



**PATIENT**

Baxter Dutton

**SPECIES**

Canine

**BREED**

Pointer X

**SEX**

Neutered Male

**AGE**

2 Years

**WEIGHT**

33.6 kg

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Dr. Callihan

**HOSPITAL NAME**

Animal Emergency  
Care

**REFERRING VET**

Dr. Drummond

**INVOICE**

24700

**DATE**

8/14/21

**PRESENTING CLINICAL SIGNS**

Baxter, a 2-year old MN Border Collie X, presented as a transfer from his pcdvm (All Creatures, Arlington) where he was seen for a 3-day history of anorexia, intermittent vomiting, and lethargy. Abnormal PE/Chem/CBC/UA Results: Admitting labs were very concerning for Addison's and Baxter was transferred for continued care and work-up. CBC showed severe hemoconcentration (HCT 62%, reported TP: 6.5), leukogram WNL, azotemia (BUN: 50, Cr: high end normal @ 1.7), USG: 1.020, hyperphosphatemia (9.5), hypercalcemia (12.3, total), and electrolyte derangement suggestive of hypoadrenocorticism (hyponatremia: 126, hyperkalemia: 7.5, hypochloremia: 98). 2 lateral rads show no evidence of obvious foreign bodies or obstructive patterning, but do show a very tiny cd vena cava. Electrolyte abnormalities are improved but not resolved with fluid therapy; a basal cortisol in-house was 2.0, and a pre and post stim sample were submitted to lab today, results expected in the morning. Pt has been given 0.2 mg/kg DexSP IV after blood drawn post ACTH stim.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 4.0 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.

The residual prostate was symmetrically normal in size with uniform parenchyma and slight coarse echotexture. The prostate measured 1.3 cm in width.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. The left kidney measured 7.0 cm. The right kidney measured 7.5 cm. No evidence of overt pyelonephritis.

**Adrenal Glands**

The left adrenal gland was small in size with flattened contour and a uniformly hypoechoic parenchyma. The left adrenal gland measured 2.4 cm length x 0.26 cm width. The right adrenal gland was indistinctly visualized, yet subjectively subnormal in size, measuring 0.35 cm at the caudal pole.

**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**

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 normal in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.



**PATIENT**

***Gastrointestinal***

Baxter Dutton

The stomach exhibited intact yet subjective mild prominent wall layering. Gastric body wall measured 0.76 cm. No evidence of retained ingesta, fluid or foreign material in the stomach.

**SPECIES**

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 0.46 cm. Jejunum wall measured 0.3 cm.

Canine

**BREED**

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

Pointer X

***Pancreas***

**SEX**

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.

Neutered Male

***Free Abdomen***

**AGE**

A solitary, mildly prominent to enlarged medial iliac lymph node was present measuring 0.58 cm diameter. The lymph node was essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). This is likely incidental and not consistent with inflammatory or neoplastic criteria.

2 Years

**WEIGHT**

No effusion.

33.6 kg

**ULTRASONOGRAPHIC FINDINGS**

- Gastritis/gastroenteritis
- Sonographically unremarkable bilateral kidneys – no evidence of dysplasia, nephritis, etc.
- Subjective subnormal bilateral adrenal glands

**INTERPRETED BY**

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Given the electrolyte abnormalities, azotemia in light of normal kidney appearance, and patient's clinical signs, hypoadrenocorticism is considered a primary rule out in this case. If hypoadrenocorticism is ruled out, potential for possible acute kidney injury or insult without corticomedullary changes may be considered. Continued supportive care indicated pending ACTH stimulation test.

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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.

**SPECIES**

Canine

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

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