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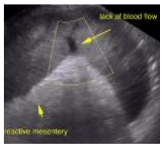
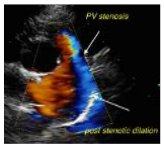
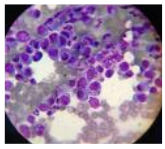
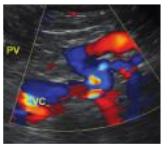





SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Jasper Schaaf

SPECIES

Canine

BREED

Maltese

SEX

Neutered Male

AGE

13 Years

WEIGHT

5.44 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Schwanebeck

HOSPITAL NAME

AEH, Deland

REFERRING VET

Dr. Schwanebeck

INVOICE

14637

DATE

4/8/22

PRESENTING CLINICAL SIGNS

History: Patient presented 4/7 for severe lethargy, not eating or drinking. Patient presented night prior (4/6) for lethargy, vomiting. His owner had given him 3units at 6pm after eating and his blood sugar was 512g/dL around 9:30pm. He left without further diagnostics. He did not eat the morning of 4/7 and his owner gave 4 units of insulin at 8am. His owner gave him 4 units again at 4pm. He has since been very weak and lethargic. Bloodwork showed BG 44 on presentation. He also had azotemia (BUN 79, crea 3.8), hyperphosphatemia, metabolic acidosis, minimally increased ALP. CPLi normal. Ketones small Radiographs showed mild hepatomegaly Urinalysis showed UTI with USG 1.018 Ultrasound performed after 10hr hospitalization

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 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. 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 loss of corticomedullary symmetry and definition expected for the age of the patient. Mild pyelectasia was present in both kidneys. The left kidney measured 3.9 cm in length. The right kidney measured 4.0 cm in length.

Adrenal Glands

The left adrenal gland was overtly normal in size, position and shape without evidence of pathology. The left adrenal gland measured 0.48 cm width at the caudal pole and 0.47 cm width at the cranial pole.

No overt pathology in the area of the right adrenal gland, although not definitively visualized.

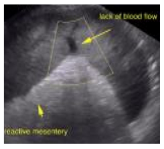
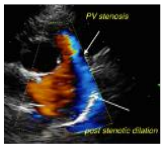
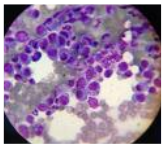
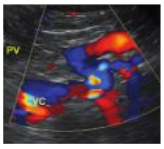
Spleen

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 presented moderately enlarged in size. The liver parenchyma exhibited mild uniform increased echogenicity compared to the spleen and falciform fat. 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. No masses or nodules were noted.

The gallbladder was non-distended with anechoic content with moderate congealed to nondependent striated debris within the central gallbladder lumen. The gallbladder walls were overtly normal without

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evidence of inflammatory criteria. No evidence of peripheral gallbladder inflammation or free fluid. 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 gastric body wall measured 0.42 cm.

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. The duodenum wall measured 0.32 cm. The jejunum wall measured 0.30 cm.

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

Pancreas

The pancreas base and right pancreatic limb exhibited prominent size with areas of mild capsule asymmetry with generalized nonhomogeneous to mixed echogenic parenchyma compared to adjacent subjective nonreactive or inflamed peripancreatic omentum. Segmental to generalized mild pancreatic duct dilation was noted. No evidence of overt pancreatic masses noted.

Free Abdomen

No evidence of significant lymphadenopathy or free fluid.

ULTRASONOGRAPHIC FINDINGS

- Benign hepatomegaly- consistent with metabolic/vacuolar/reactive (diabetic) hepatopathy given the low-grade ALP elevation with potential for cholestasis or inflammatory hepatopathy possible (i.e., cholangiohepatitis). No overt evidence of hepatic or hepatobiliary neoplastic criteria.
- Moderate nondependent to mildly organized striated gallbladder debris, consistent with early noninflamed mucocele.
- Prominent to nonhomogeneous pancreas
- Mild chronic renal changes with bilateral mild pyelectasia

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The left and right kidney pyelectasia may be owing to chronic renal changes, potential pelvic scarring possibly owing to previous calculi passage, IV fluid therapy (if applicable). Urine C/S and protein: creatinine ratio on sterile urine sample is recommended.

Given the reported normal cPL in this patient, the pancreatic presentation was nonspecific yet sonographically suggestive of parenchymal remodeling owing to previous inflammation with chronic active pancreatitis pattern criteria. Chronic active pancreatitis would be suspected if evidence of cranial abdominal subxiphoid discomfort on palpation. Potential for chronic renal failure, given the renal azotemia in this patient, is possible. Empirically, IV fluids with assessment of renal response, gastrointestinal supportive care, stabilization of serum, blood glucose levels and empirical therapy for chronic active pancreatitis would be reasonable.

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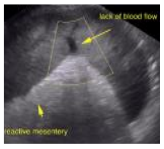
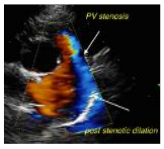
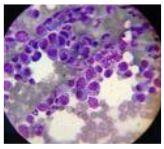
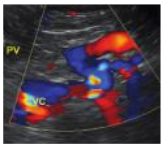

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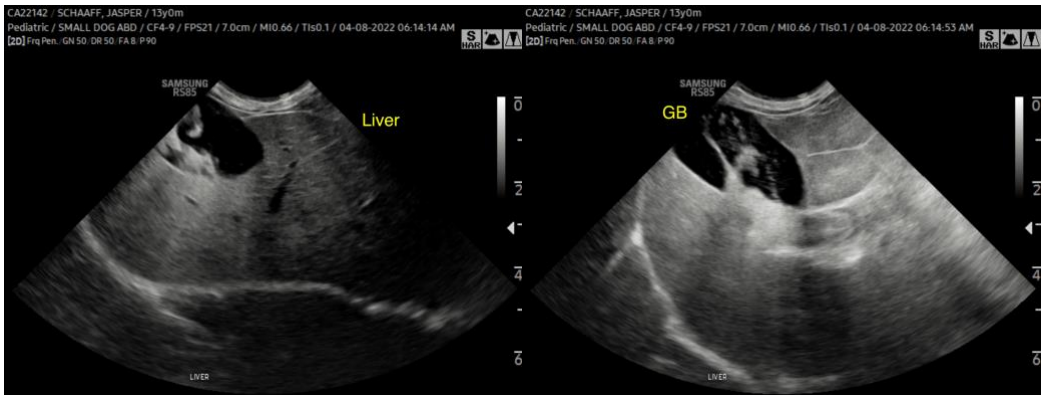
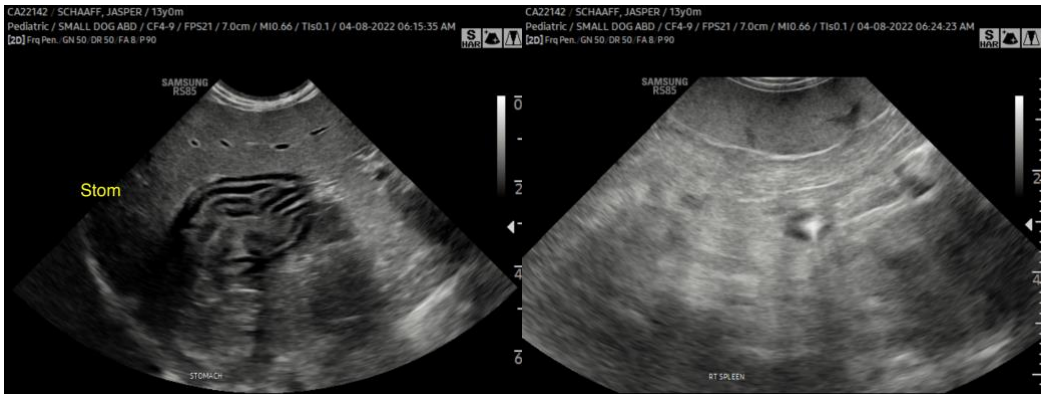
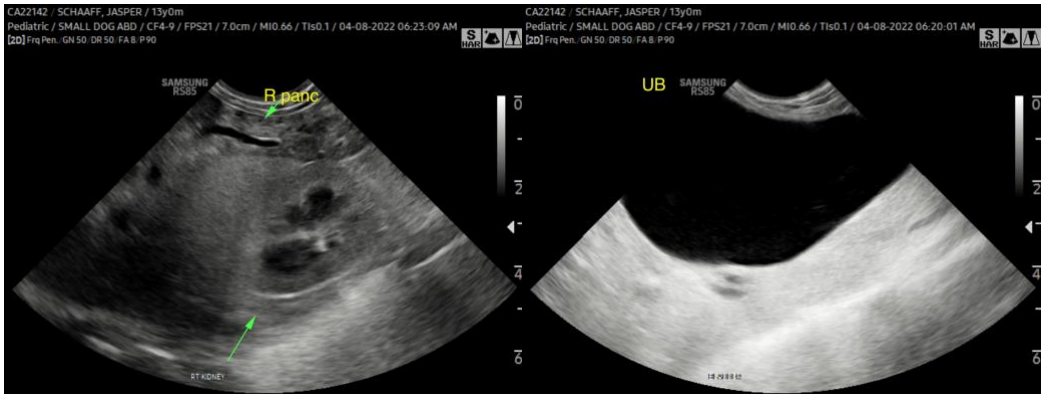
For an additional charge, internal medicine consult can be utilized through Sonopath.com. You can select the internal medicine drop down at http://spa.sonopath.com/.

One of the world's top internists & SonoPath associate Dr. Remo Lobetti BVSc, MMedVet, PhD, DECVIM can evaluate your case through SonoPath. https://sonopath.com/resources/sonopath-services/internal-medicine-teleconsultation-services







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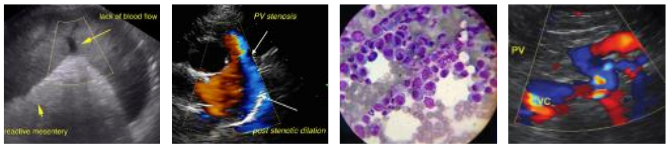

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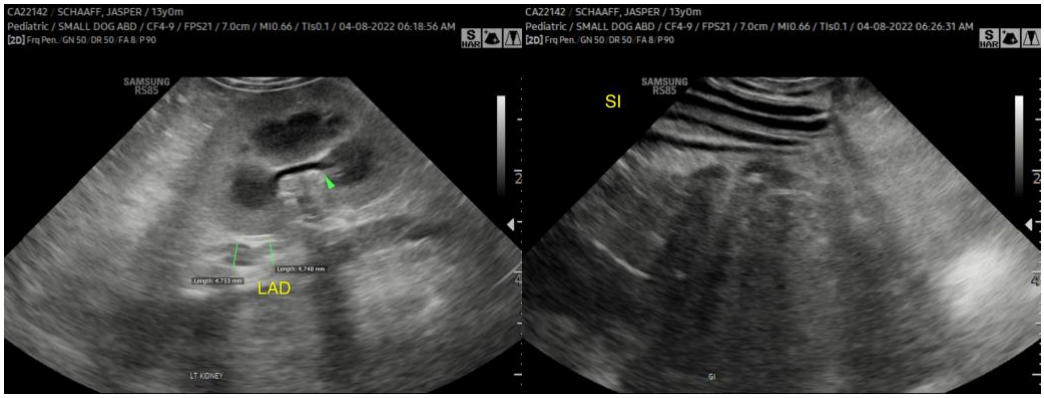

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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