PATIENT

Fenway Olivieri

SPECIES

Canine

BREED

Cockapoo

SEX

FS

AGE

15 years

WEIGHT

20.3 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Pamela Harrigan, RDCS

HOSPITAL NAME

Norfolk County VS

REFERRING VET

Amelia Ragon, DVM

INVOICE

14339

DATE

3/17/22

PRESENTING CLINICAL SIGNS

Presented for hyporexia and vomiting x 2 weeks. BW = Stage 3 kidney disease and elevated liver enzymes. History hypertension (average in hospital 170 mmHg). UA and culture pending. Lepto vaccinated. Started enalapril 5 mg BID.
Abnormal PE/Chem/CBC/UA Results: HCT 36; BUN 93; creat 3.7; ALT 291; ALP 495; AST 112

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0cm 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 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. Mild loss of corticomedullary distinction was also present. The renal medullary volume was subjectively reduced. Focal to multiple cortical cysts were present in both kidneys. Mild pyelectasia was noted in both kidneys as well as pinpoint to focal areas of medullary mineral. The left kidney measured 5.4 cm in length. The right kidney measured 5.0 cm in length.

Adrenal Glands

The Left adrenal gland was mildly prominent in size with nonhomogeneous to indistinctly nodular parenchyma with potential evidence of parenchymal expansion into the area of the phrenicoabdominal vein. The left adrenal gland measured 0.89 cm width in the cranial pole and 0.71 cm width in the caudal pole.

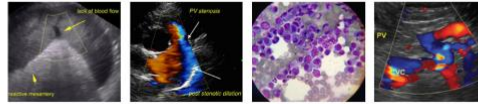
The right adrenal gland was normal in size. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The right adrenal gland measured 0.52 cm width in the cranial pole and 0.48 cm width in the caudal pole.

Spleen

The spleen was normal in overall size and contour with generalized mild parenchyma heterogeneity. A solitary, subtly echogenic, non-expansive nodule was noted in the media spleen, measuring 2.0 cm in diameter.

Liver/ Gallbladder

The liver was subjectively normal in size, structure, and contour. The liver exhibited generalized mild nonuniform increased parenchyma echogenicity. Multiple, variably sized, hypoechoic macronodules to small masses were present. An example of a micronodule measured 2.0 cm in diameter. An example of a small mass measured 3.6 cm. in diameter. The hepatic and portal vasculature were normal in appearance without signs of congestion.



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The gallbladder was non distended in size with moderate, nondependent, nonorganized, subjectively mobile gallbladder debris. The gallbladder was otherwise normal. No evidence of peripheral gallbladder inflammation. The cystic duct and common bile ducts were normal without evidence of dilation.

Gastrointestinal

The stomach presented intact yet mild prominent wall layering, primarily in the area of the antrum and pylorus. The lumen of the stomach was empty with mild luminal gas and without evidence of retained ingesta, fluid or foreign material. The pylorus wall measured 0.41 cm.

The duodenum presented intact yet mild prominent wall layering owing to propensity for prominent duodenal mucosa as well as minor duodenal mucosal speckling. The duodenum wall measured 0.50 cm. The jejunum and ileum to the level of the colon were overtly normal.

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

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 variable parenchymal swelling and mild peripancreatic reactivity / inflammation. No overt evidence of neoplasia.

Free Abdomen

Intermittent, enlarged perigastric lymph nodes were present. These lymph nodes were homogenous, mildly hypoechoic and smoothly marginated. A normal width: length ratio was maintained (<0.5). Evidence of mild perigastric reactive mesentery noted.

A solitary probable cystic lymph node present adjacent to the duodenum, measuring 1.1 cm in diameter. Potential for pancreatic or omental cyst possible.

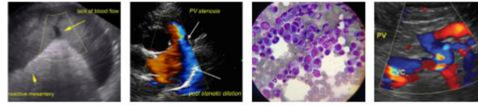
No free fluid was noted.

ULTRASONOGRAPHIC FINDINGS

- Hepatopathy, exhibiting multifocal hypoechoic macronodules to small masses- hematopoiesis, nodule to regenerative hyperplasia, neoplasia possible.
- Mild to moderate gallbladder debris (non-mucocele)
- Nonspecific non-expansive splenic nodule- suspect benign myelolipoma
- Nonspecific chronic degenerative renal changes, exhibiting cortical cysts, nonobstructive medullary mineral and mild bilateral pyelectasia
- Mild active to chronic active pancreatitis pattern with suspect secondary gastroduodenitis, intermittent subjectively benign to potential mild inflamed gastric and cystic omental lymph node
- Mildly prominent to nonhomogeneous left adrenal gland with potential early phrenicoabdominal vascular invasion

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Assuming normal clotting status, hepatic nodule to small mass FNA +/- screening splenic FNA, using a 25-gauge needle warranted for screening cytology. In addition to pending urine culture and sensitivity,



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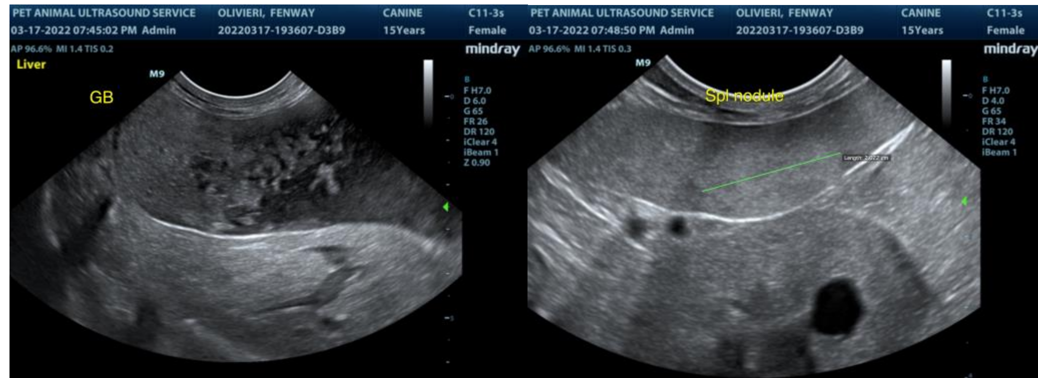
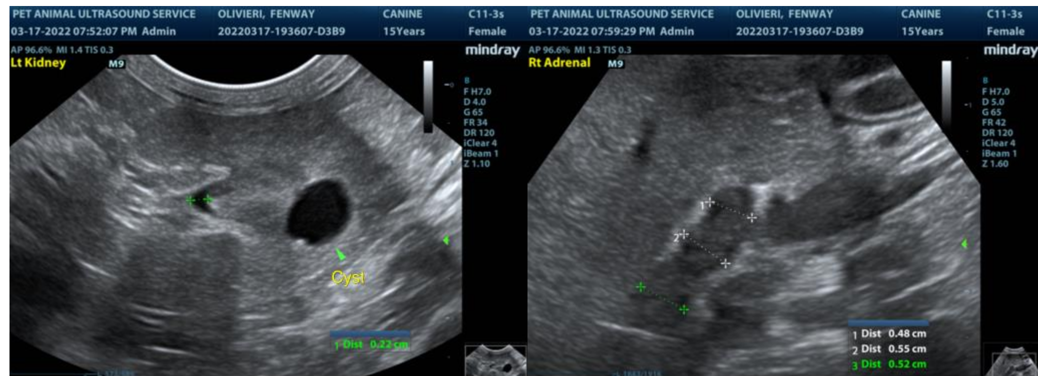
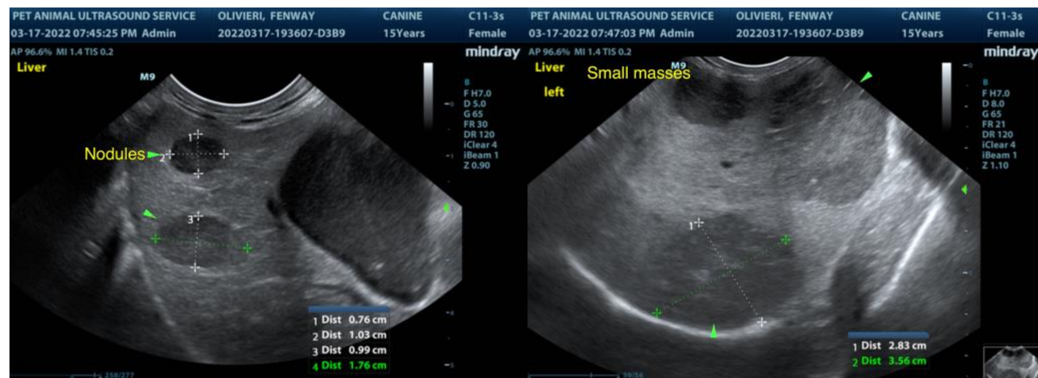
baseline UPC is suggested. The hypertension in this patient maybe owing to CKD, although the possibility of emerging left adrenal neoplasia, such as pheochromocytoma cannot be excluded. Sonographic monitoring of the left adrenal gland for evidence of progressive enlargement, parenchymal changes or vascular invasion recommended.

Empirical therapy for pancreatitis and gastroduodenitis would be reasonable.







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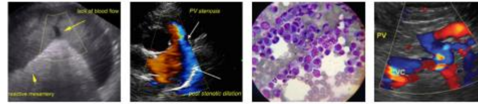

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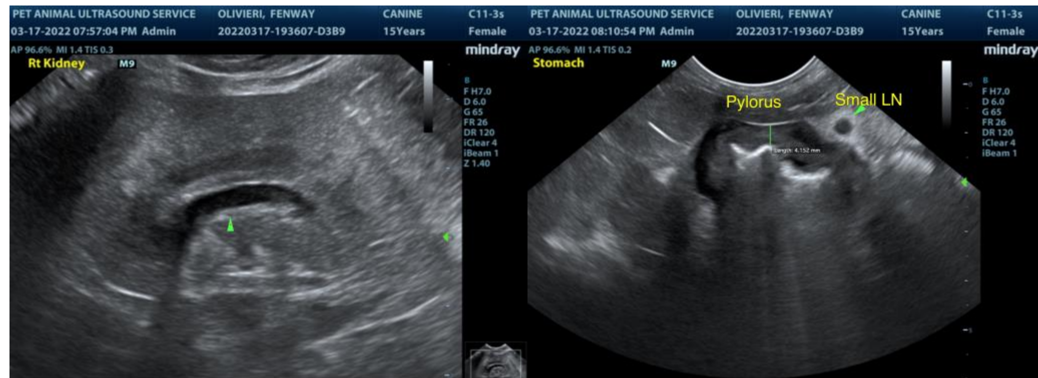

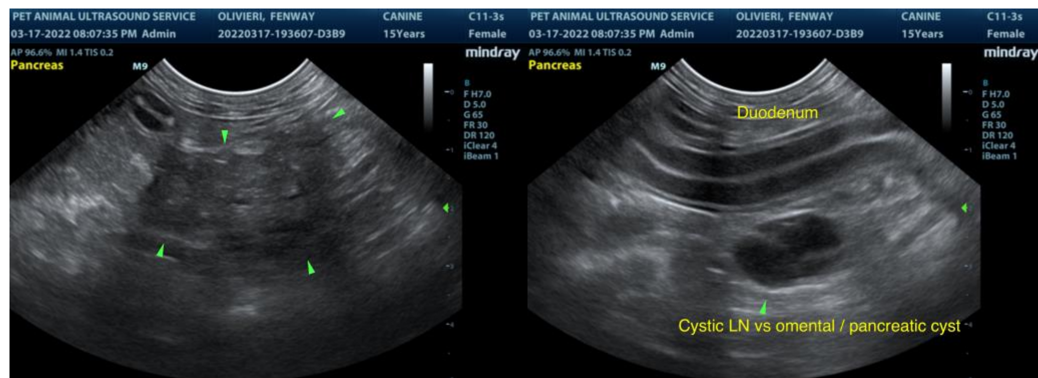

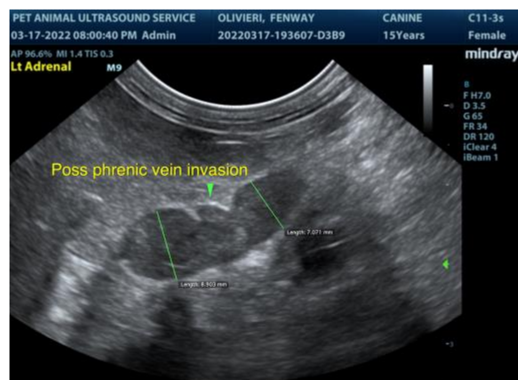

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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