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Clinical Sonography & Telecytology
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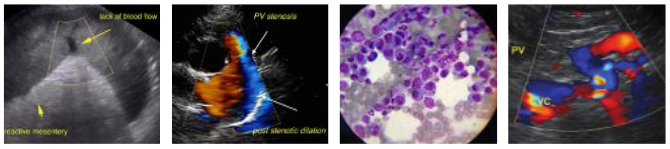


SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Butterball Fabiseski

SPECIES

Canine

BREED

Pekingese

SEX

Neutered Male

AGE

11 Years

WEIGHT

19.3 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Michelle Bartus

HOSPITAL NAME

Valley Veterinary Services

REFERRING VET

Dr. Michelle Bartus

INVOICE

14475

DATE

3/24/22

PRESENTING CLINICAL SIGNS

History: Chronic, intermittent diarrhea for a few months. Will not have a BM a few days, then have diarrhea. No vomiting. No appetite change. No weight loss. Past history of collapsing trachea; has occasionally passed out from extreme excitement (years ago).

Abnormal PE/Chem/CBC/UA Results: Negative fecal analysis. Negative Giardia. Slightly high RBC 9.36 (5.65-8.87), rest of CBC & chemistries are WNL. Abdominal radiographs NSF.

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. Very minor nondependent particulate sediment, likely indicative of minor cellular or crystalline debris. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted. Aortic trifurcation was normal.

No overt pathology in the area of the residual prostate.

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 mild to moderate loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. Pinpoint medullary dystrophic mineral noted in both kidneys. The left kidney measured 4.3 cm in length. The right kidney measured 4.6 cm in length.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.44 cm width at the caudal pole and 0.9 cm width at the cranial pole. A well-defined, hyperechoic nodule was present in the left cranial adrenal gland with mild associated symmetrical capsule expansion. The nodule did not exhibit signs of mineralization or vascular invasion. The nodule measured 1.1 cm x 0.9 cm.

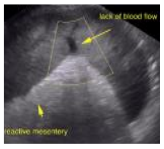
The right adrenal gland was enlarged in size, exhibiting nonhomogeneous to mineralized parenchyma. An area of cranial right adrenal mineralization was present, measuring approximately 0.8 cm. The right adrenal gland measured2.2 cm x 1.2 cm.

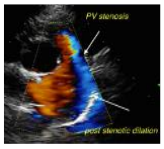
Spleen

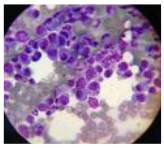
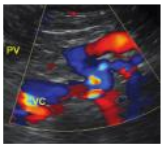
The spleen exhibited primarily finely textured parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Mild generalized parenchyma heterogeneity was present without evidence of nodular changes. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. The parenchymal heterogeneity is likely consistent with benign changes such as extramedullary hematopoiesis or age-related remodeling with minor potential for inflammatory or neoplastic disease.

Liver

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to





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benign parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion.

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 contained mild retained ingesta/chyme without signs of obstruction or foreign material. The stomach was otherwise normal. The gastric body wall measured 0.27 cm.

The small intestine presented intact wall layering and primarily maintained 1:3 muscularis/mucosa ratio. Minor nonspecific duodenal to duodenojejunal mucosal speckling was present. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material. The duodenum wall measured 0.42 cm. The jejunum wall measured 0.30 cm.

Normal visible colon wall layers were present. The colon contained generalized semi formed to soft feces, consistent with reported diarrhea.

Pancreas

The left limb 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

No overt lymphadenopathy or effusion was present.

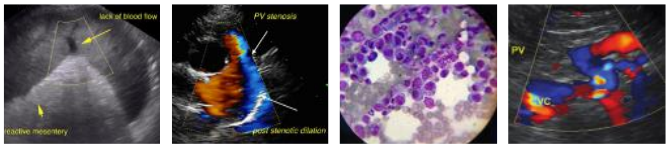
ULTRASONOGRAPHIC FINDINGS

- Left adrenal nodule
- Right adrenomegaly, exhibiting nonhomogeneous to mineralized parenchyma
- Suspect, segmental to generalized enteropathy, possible inflammatory bowel
- Overtly normal colon, containing generalized semi formed to soft feces
- Chronic active pancreatitis pattern with subtle peri-pancreatic reactive mesentery

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Both mild to chronic active pancreatitis as well as inflammatory enteropathy/enterocolonopathy, both. may be contributing to the patients recurrent to intermittent diarrhea. Further assessment may include a GI panel, to include PLI, TLI, cobalamin and folate. Empirically, hydrolyzed diet trial, high colony count probiotics (such as Proviable), broad spectrum deworming (even with negative fecal analysis) and antibiotic trial with assessment of clinical response would be reasonable. Possible long-term dietary therapy may be indicated.

Both of the adrenal glands in this patient are abnormal. The left adrenal nodule may indicate functional versus nonfunctional adenoma, lipogranuloma, hyperplasia, while the possibility of bilateral adrenal tumors (i.e., pheochromocytoma, adenocarcinoma or other) with highly likely neoplastic right adrenal gland may be possible. Overt evidence of vascular invasion was not evident yet cannot be definitively



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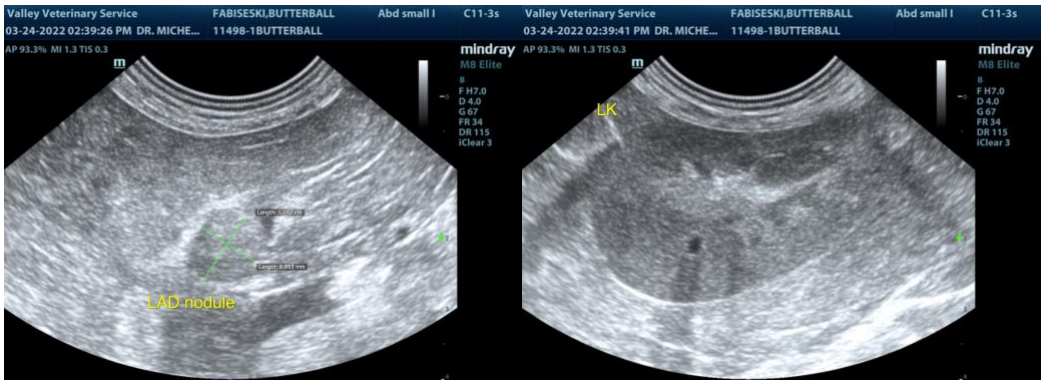
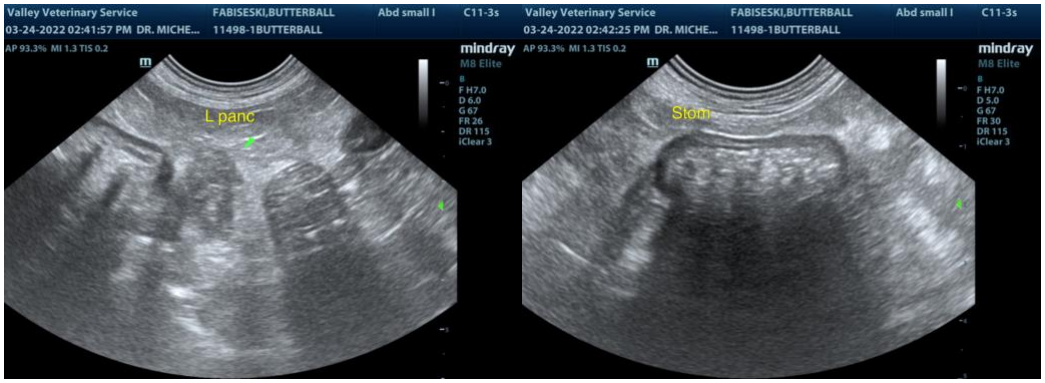
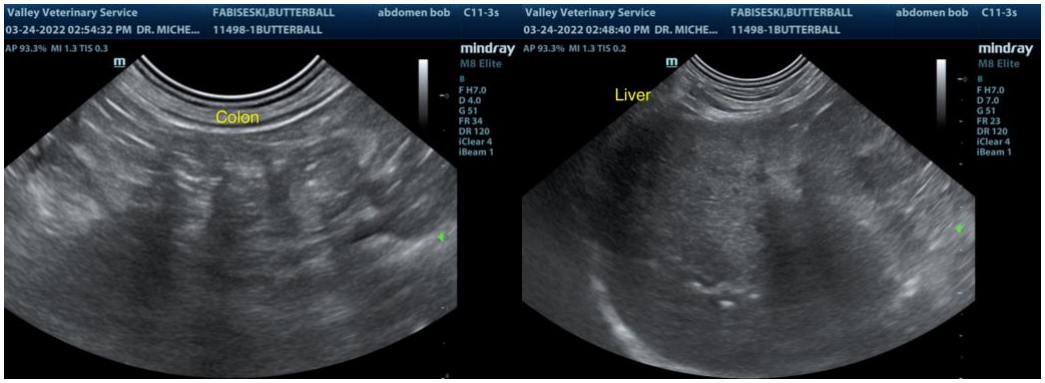
excluded. Full adrenal work up could be considered, if clinical signs consistent with adrenal hyperfunction are present. Screening blood pressures suggested to assess for evidence of hypertension, which may allude to a pheochromocytoma. Abdominal CT is likely ideal for further assessment if possible.







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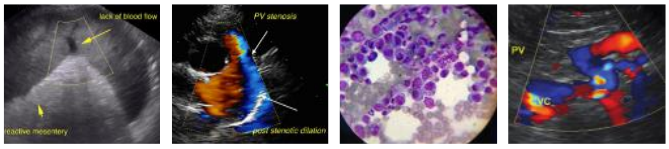

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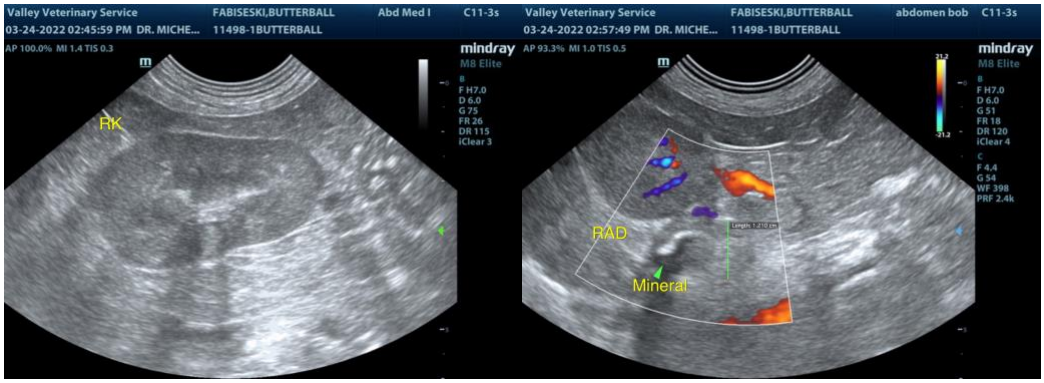

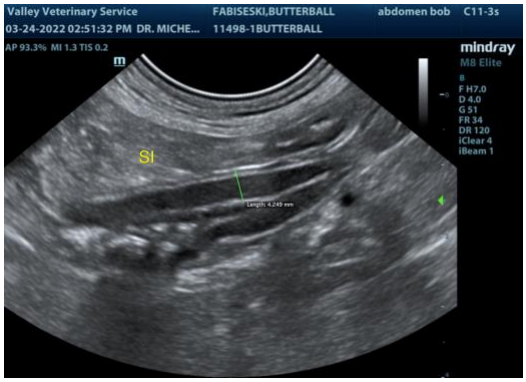

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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