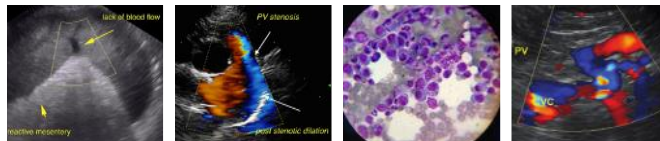
SonoPath

Clinical Sonography & Telecytology

EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Lola Bromley

SPECIES
Canine

BREED
Tibetan Terrier

SEX
FS

AGE
12yr

WEIGHT
49lb

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

IMAGING PERFORMED BY
Sorbo

HOSPITAL NAME
Mill Brook Animal Clinic

REFERRING VET
Sorbo

INVOICE
13465ag

DATE
04/14/2023

PRESENTING CLINICAL SIGNS

Sudden vomiting and diarrhea this morning. Tenesmus vs urinary straining vs both all day.

Abnormal PE/Chem/CBC/UA Results: Cranial abdominal distension (subjective), sunken caudal abdomen. ALP 828, the rest of cbc/chem wbl. Urine by cystocentesis: Cocci and rbcs and leukocytes in the urine. Urine protein 500mg/dL (active sediment). No fecal submitted. -Enterocolitis of unknown origin - possibly stress as a P is high stress per Os -Bacterial cystitis (may have caused the stress).

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder was normal in size and tone. Mildly prominent apical urinary bladder wall exhibiting subtle asymmetrical luminal surface contour was present measuring 0.5 cm in width. The trigone, cystourethral junction, and visible pelvic urethra to a depth of 3 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.

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 loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 5.4 cm in length. The right kidney measured 6.0 cm in length.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

A mixed echogenic mildly expansive irregular left adrenal nodule measuring 2.1 cm x 1.7 cm was present. Subjective maintained yet mildly asymmetrical left adrenal capsule was present.

The right adrenal gland exhibited mild variable enlargement and mild capsule asymmetry. Mild non-homogenous right adrenal parenchyma was present. The right adrenal gland measured 1.1 cm width at the caudal pole and 2.8 cm length.

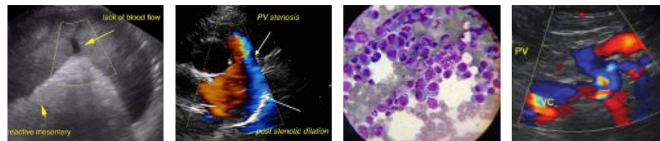
Spleen

The spleen exhibited primarily finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Multifocal to coalescing well-defined, symmetrical, hyperechoic nodules were present throughout the medial parenchyma, an example measuring 1.9 cm in diameter. 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 or neoplastic changes were not noted. The hyperechoic nodules tend to trend benign and are most consistent with benign hyperplasia or myelolipomas.

Liver/Gallbladder

The liver presented 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 and mild echogenic debris. The cystic and common bile ducts were normal.

Gastrointestinal



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The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained moderate retained anechoic fluid and luminal gas with no signs of ileus, obstruction or foreign material.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. Minor segmental non-obstructive ileus was present. The lumen of the small intestine was empty with no signs of obstruction or foreign material.

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

Pancreas

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

Free Abdomen

No omental masses, overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Minor apical cystitis pattern.
- Non-specific mild chronic renal changes.
- Bilateral variably enlarged non-homogenous/nodular adrenal glands.
- Benign/coalescing splenic nodules-consistent with benign myelolipomas, potential for emerging splenic mineralization.
- Vacuolar hepatopathy pattern-subjectively benign.
- Minor gallbladder debris (non-mucocele).
- Gastroenteritis pattern with hypomotile stomach.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A full urinary workup including UA and C/S is suggested.

The bilateral adrenal glands may indicate functional vs nonfunctional adenomatous change or benign hyperplasia with potential for emerging neoplasia in the left adrenal gland possible. A screening BP is advised to assess for evidence of hypertension which may allude to emerging adrenal neoplastic criteria i.e., pheochromocytoma. Adrenal testing suggested if clinical signs consistent with Cushing's syndrome are present/arise. Sonographic monitoring of the bilateral adrenal glands for evidence of progression with initial recheck in 4-6 weeks would be ideal. No obvious evidence of adrenal vascular invasion.

Dietary indiscretion / food hypersensitivity, occult parasitism, structurally insignificant inflammatory gastroenteropathy or low grade to chronic pancreatitis both of which may appear sonographically normal are all potentials. Occult infiltrative intestinal neoplasia thought less likely. As needed GI support should prove beneficial.

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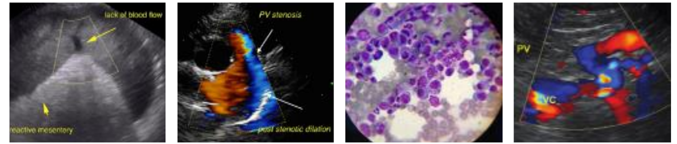

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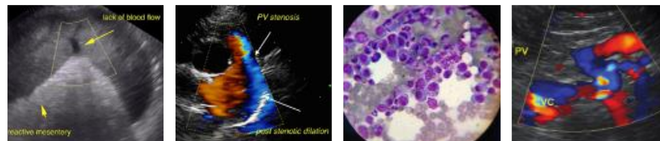

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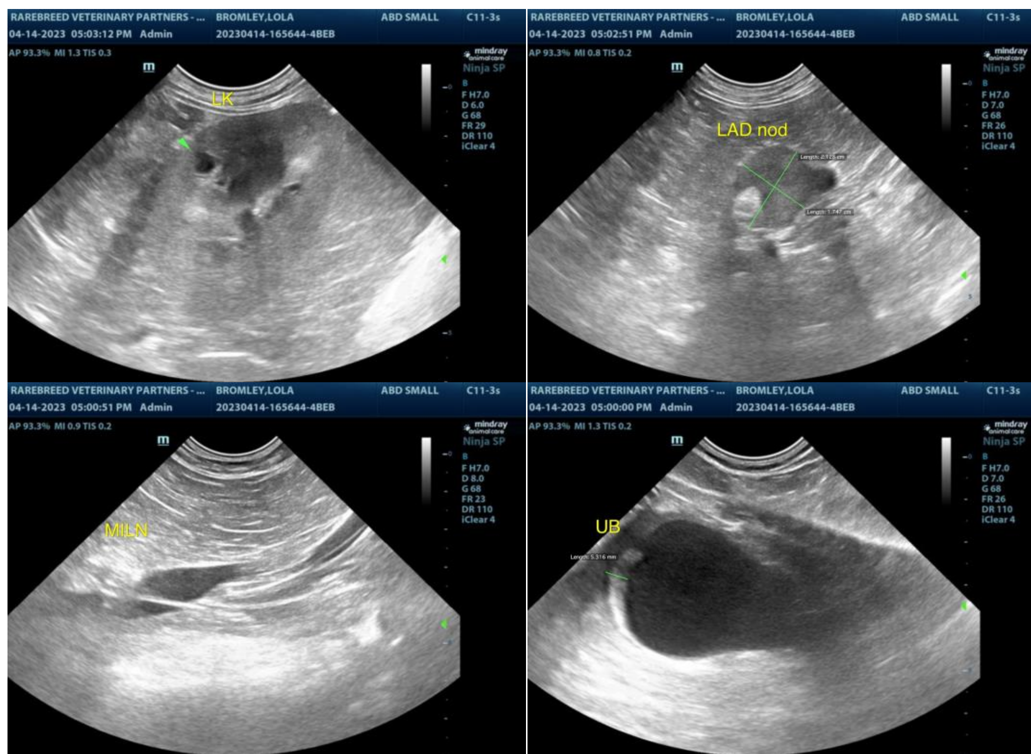

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

mac.daniel@sonopath.com