenomegaly exhibiting uniform parenchyma and symmetrical contour
- Hepatomegaly with generalized mild parenchyma hyperechogenicity
- Heterogeneous pancreas
- Sonographically unremarkable gastrointestinal tract
- Intermittent small pockets of scant peritoneal free fluid

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Further renal staging to include urine C/S and protein: creatinine ratio on sterile urine sample may be considered.

The appearance of the liver was nonspecific with potential considerations including vacuolar hepatopathy, chronic hepatitis / cholangiohepatitis, lipidosis, or other hepatopathy while the possibility of hepatic neoplasia, although thought less likely, cannot be definitively excluded. Likewise, the splenomegaly may indicate reactive hyperplasia or hematopoiesis, given the presence of anemia, incidental splenitis, with less likely potential for splenic neoplasia.

Assuming normal clotting status, ultrasound guided hepatosplenic FNA using a 25-gauge needle could be considered primarily to assess for hepatic Inflammatory cells and ensure benign changes are present.

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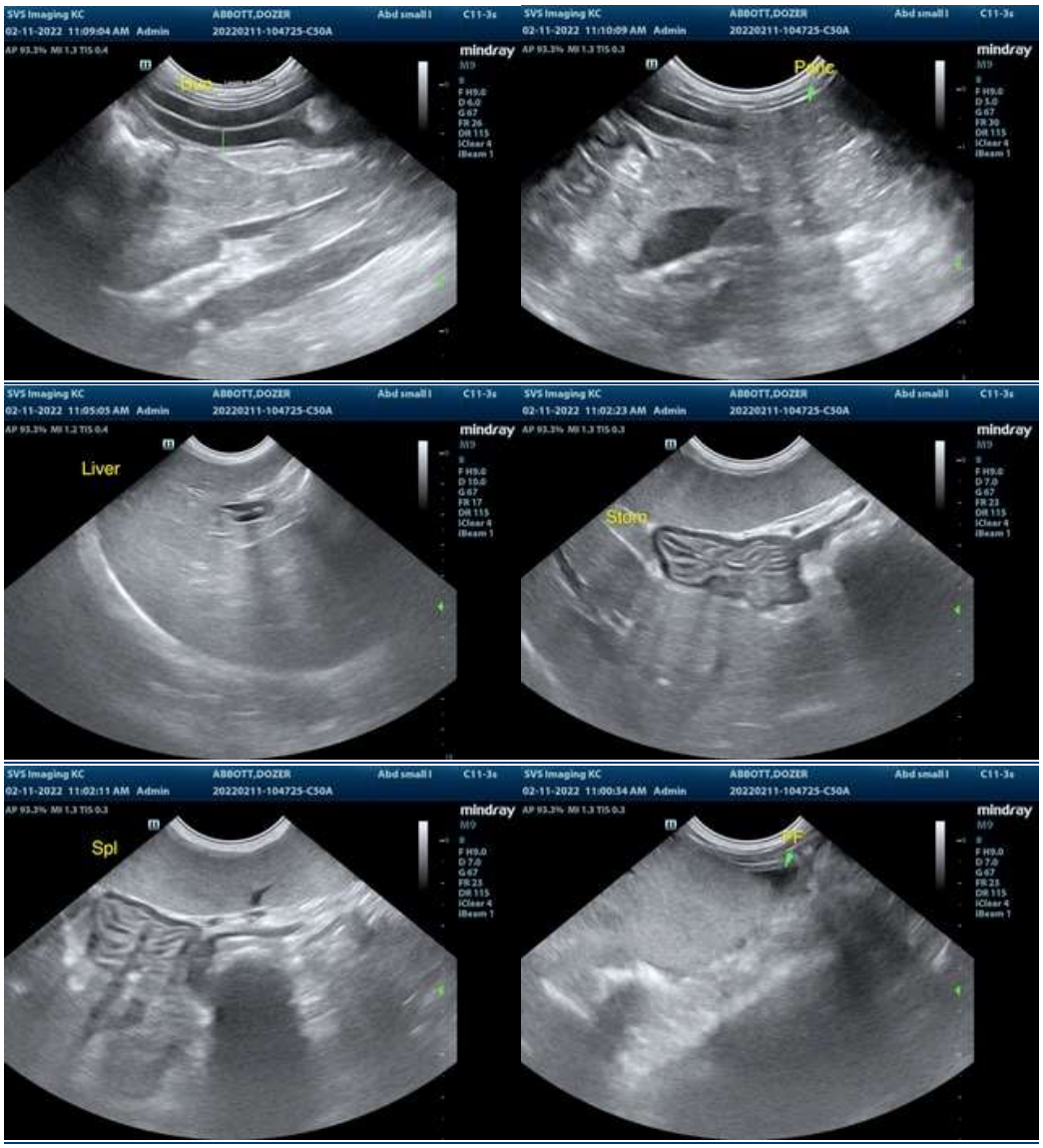
Low-grade to chronic pancreatitis which may present as essentially sonographically normal would be suspected if evidence of cranial abdominal or subxiphoid discomfort on palpation. Further assessment may include a Spec cPl or a GI panel to include PLI/TLI/Cobalamin/Folate to rule out occult gastrointestinal disease.

If strong clinical suspicion for hyperadrenocorticism, potential recheck LDDST or screening UCCR could be considered.

Hepatosupportive medications including Denamarin and Ursodiol and as-needed gastrointestinal support or therapy for chronic pancreatitis may be considered.



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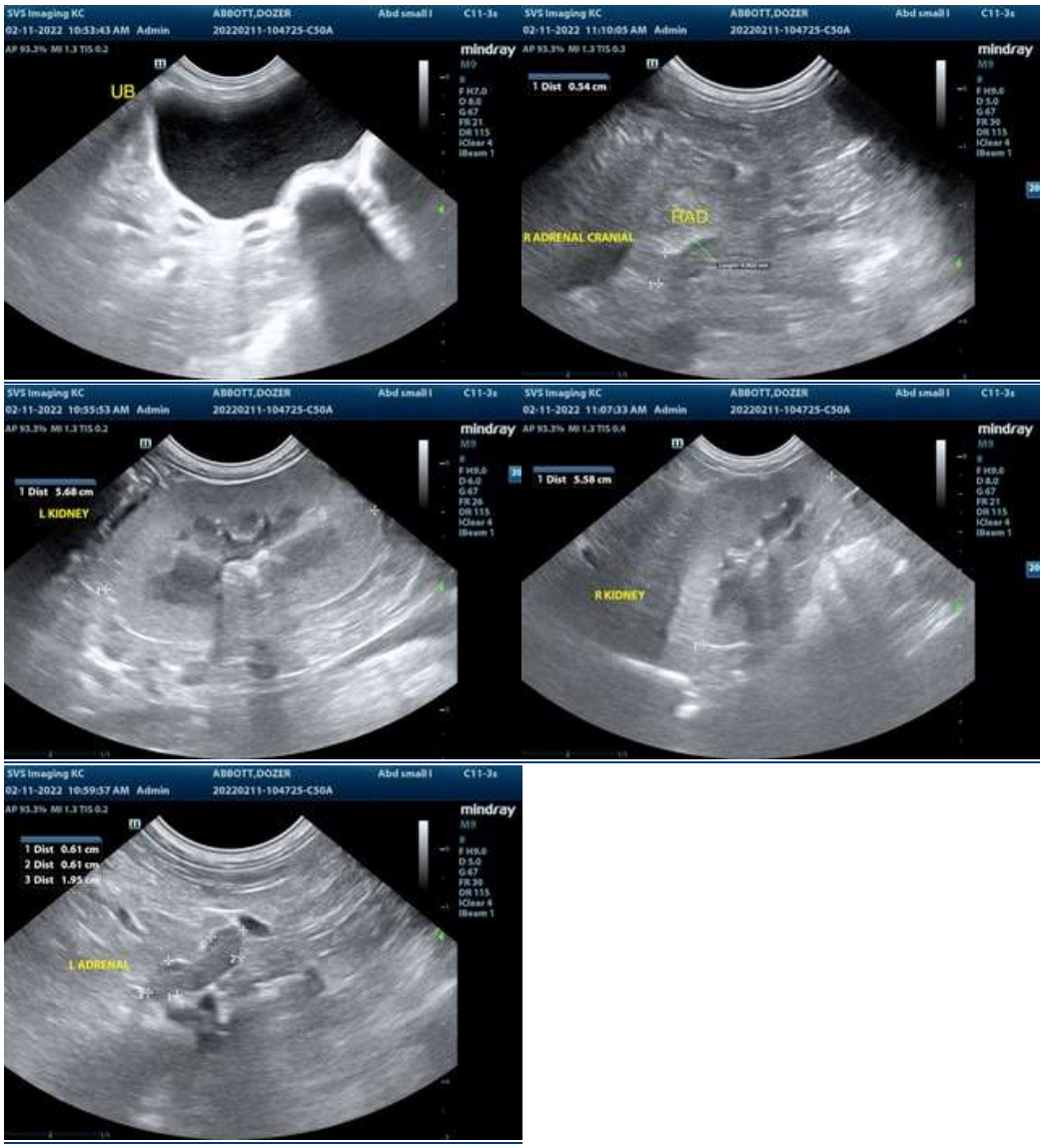

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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