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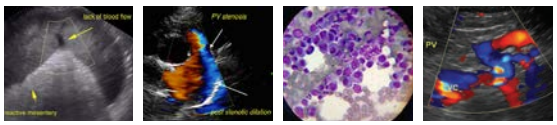

ANIMAL SOUNDS NW
MOBILE VETERINARY ULTRASOUND
IMAGING PERFORMED BY
AnimalSoundsNW.com 541-357-9423

PATIENT

Gracie Dechiara

SPECIES

Canine

BREED

Schnauzer

SEX

Spayed Female

AGE

15 Years

WEIGHT

15 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Heidi Putnam

HOSPITAL NAME

The Veterinary Hospital

REFERRING VET

Dr. Johnson

INVOICE

24596

DATE

8/12/21

PRESENTING CLINICAL SIGNS

weight loss, inappetence, systolic murmur grade 4/6 has had previous echo and abdominal ultrasounds with you Denamarin, spironolactone 25 mg - 1/2 BID, sildenafil 10 mg BID , lasix 20mg q 8-12 hours, Vetmedin 3.75 mg - 1/2 BID, enalipril 5 mg SID
Abnormal PE/Chem/CBC/UA Results: CBC - slightly anemic- hct 33, rbc 4.88 CHem - marked hepatic disease - ALT >1000 (was 560 in 1/2021) AST 140, Alk Phos 498 (was 548) GGT 17 BUN is 58, creat is WNL at 1.4

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.

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 mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. Minor non-obstructive medullary mineral was present in both kidneys. The right kidney measured 5.3 cm. The left kidney measured 4.7 cm.

Adrenal Glands

The bilateral adrenal glands were mildly prominent in size. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The left adrenal gland measured 1.5 cm length x 0.75 cm at the caudal pole. The right adrenal gland measured 1.9 cm length x 0.50 cm at the caudal pole.

Spleen

The spleen exhibited primarily finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Hyperechoic, diffuse, variably sized echogenic nodules were present throughout the cranial to caudal parenchyma. Example fo splenic nodule measured 1.1 cm 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 echogenic nodules tend to trend benign and are most consistent with benign hyperplasia or myelolipomas.

Liver

The liver was mild to moderately enlarged. 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 mild, echogenic, non-dependent yet non-organized debris. No evidence of peripheral gallbladder inflammation. The cystic duct and common bile ducts were normal without evidence of dilation.

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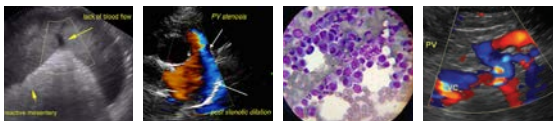

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Gastrointestinal

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. Stomach wall measured 0.48 cm in width.

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. Duodenum wall measured 0.42 cm. Jejunum wall measured 0.28 cm. Minor intermittent jejunal mucosal speckling was present.

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

Pancreas

The left limb, right limb, and base of the pancreas presented hypoechoic to heterogeneous echogenicity compared to adjacent omental fat. Mild asymmetrical capsule margination was present with mild variable parenchymal swelling and mild peripancreatic inflammation. No overt evidence of neoplasia.

Free Abdomen

A small pocket of scant free fluid was noted between the craniolateral spleen and caudal left liver margins. Regional peripancreatic to mild generalized cranial omental increased echogenicity was present. No overt lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

- Bilateral chronic renal changes with minor medullary mineral
- Chronic hepatopathy with mild gallbladder debris (non-mucocele)
- Diffuse hyperechoic splenic nodule
- Suspect mild active to chronic active pancreatitis with regional peripancreatic to cranial abdominal echogenic mesentery.
- Small pocket of scant free fluid between cranial spleen and caudal left liver

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The hyperechoic splenic nodules were non-specific with considerations including benign myelolipomas, nodular hyperplasia, previous infarcts, or potential emerging mineralization. The possibility of splenic neoplasia cannot be definitively excluded. Splenic FNA obtained without complication for screening cytology.

Chronic hepatic parenchymal or hepatobiliary inflammatory process is suspected given the ALT/AST combination. Some degree of vacuolar hepatic changes and cholestasis possible given the ALP/GGT combination. Hepatic neoplasia is considered a less likely differential diagnosis.

Empirical therapy for hepatitis/cholangiohepatitis may be considered with reassessment of hepatic enzymes in two weeks. The small pocket of scant free fluid may be owing to hepatic or pancreatic inflammation. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. If not done, 3-view chest radiographs are suggested to rule out occult thoracic or esophageal pathology as potential cause of the patient's weight loss and inappetence.

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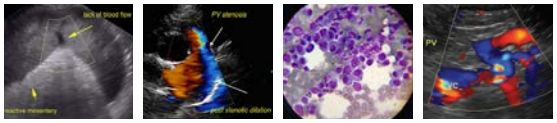

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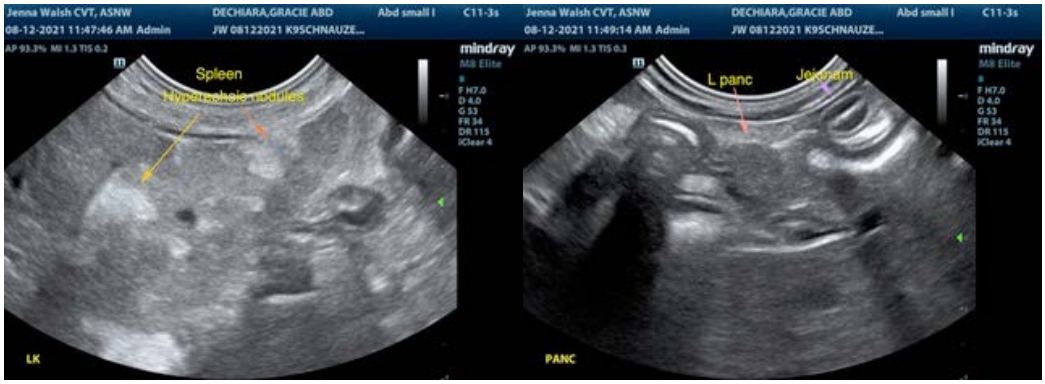

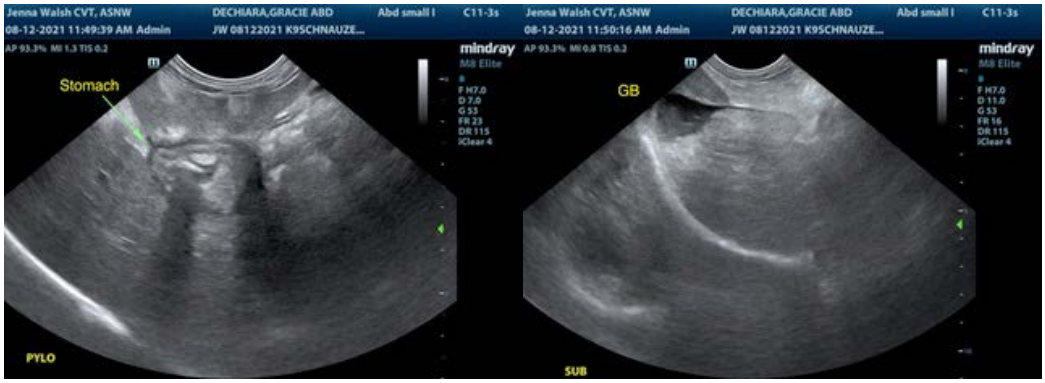

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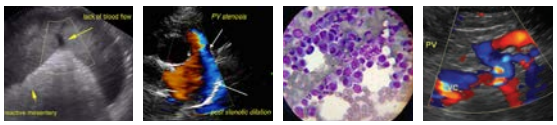

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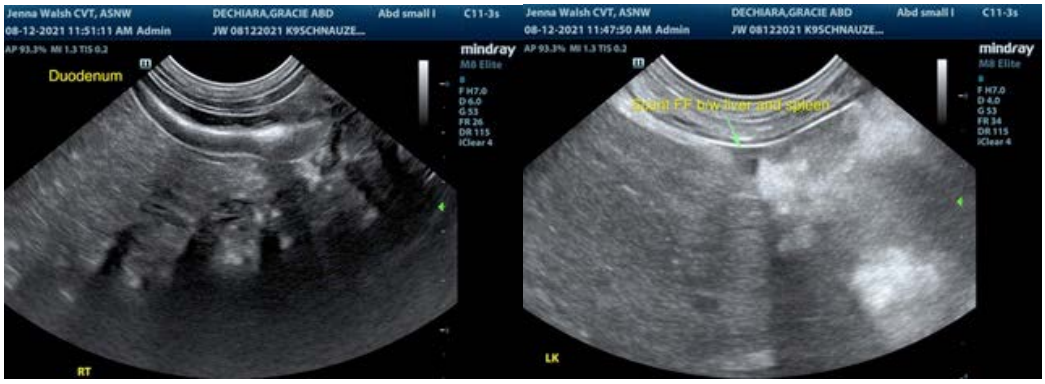

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@SonoPath.com