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Clinical Sonography & Telecytology
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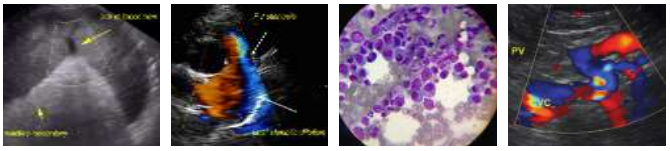

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1-800-838-4268 info@sonopath.com

PATIENT
Fancy Tsolakis

SPECIES
K9

BREED
Poodle X

SEX
FS

AGE
7 Years, 9 Months

WEIGHT
54 lbs

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

IMAGING PERFORMED BY
Sorbo

HOSPITAL NAME
Back Bay Veterinary Clinic

REFERRING VET
Sorbo

INVOICE
47436

DATE
9-19-21

PRESENTING CLINICAL SIGNS

Senior P on vetoryl last 6mo for confirmed Cushings. Sudden weight loss of 20% with PUPD for past 14dd.
Abnormal PE/Chem/CBC/UA Results: Severe and sudden weight loss of close to 20%. Lethargy, inappetance. Hematochezic diarrhea. Labs show severe azotemia, CREA 4.5mg/dL, BUN 98mg/dL, Phos 10.3mg/dL, Ca 7.7mg/dL. ALT 143, ALP 1,854, GGT 24 (U/L). IUSG 1.013, pyuria: WBC, rods, cocci.

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. Minor particulate sediment, which may indicate minor cellular or crystalline debris, was present. Anechoic urine was present in the lumen. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted. No evidence of significant pyuria.

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

Normal size with mild asymmetrical margination was present in the kidneys. Both kidneys exhibited marked yet mildly nonuniform increased cortex echogenicity with mild increased medullary echogenicity and minor right kidney pyelectasia. The left kidney measured 7.1 cm in length. The right kidney measured 8.0 cm in length.

Adrenal Glands

Symmetrical left adrenal gland enlargement with uniformly hypoechoic parenchyma was present. The left adrenal gland measured 4.5 cm length x 2.1 cm width at the cranial pole and 1.6 cm width at the caudal pole.

The right adrenal gland was indistinctly visualized with suspect similar enlargement compared to the left adrenal gland subjectively measuring 3.7 cm length x 2.3 cm width at the cranial pole and 1.4 cm width at the caudal pole.

Spleen

The spleen exhibited primarily finely textured parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Pinpoint hyperechoic parenchymal foci, which may indicate pinpoint areas of fibrosis, microinfarction, or mineralization were present. Mildly expansive mid splenic to cranial splenic nodule to nodules exhibiting subtle yet symmetrical distortion of the capsule were present. An example measured 1.7-1.8 cm in diameter. The nodules were uniform and exhibited isoechoic echogenicity compared to adjacent splenic parenchyma. Mild generalized parenchyma heterogeneity was present. 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. No evidence of perisplenic effusion or omental inflammation.

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. 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.

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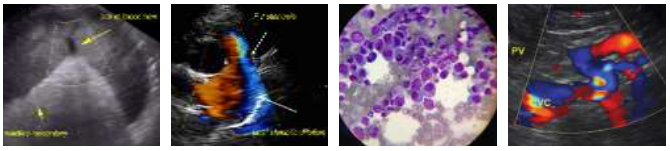

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The gallbladder was non distended in size with mild echogenic, nonmineralized gallbladder debris. The cystic duct and common bile ducts were normal without evidence of dilation.

Gastrointestinal

The visible gastric walls exhibited intact wall layering without mural pathology or hypertrophy. Moderate to significant echogenic ingesta exhibiting subtle progressive distal acoustic shadowing and no evidence of mechanical pyloric outflow obstruction. The gastric body wall measured 0.46 cm 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. The jejunum wall width measured 0.39 cm.

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

Pancreas

The pancreas base and right pancreatic limb were hyperechoic to adjacent omental fat with diffuse parenchyma remodeling. The capsule of the pancreas was mildly asymmetrical in contour without evidence of peripancreatic inflammation. These changes may suggest chronic inflammation, fibrosis, or saponification if previous history of pancreatitis. No overt signs of pancreatic neoplasia.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Bilateral chronic nephropathy - chronic renal changes; potential for nonspecific nephritis such as interstitial nephritis or other.
- Enlarged left adrenal gland, probable bilateral adrenomegaly - subjectively consistent with PDH, potential for adrenal neoplasia considered unlikely.
- Mildly expansive splenic nodule/nodules - hyperplasia, hematopoiesis, hematoma, infarction, neoplasia, or other possible.
- Vacuolar hepatopathy pattern - subjectively benign.
- Mild gallbladder debris (nonmucocele).
- Chronic pancreatitis.
- Gastric ingesta with sonographically unremarkable small bowel, likely mild colitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The presence of gastric ingesta is nonspecific and likely indicates post-prandial presentation. Correlation with most recent meal ingestion is recommended. If documented NPO prior to the ultrasound, the presence of gastric ingesta may indicate some degree some of gastric hypomotility or metabolic stasis. The sonographic presentation of the ingesta was most consistent with food, without evidence of foreign material.

Pending urine culture and sensitivity, baseline UPC may be considered given relatively quiet urinary bladder sediment. Recheck ACTH stimulation test if not recently done recommended.

Assuming normal clotting status, FNA of the splenic nodules for screening cytology would be warranted.

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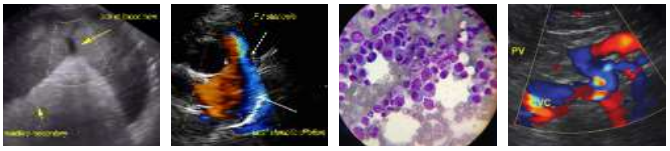

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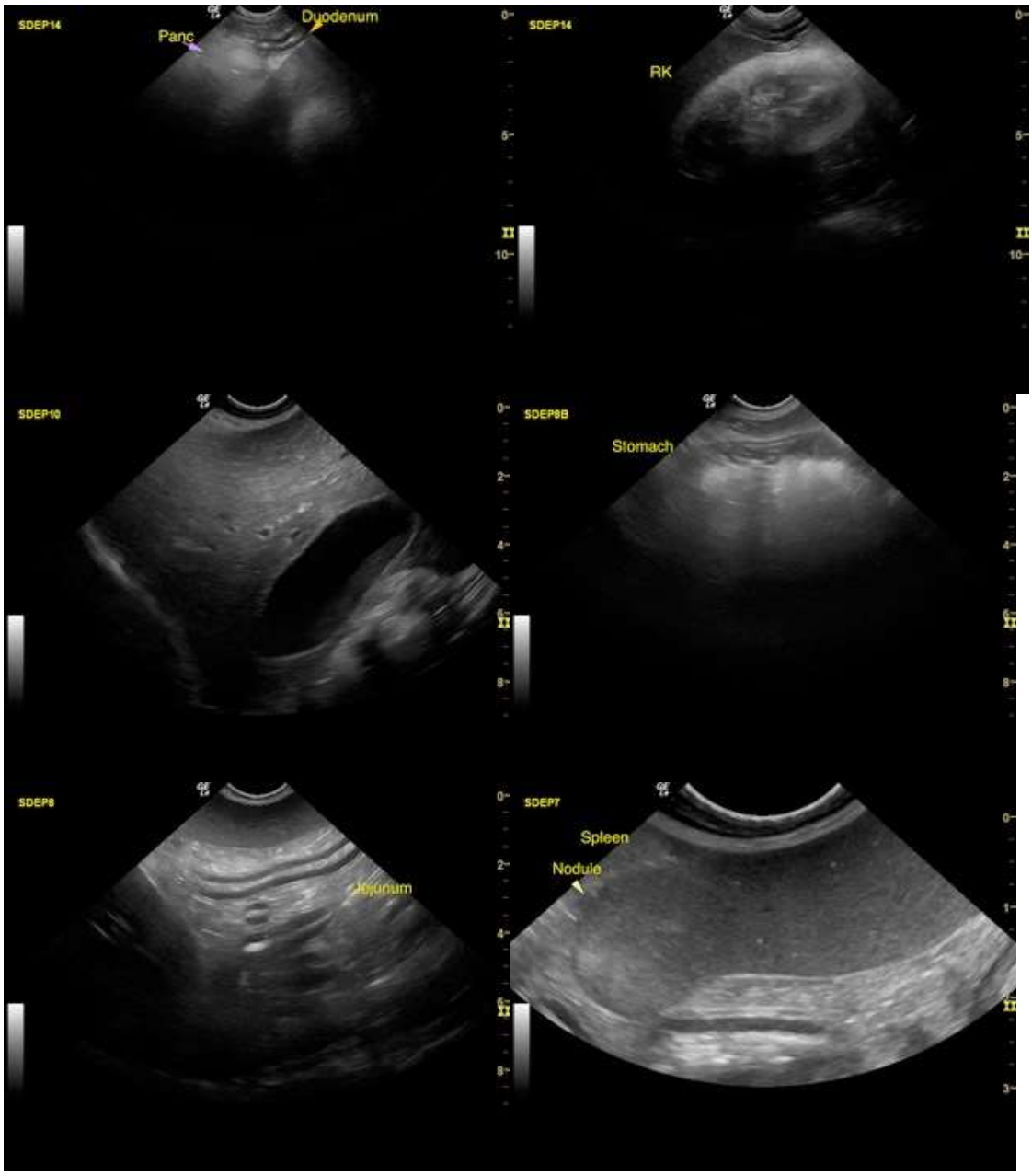
A GI panel to include PLI/TLI/Cobalamin/Folate as well as three view chest radiographs and neurological / musculoskeletal examination are recommended to assess for or rule out occult disease which may cause weight loss.



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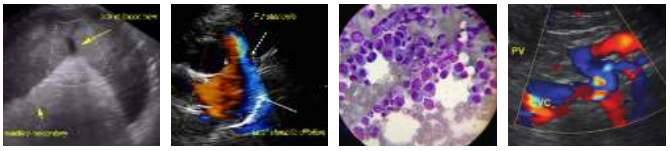

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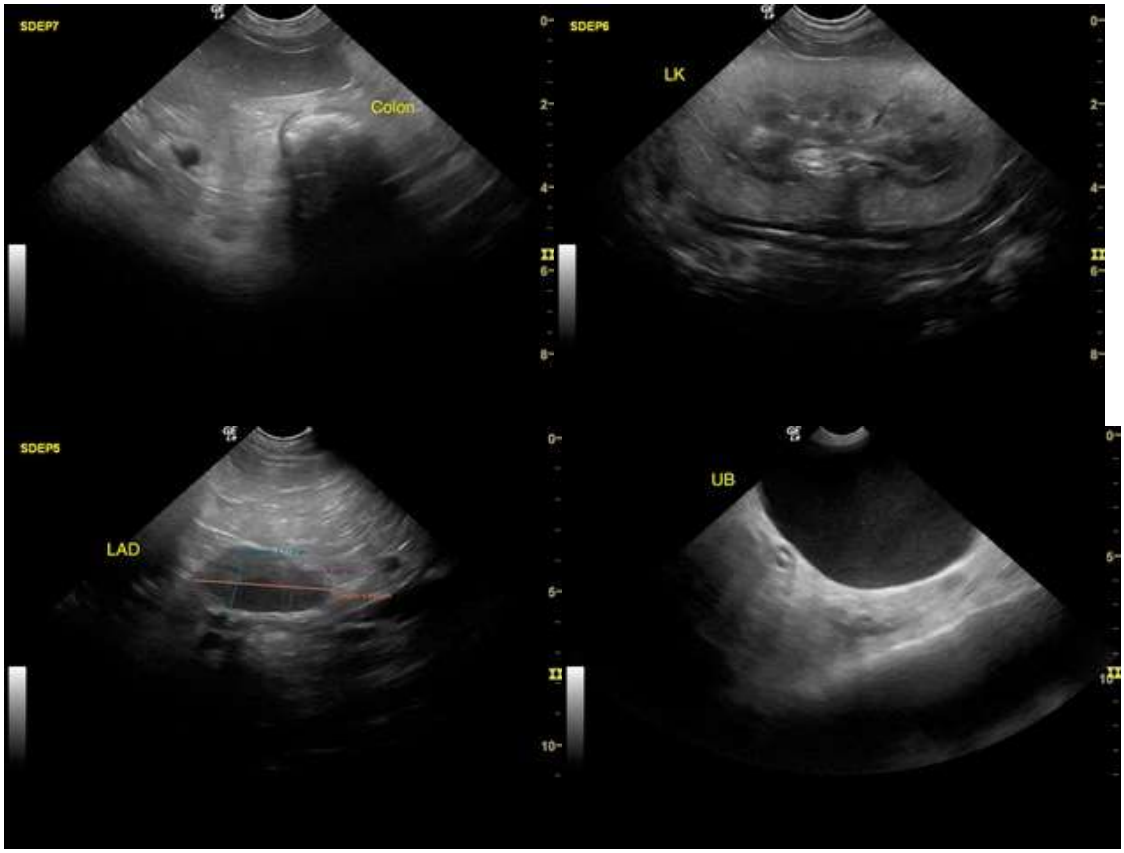

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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