



PATIENT

Kerry Leon

SPECIES

Canine

BREED

Bichon Frise

SEX

Male

AGE

14 years

WEIGHT

13.8 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Paul Kim

HOSPITAL NAME

Ridgefield Park AH

REFERRING VET

Dr. Paul Kim

INVOICE

16696

DATE

4/25/23

PRESENTING CLINICAL SIGNS

Patient came to the hospital today due to a decrease in appetite for about the past week and the same thing with drinking water, and also the dog has been lethargic for about 1 week, and has a tense abdomen.

The submitted study contained 25 still images and 6 videos for review.

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 was noted.

The prostate gland was not definitively visualized.

The area of the aortic trifurcation was free of pathology.

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 moderate loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. Potential right kidney cortical infarcts are noted. The left kidney measured 4.4 cm in length. The right kidney measured 3.8 cm in length.

Adrenal Glands

The left adrenal gland was borderline prominent size based on caudal pole width measurement. The left adrenal gland measured 1.6 cm length x 0.58 cm width at the caudal pole. The right adrenal gland exhibited a mildly enlarged cranial pole with a borderline prominent caudal pole. The right adrenal gland measured 1.9 cm length x 1.2 cm width at the cranial pole and 0.64 cm width at the caudal pole. Mild parenchyma heterogeneity and mild capsule asymmetry were present in both adrenal glands without suspicion for overt neoplasia.

Spleen

The spleen exhibited primarily finely textured parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Mild generalized parenchyma heterogeneity was present. No visualized splenic masses were noted. Possible discrete hyperechoic splenic nodules or areas of hyperechoic splenic parenchyma were noted which although nonspecific, may indicate benign myelolipomas. 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. No overt suspicion for splenic neoplastic criteria.

Liver/ Gallbladder

The liver presented 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



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margination. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with primarily anechoic content containing mild to moderate nonorganized hyperechoic gallbladder debris. No overt gallbladder or peripheral gallbladder inflammatory criteria was noted. The common bile duct was not definitively visualized.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained variably echogenic, nonshadowing ingesta without signs of obstruction or foreign material. No evidence of mechanical pyloric outflow obstruction was noted.

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 heterogeneous subtly hypoechoic parenchyma compared to adjacent nonreactive omentum. No signs of active inflammation or neoplasia.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

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ULTRASONOGRAPHIC FINDINGS

- Moderate chronic renal changes
- Nonspecific hepatomegaly with mild to moderate gallbladder debris - gallbladder not overtly consistent with mucocele criteria
- Mildly prominent nonhomogeneous pancreas
- Structurally unremarkable visualized gastrointestinal tract with gastric ingesta
- Variably prominent bilateral adrenal glands with mild cranial right adrenomegaly - nonspecific

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Potential for low-grade chronic to chronic active pancreatitis may be suspected if evidence of cranial abdominal or subxiphoid discomfort on palpation. Correlation with a Spec cPL or ideally a full GI panel to include PLI/TLI/Cobalamin/Folate to concurrently assess for occult intestinal disease as a contributing factor to the patient's clinical signs is suggested.

The adrenal presentation is nonspecific with considerations including adenomatous change, and benign hyperplasia, while the possibility of emerging right adrenal neoplastic criteria, although thought less likely, cannot be definitively excluded. Screening blood pressure to assess for evidence of hypertension, which may allude to an emerging right adrenal neoplasia i.e., pheochromocytoma is suggested. Sonographic monitoring specifically of the right adrenal gland for evidence of progression with initial recheck in 4-6 weeks would be ideal. Correlation with full CBC/Chemistry panel/Urinalysis, +/- further renal staging to include screening C/S and baseline UPC level, if clinically indicated, is



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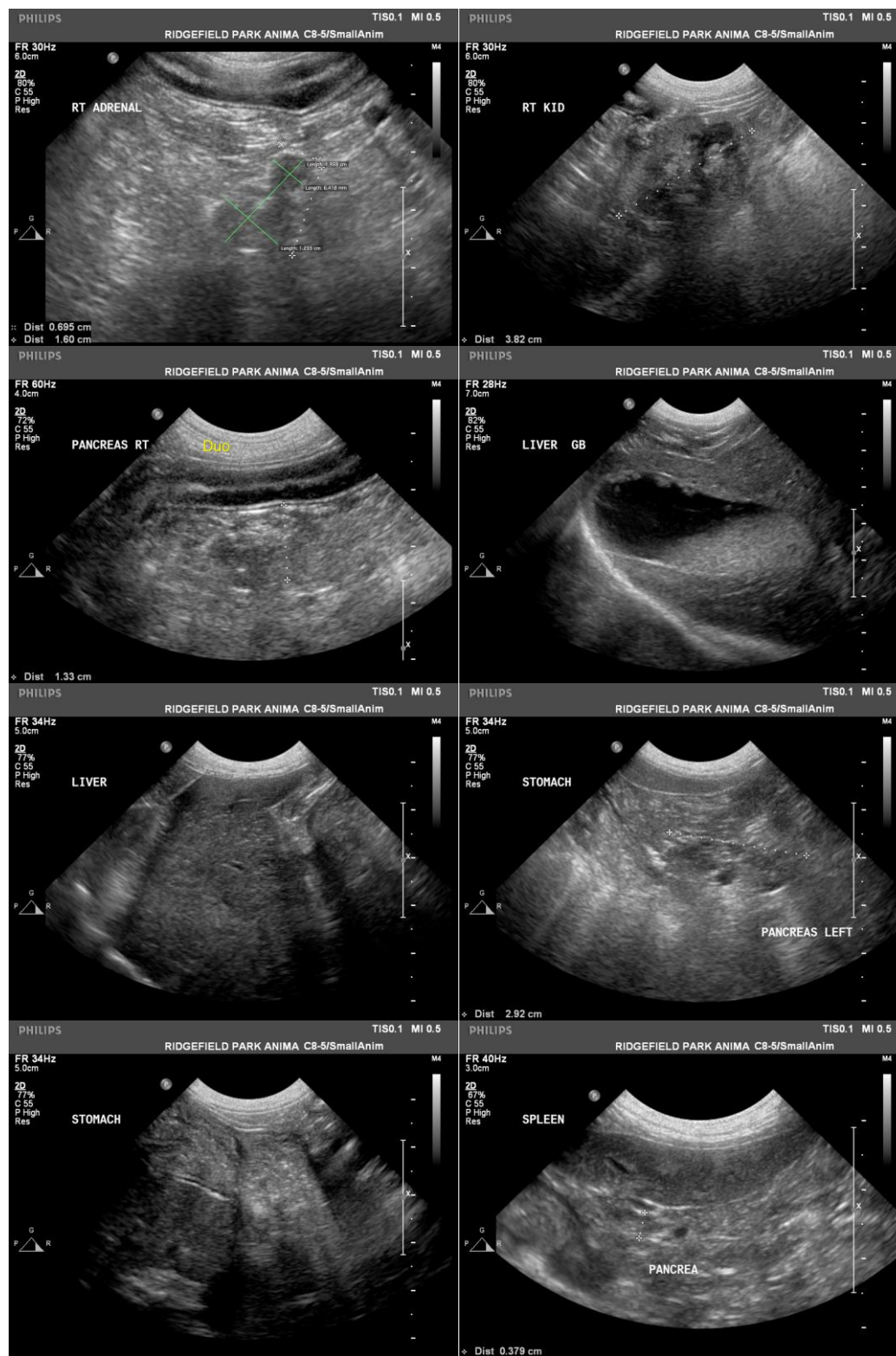
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recommended. Empirically, hospitalization with 24-48/hour supportive IV fluids, gastrointestinal support, and potential empirical therapy for low-grade pancreatitis would be reasonable.





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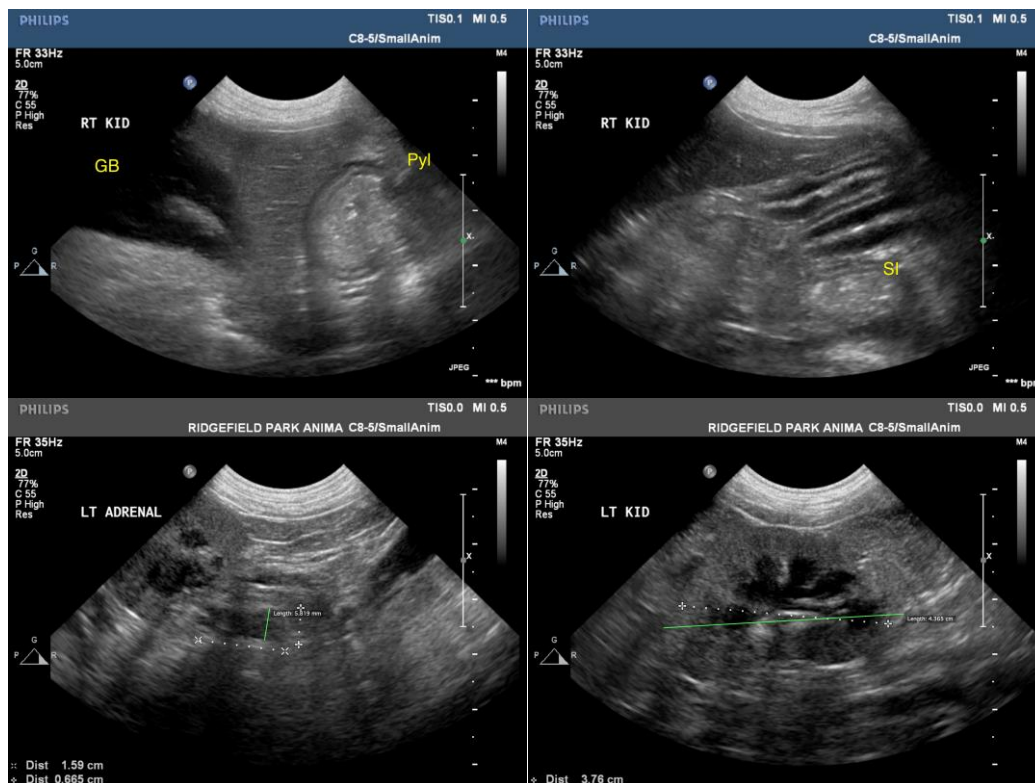
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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