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Clinical Sonography & Telecytology
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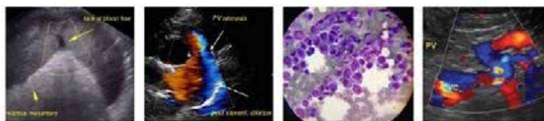


THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Dawson Dougherty

SPECIES

Canine

BREED

Sheltie

SEX

Intact Male

AGE

12 Years

WEIGHT

8.7 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Colborne Vet Clinic

REFERRING VET

Dr. Richards

INVOICE

46541

DATE

4/10/23

PRESENTING CLINICAL SIGNS

Owner has noticed not eating as well and knuckling with one front leg. Seems weak in hind end.PE - QAR, BCS2/5 very thin, has lost weight since November. MM pink, CRT less than 2 seconds, MM tacky, no palpable masses etc. chest sounds normal. Decreased proprioception R front leg, rest of limbs normal. Dehydrated, weight loss, resists dorsoflexion of neck. Started Vetergesic, Metronidazole and Cerenia. Did eat a small meal this morning very early. Rule out neoplasia, pancreatitis.

Abnormal PE/Chem/CBC/UA Results: ALK phos 355, Creatinine 145, SDMA 20, Potassium 5.7, Sodium/Potassium ratio 26, Cholesterol 16.30, Triglycerides 5.10, Amylase 1591, Precision PSL 168, Platelet count 528. Please see bloodwork attached.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and cystourethral junction 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.

The area of the aortic trifurcation was free of pathology.

The prostate was enlarged in size with intact, symmetrical capsule contour. The margins of the gland were intact and able to be differentiated from the surrounding tissue. The prostatic parenchyma was mildly echogenic to heteroechoic without parenchymal mineralization. Several small cysts were noted in the parenchyma. The prostate measured approximately 4.0 cm in diameter.

Normal size and margination was 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 pelvic dilation was present. Pinpoint hyperechoic cortical foci were noted, which may indicate suspect pinpoint cortical microinfarction with potential for pinpoint cortical fibrosis or mineralization. The left kidney measured 5.1 cm. The right kidney measured 5.7 cm.

Adrenal Glands

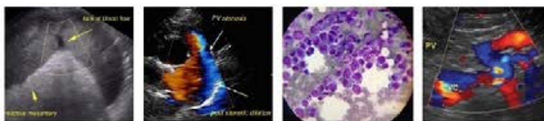
The adrenal glands were indistinctly visualized owing to isoechoic echogenicity compared to adjacent periadrenal tissue. Borderline prominent bilateral caudal pole widths in light of body weight. The left adrenal gland measured 0.60 cm at the caudal pole. The right adrenal gland measured 0.70 cm at the caudal pole. No overt adrenal tumors.

Spleen

The spleen was normal in size and contour with generalized mild parenchyma heterogeneity. Pinpoint hyperechoic splenic foci were noted, which may indicate pinpoint areas of splenic microinfarction, fibrosis, or mineralization. No splenic tumors.

Liver

The liver was mildly enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with primarily anechoic luminal content. Mild non-organized echogenic debris



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present. No evidence of gallbladder or peripheral gallbladder inflammation. 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.

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 overt lymphadenopathy or peritoneal effusion was present.

The left and right testicles were both normal in size. Thinly walled left testicular intraparenchymal cyst noted measuring 1.5 cm in diameter. The testicular cyst contained anechoic fluid.

ULTRASONOGRAPHIC FINDINGS

- Benign prostatic hyperplasia with small parenchymal cysts – minor potential for prostatitis. No overt prostatic neoplastic criteria.
- Left testicular cyst – benign.
- Moderate chronic renal changes with possible cortical microinfarction
- Age related spleen, benign
- Subjective benign hepatopathy – sonographically suggestive of vacuolar hepatopathy pattern
- Mild gallbladder debris (non-mucocele)
- Pancreatic remodeling, no sonographic evidence of active pancreatitis or pancreatic neoplastic criteria.
- Sonographically unremarkable gastrointestinal tract.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Overall, largely geriatric abdomen without evidence of significant visceral pathology. Potential for low-grade pancreatitis if evidence of cranial abdominal or subxiphoid discomfort on palpation. The patient's clinical signs are not overtly suggestive of primary adrenal disease. Screening blood pressure to assess for evidence of hypertension suggested. GI panel to include PLI, TLI, cobalamin and folate could be considered to assess for occult intestinal disease, as well as potential low-grade pancreatitis as a contributing factor to the weight loss. No evidence of intraabdominal neoplastic criteria/tumors. Potential extraabdominal disease (i.e., neurological disease), given the patient's clinical signs, may be a potential primary contributing factor in this patient.

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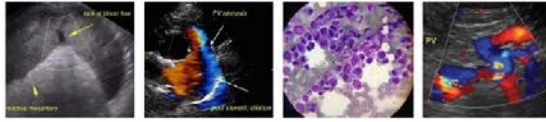

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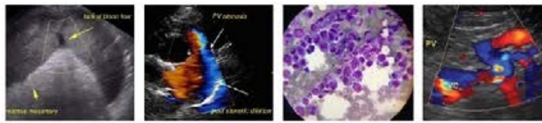

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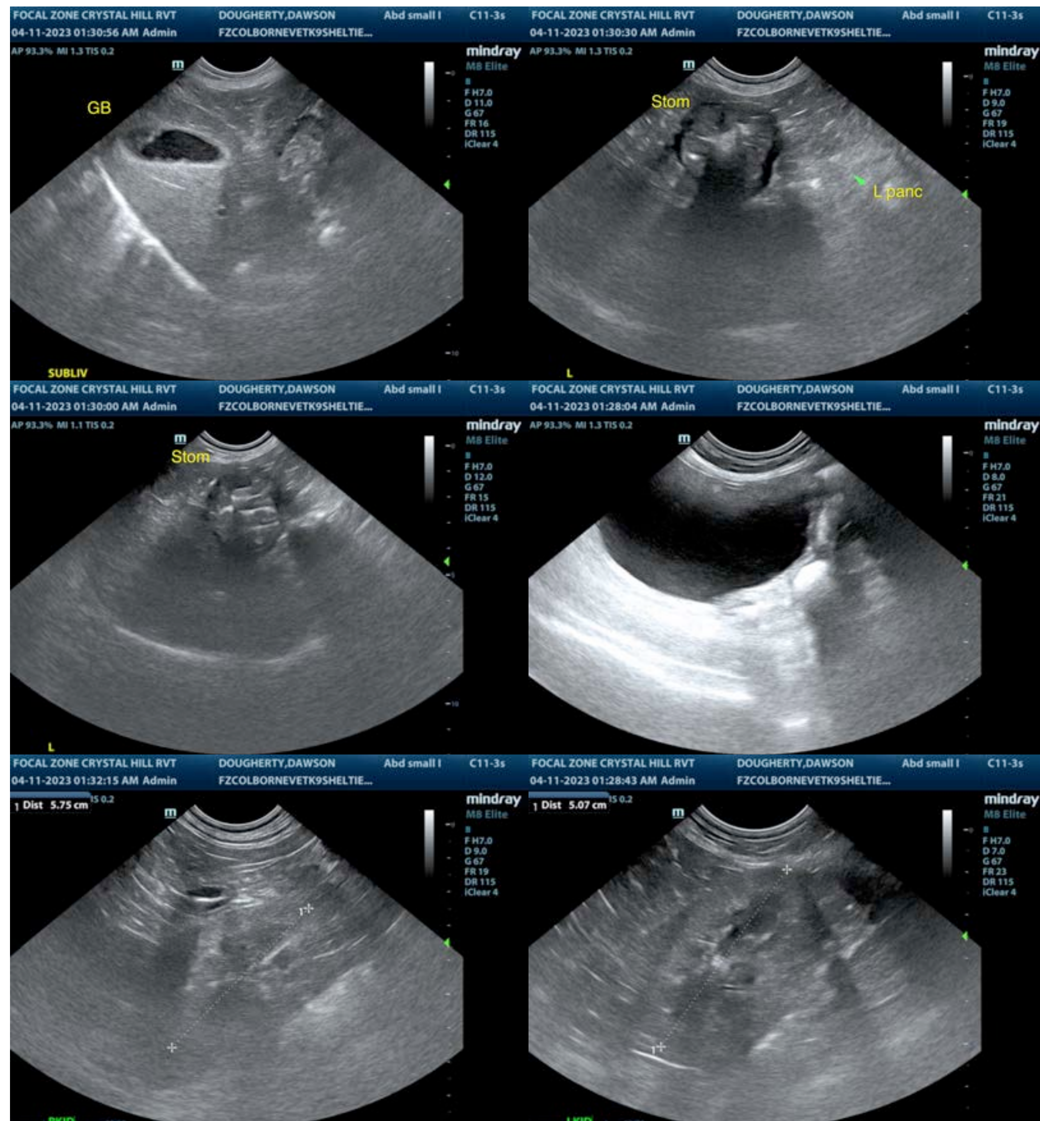

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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