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Clinical Sonography & Telecytology
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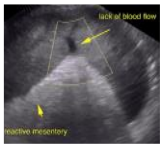
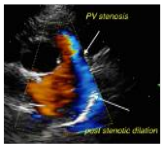
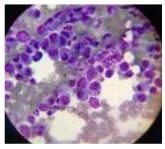
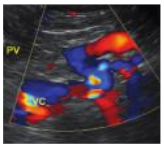




SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Knabe Miller

SPECIES

Canine

BREED

Dachshund

SEX

M/N

AGE

14 yrs

WEIGHT

11.4

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Tracy Nyberg

HOSPITAL NAME

Stuga North

REFERRING VET

Dr. Tracy Nyberg

INVOICE

14687

DATE

8/24/22

PRESENTING CLINICAL SIGNS

Decreased appetite, vomiting, weight loss, PU/PD
Abnormal PE/Chem/CBC/UA Results: No major findings

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 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.

The residual prostate was symmetrically normal in size with uniform parenchyma and slight coarse echotexture measuring 0.84 cm in diameter.

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 moderate loss of corticomedullary symmetry and definition expected for the age of the patient. Nonobstructive medullary mineralization was present in both kidneys, along with intermittent small cortical cysts. No evidence of pelvic dilation was present. The left kidney measured 4.2 cm in length. The right kidney measured 4.9 cm in length.

Adrenal Glands

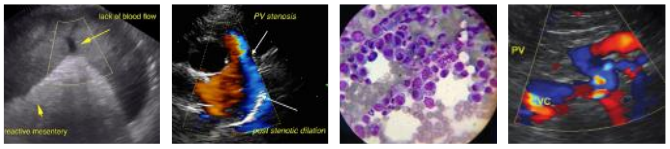
The bilateral adrenal glands were both within normal limits for size. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The left adrenal gland measured 2.2 cm length x 0.6 cm width at the caudal pole. The right adrenal gland measured 2.3 cm length x 0.63 cm width at the caudal pole. No evidence of adrenal tumors was evident.

Spleen

The spleen exhibited primarily finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Multifocal, well-defined, symmetrical, hyperechoic nodules were present throughout the cranial to caudal 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 or neoplastic changes were not noted. The echogenic nodules tend to trend benign and are most consistent with benign hyperplasia or myelolipomas.

Liver/ Gallbladder

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to benign parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size containing anechoic content with moderate, nondependent to congealed yet subjectively mobile, mildly hyperechoic luminal



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debris. No evidence of gallbladder or peripheral gallbladder inflammation was noted. 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 width measured 0.32 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 0.46 cm width. The jejunum wall measured 0.34 cm width. Intermittent jejunal mucosal speckling was present.

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

Pancreas

The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

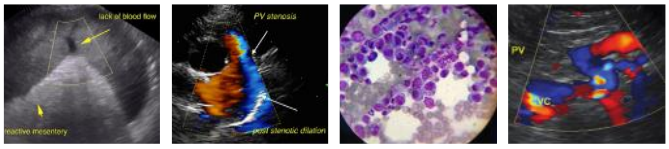
- Moderate chronic renal changes with nonobstructive medullary mineral and small cortical cysts
- Benign splenic nodules - consistent with benign myelolipomas
- Hepatic parenchymal remodeling
- Moderate nondependent congealed yet mobile gallbladder debris (non-mucocele)
- Intact gastrointestinal wall layering with intermittent small intestinal mucosal speckling - suggestive of enteritis
- Mild pancreatic remodeling - age-related pancreatic changes suspected, potential for low-grade to chronic pancreatitis possible

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Further renal staging to include urine C/S and protein: creatinine ratio on sterile urine sample may be considered.

Potential for low-grade to chronic pancreatitis may be suspected if evidence of cranial abdominal or subxiphoid discomfort on palpation. A GI panel to include PLI/TLI/Cobalamin/Folate could be considered for further assessment of the pancreas, as well as assessment of occult small intestinal disease as a contributing factor to the patient's weight loss.

Adrenal disease as a contributor to the PU/PD is considered a less likely differential diagnosis, given the lack of hepatic enzyme elevations, as well as hepatic and adrenal presentation. Monitoring for evidence of hepatic enzyme elevations, cholestasis, +/- adrenal testing could be considered going



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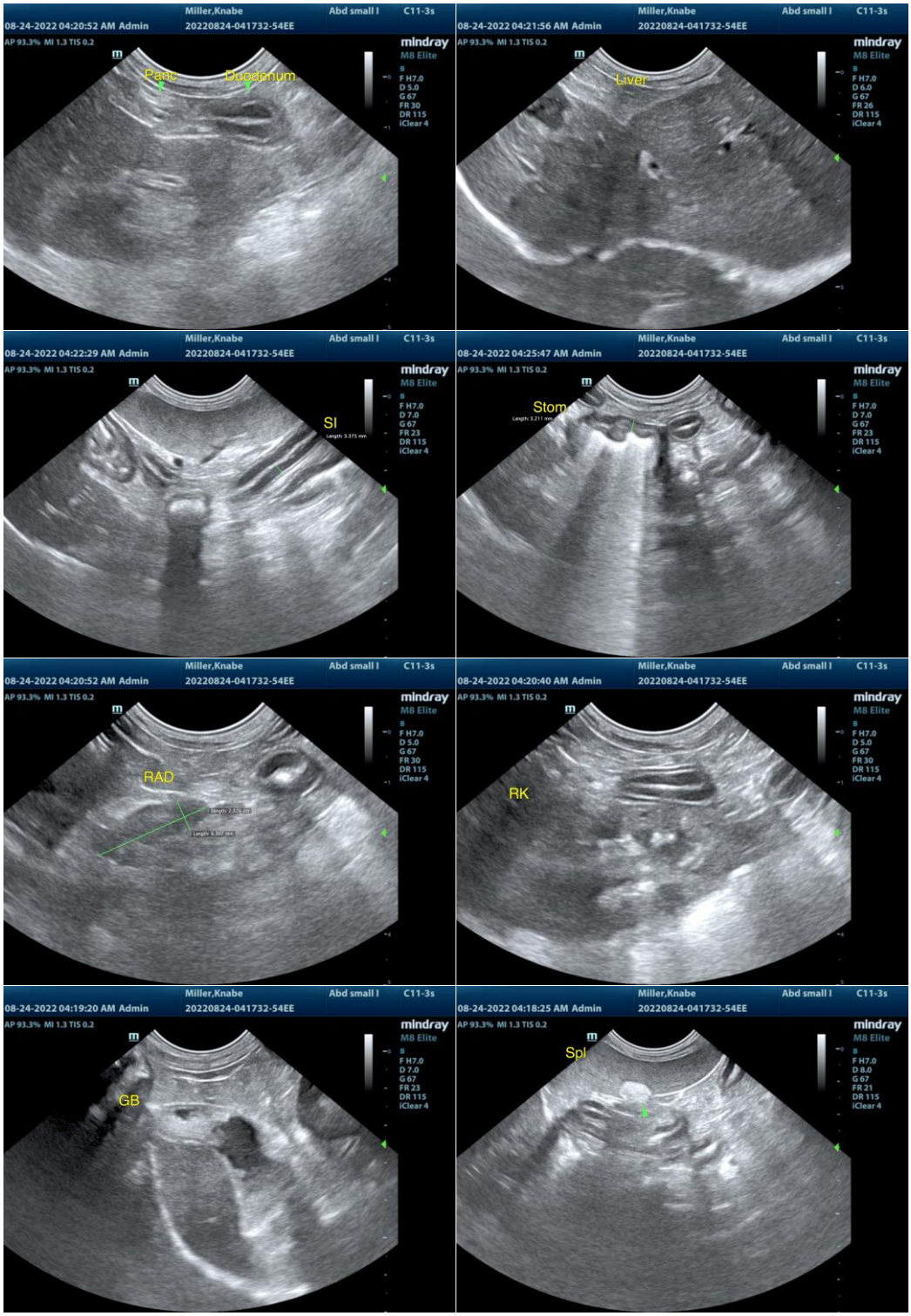
forward or if clinically indicated. Three-view chest radiographs are suggested to rule out occult thoracic pathology as a contributing factor to weight loss and clinical signs.

Empirically, as-needed gastrointestinal support +/- conservative therapy for potential low-grade pancreatitis and assessment of clinical response would be reasonable.



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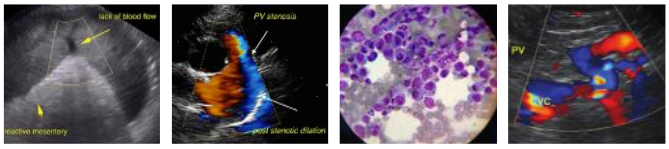

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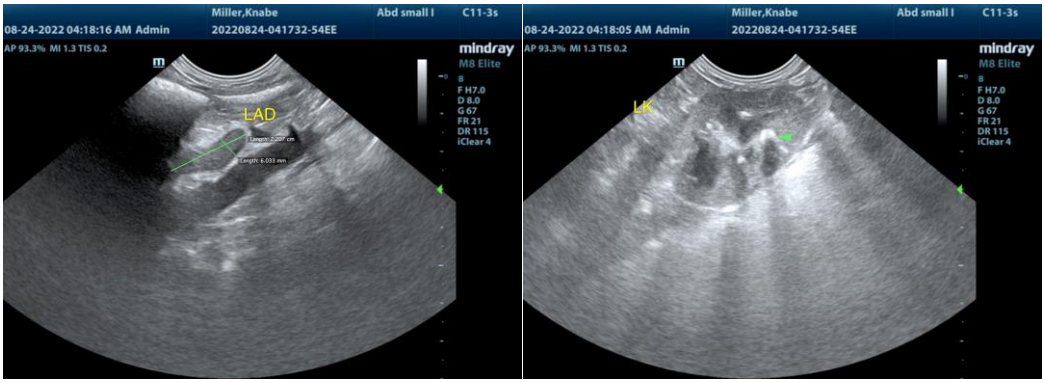

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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