



PATIENT

Sadie Leckband

SPECIES

Canine

BREED

Chihuahua Mix

SEX

FS

AGE

11 years

WEIGHT

11.4 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Patti Mayfield, DVM

HOSPITAL NAME

Ark Animal Clinic

REFERRING VET

Matthew Reed, DVM

INVOICE

14847

DATE

8/17/23

PRESENTING CLINICAL SIGNS

5/31 - presented for PU/PD, decrease appetite, lethargy. Bloodwork ran - DM/DKA, low thyroid, UTI, elevated LEs Started on vetsulin @ 4 units BID. Patient remains polyuric despite apparently well-regulated DM; even trending to hypoglycemia. Patient ate food and urinated ~ 5 hours prior to scan. Butorphanol used for mild sedation

Abnormal PE/Chem/CBC/UA Results: 6/13 - 2 week MPE, Still PU/PD but than initial visit. UA performed in house, Ketones and UTI appear resolved. O reported lethargy/sleepiness shortly after insulin injections. Concern for hypoglycemia, decreased insulin dose to 3 units BID 7/20 - Recheck d/t PU/PD still. UA was unexciting and spot glucose check as 69mg/dL. O reports p no longer sleepy after insulin and doing well besides PU/PD. Scheduled glucose curve 7/26 - Glucose curve. consistently low blood sugar throughout the day but no symptoms, tail wagging and happy in kennel. Had O d/c insulin for 3 days and return for spot glucose *BG Curve (using alphatrak): * 10 am - 26mg/dL * 11 am - 21mg/dL - offered Churu tube and P readily ate the entire contents * 12 pm - 30mg/dL - offered Churu tube and P readily ate the entire contents * 1 pm - 37mg/dL - offered Churu tube and P readily ate the entire contents * 2 pm - 46mg/dL * 3 pm - 40mg/dL * 4 pm - 36mg/dL 7/29 - recheck spot glucose, 485mg/dL and O report p is continuing to do well. Restarted insulin @ 1 unit BID and repeated blood panel. Na/K ratio of 21 - recommended ACTH stim test for hypoadrenocorticism. 8/3 - performed ACTH stim test, negative for hypoadrenocorticism. Recommend AUS as next step to investigate continued PU/PD *PRE-ACTH CORTISOL5.9ug/dL POST ACTH CORTISOL17.8ug/dL Spot glucose check - 271mg/dL

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 was noted.

No evidence of pathology in the area of the aortic trifurcation.

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 loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. No pyelectasia was noted. The left kidney measured 5.2 cm in length. The right kidney measured 5.7 cm in length.

Adrenal Glands

The bilateral adrenal glands exhibited borderline to mild enlargement based on caudal pole width measurement in light of body weight. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. There was noted evidence of adrenal tumors. The left adrenal gland measured 1.7 cm length x 0.67 cm width at the caudal pole. The right adrenal gland measured 2.7 cm length x 0.61 cm width at the caudal pole.



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Spleen

The spleen exhibited overall normal size. A mildly expansive, nonhomogeneous, mildly hypoechoic splenic macronodule to small mass measuring 1.8 cm diameter was present in the mid-lateral spleen. The macronodule to small mass mildly distorted the lateral splenic capsule without evidence of parenchymal escape. Concurrent, separate, nondisruptive, hyperechoic splenic nodules consistent with benign myelomas were also visualized.

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. Intermittent small thinly walled intraparenchymal cysts containing anechoic fluid were noted. 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 containing primarily anechoic content with mild gallbladder sediment. 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 contained mild, nonshadowing ingesta, sonographically consistent with food without signs of 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 pancreas base and right pancreatic limb were normal in size with mild capsule asymmetry and mildly nonhomogeneous, hypoechoic parenchyma compared to adjacent omentum.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Mild age-related renal changes
- Borderline to mild bilateral adrenomegaly - nonspecific, no evidence of adrenal tumors
- Benign hepatomegaly with intermittent small intraparenchymal cysts
- Mild gallbladder sediment (non-mucocele)
- Mildly expansive, nonhomogeneous splenic macronodule / small mass with concurrent intermittent benign myelolipomas - nodule may indicate benign etiologies such as hyperplasia, hematopoiesis, focal splenitis, granuloma, potential for emerging neoplasia i.e., round cell neoplasia, sarcoma, or other all potentials



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- Mild heterogeneous / hypoechoic pancreas base and right pancreatic limb - possible low-grade chronic to chronic active pancreatitis

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- Sonographically unremarkable gastrointestinal tract with gastric ingesta - sonographically consistent with food

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Recheck UA and urine C/S is suggested if not already or recently done.

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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 could be considered.

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Assuming normal clotting status, FNA cytology of the splenic macronodule to small mass using a 25-gauge needle is warranted for further clarification. Sonographic reassessment of the splenic macronodule to small mass for evidence of progression with initial recheck in 3-4 weeks would be a more conservative approach. There was no sonographic evidence of intrabdominal neoplastic criteria.

This is a suggestive checkoff list when faced with an unregulated diabetic patient:

WEIGHT

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- UTI
- Dietary indiscretion/intolerance
- Pancreatitis
- Hyperthyroidism/hypothyroidism
- Exogenous steroids (including topical eye meds)
- Cushing's
- Acromegaly
- Owner compliance
- Insulin quality issues
- Antibodies to insulin
- Underlying Neoplasia
- Diffuse liver disease

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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/>.

REFERRING VET

Matthew Reed, DVM

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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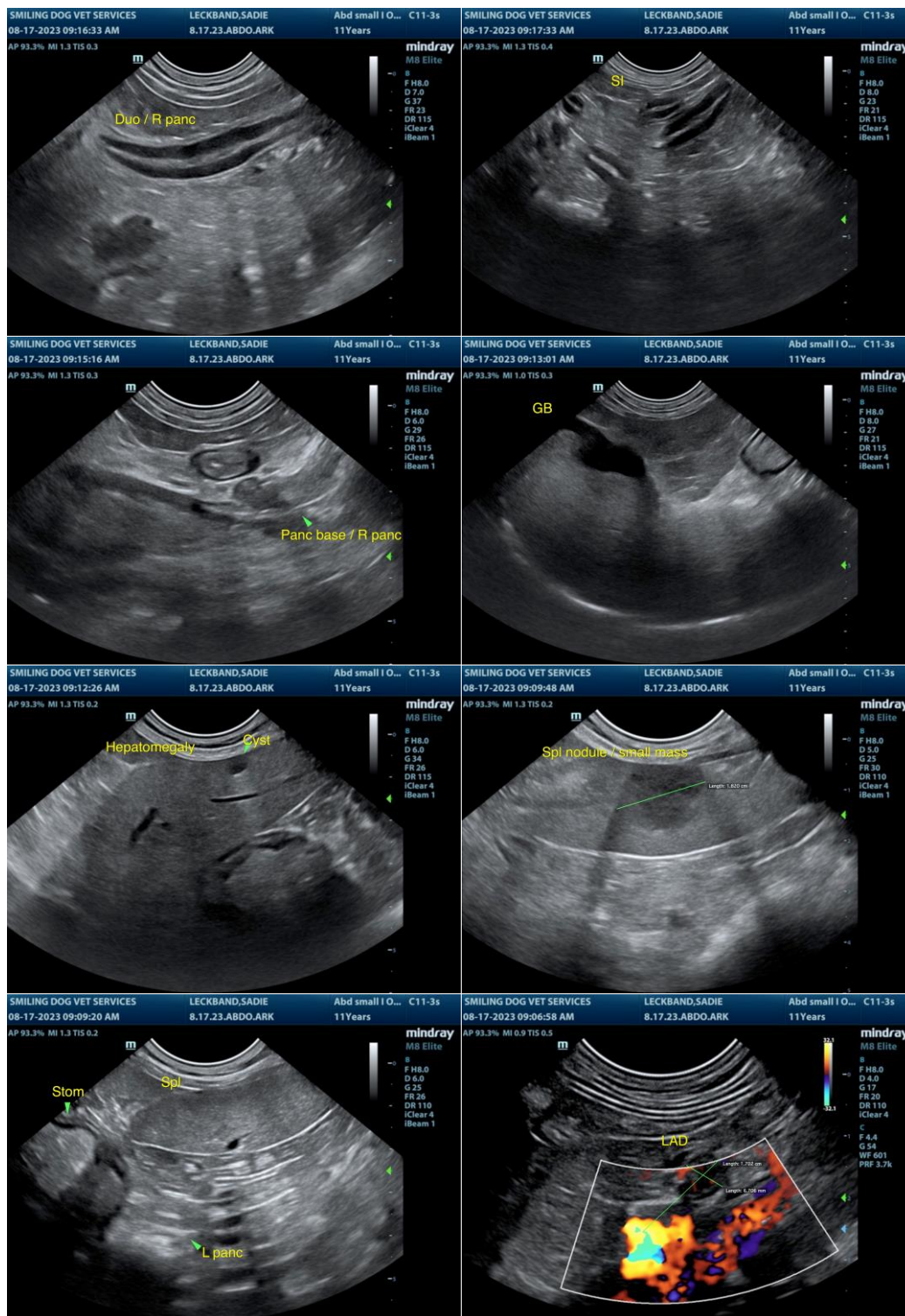
Matthew Reed, DVM

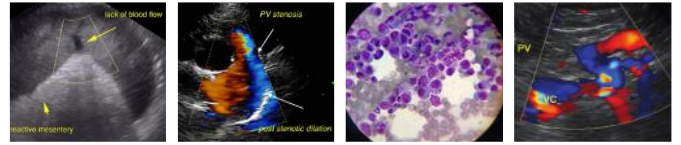
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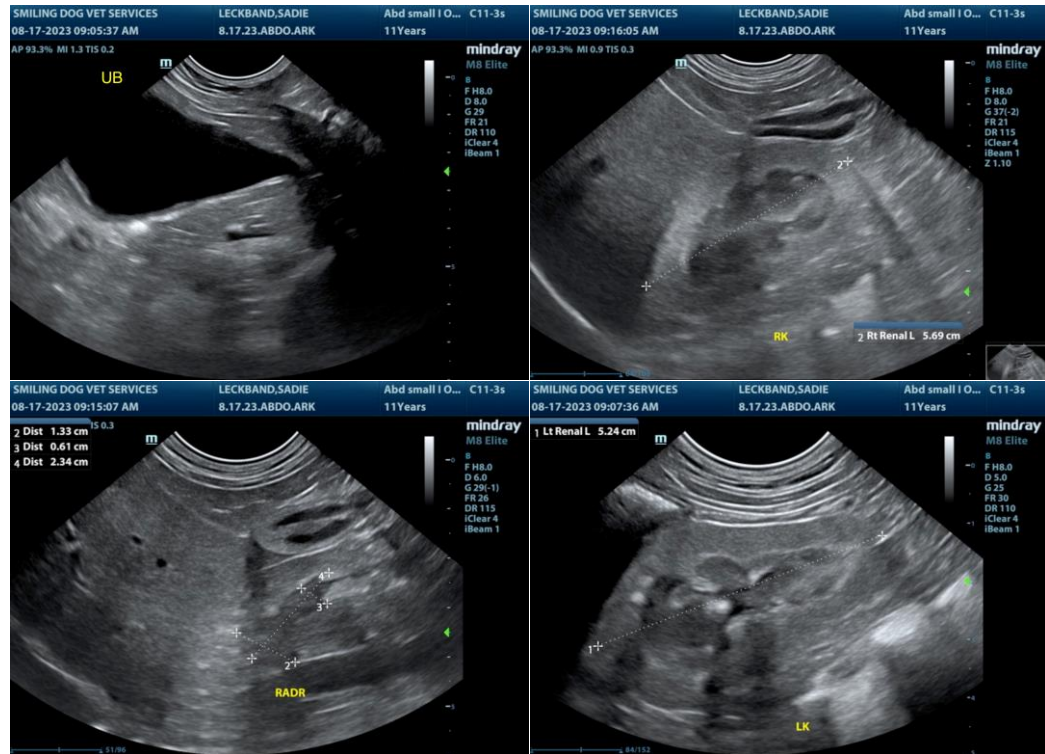
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@sonopath.com