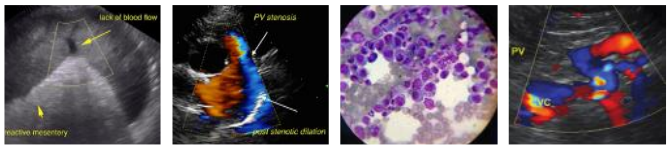
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Izzy Ofstie

SPECIES

Canine

BREED

Yorkshire Terrier

SEX

FS

AGE

14

WEIGHT

2.6kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Westcott

HOSPITAL NAME

Dr. Westcott

REFERRING VET

Dr. Westcott

INVOICE

13417ag

DATE

04/04/2023

PRESENTING CLINICAL SIGNS

About a year ago had hematamesis and hematochezia that was investigated. At that time there was an elevated SDMA/BUN but no UA so a statement about renal disease could not be made. There was abnormal CPL at that time. At that time was given maropitant, metronidazole and omeprazole with Fortiflora. Since then there has been some occasional episodes of vomiting with hematemesis and some diarrhea with hematochezia. In between events has been relatively normal.

Abnormal PE/Chem/CBC/UA Results: Periodic and intermittent hematemesis/diarrhea with hematochezia Severe dental disease Unremarkable CBC and leukogram Moderate elevation in SDMA Mild elevation in BUN Isosthenuria, Marked strip-protein. Quantified with UPC as extreme proteinuria Quiescent sediment

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with mild hyperechoic mildly shadowing sand/mineral. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

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. Bilateral intermittent cortical cysts and discrete pinpoint medullary mineral. The renal medullary volume was subjectively reduced. The left kidney measured 3.8 cm in length. The right kidney measured 4.1 cm in length.

The area of the aortic trifurcation was free of pathology.

The area of the uterine remnant appeared normal and free of pathology.

Adrenal Glands

The bilateral adrenal glands were variably enlarged exhibiting mild irregular contour. Potential left adrenal expansion in the area of the left phrenicoabdominal vein. The bilateral adrenal glands exhibited variable nodular changes. Primarily well demarcated mildly hyperechoic nodules without evidence of mineralization were present. A left adrenal nodule measured 0.59 cm x 0.46 cm. A mid to cranial right adrenal nodule measured 1.1 cm x 0.8 cm.

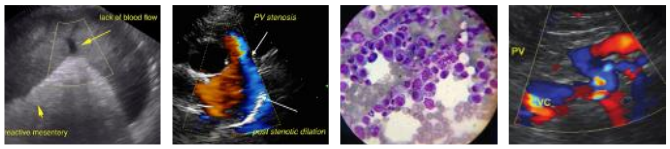
The left adrenal gland measured 0.42 cm width at the caudal pole and 2.1 cm length. The right adrenal gland measured 0.50 cm width at the caudal pole and 1.9 cm length.

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. 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, neoplastic, or benign parenchyma changes were not noted.

Liver/Gallbladder

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were



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normal in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content with mild congealed non-organized variably echogenic debris. No evidence of gallbladder or peripheral gallbladder inflammation was present. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. A solitary well demarcated hypoechoic nodular lesion was present in the area of the ventral fundus measuring 1.0 cm in diameter. The lumen of the stomach contained mild variably echogenic non-shadowing ingesta 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 parenchyma of the pancreas was mildly hyperechoic to adjacent omental fat with diffuse parenchyma remodeling. The capsule of the pancreas was symmetrical in contour without evidence of peripancreatic inflammation. These changes may suggest chronic inflammation, fibrosis, or saponification if there is a previous history of pancreatitis. No overt signs of pancreatic neoplasia.

Free Abdomen

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

ULTRASONOGRAPHIC FINDINGS

- Small gastric intramural nodular lesion area of the fundus.
- Sonographically unremarkable intestinal tract/colon.
- Non-specific moderate chronic renal changes with cortical cysts.
- Bilateral irregular/nodular adrenal glands-adenoma, benign hyperplasia or emerging neoplasia possible.
- Gallbladder debris (non-mucocele).
- Mild dependent urinary bladder sand/mineral.
- Mild chronic pancreatitis/fibrosis pattern.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Potential early phrenicoabdominal vein invasion associated with the left adrenal gland and/or possible right adrenal gland vascular invasion is not definitive yet cannot be excluded. A screening BP is advised to assess for evidence of hypertension which may allude to emerging adrenal neoplastic criteria i.e., pheochromocytoma.

Biopsy of the gastric intramural nodular lesion is likely required for a definitive diagnosis. Considerations for the nodular lesion may include emerging neoplastic criteria, previous ulcer, granuloma or other.

ACE inhibitor medication or similar with urinary diet and monitoring of UPC is recommended.

As needed GI support including gastroprotectants would be reasonable. Sonographic monitoring of the bilateral adrenal glands and gastric nodular lesion with initial recheck in 4 weeks for evidence of progression is recommended.

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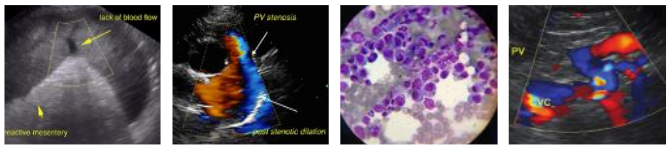

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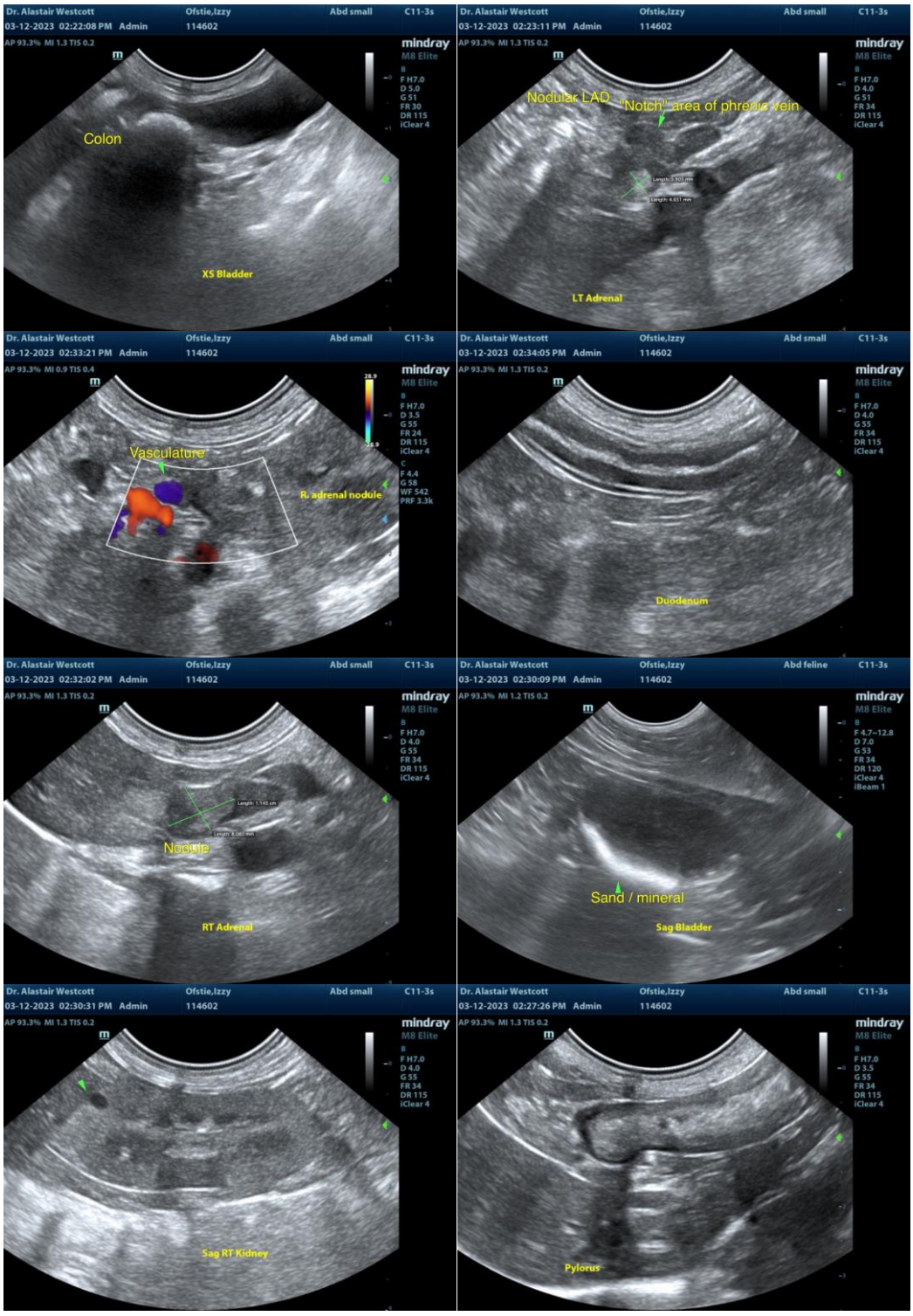

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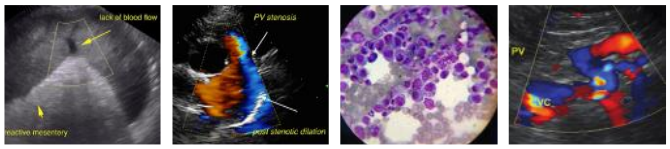

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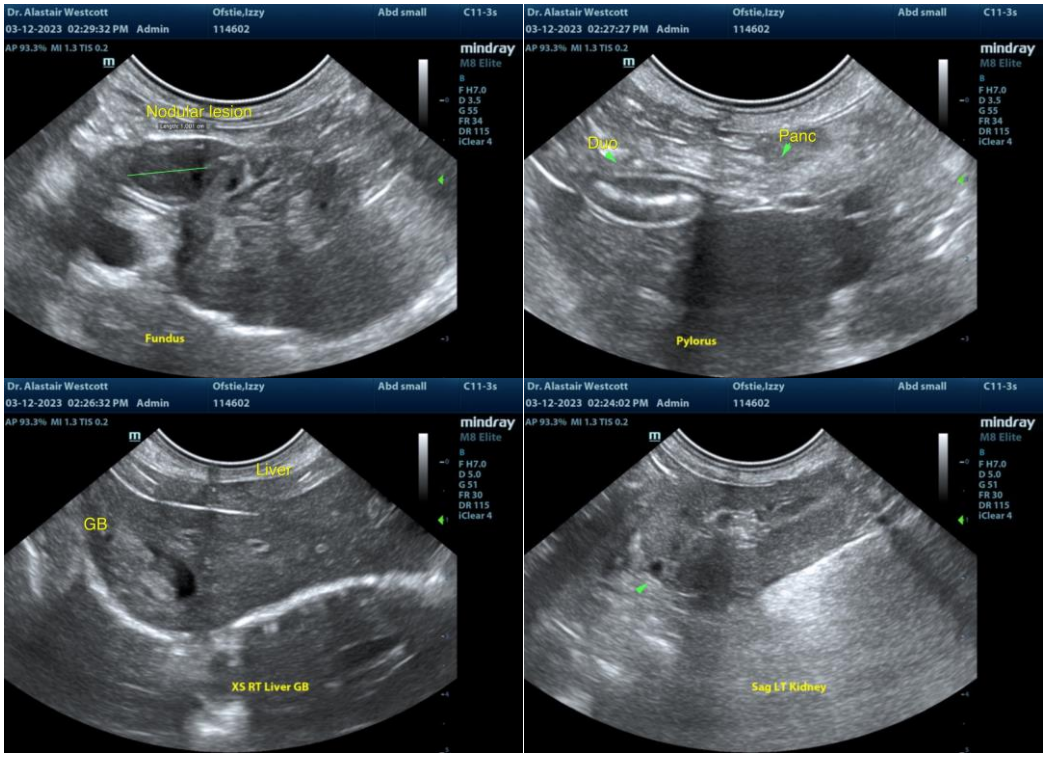

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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