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Clinical Sonography & Telecytology
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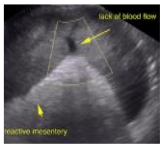
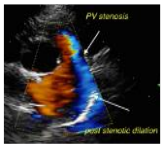
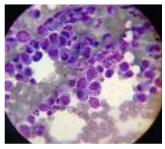
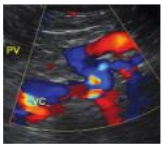




SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Buddy Dame

SPECIES

Canine

BREED

Bichon Frise X

SEX

MN

AGE

10

WEIGHT

6.03 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Donna Markland, DVM

HOSPITAL NAME

Island Mobile Paws Veterinary Services

REFERRING VET

Central Island Veterinary Emergency Hospital

INVOICE

14783

DATE

9/2/22

PRESENTING CLINICAL SIGNS

Presented on 8/31 with a 1-2 week history of lethargy and intermittent vomiting and a 24-hr history of inappetence and diarrhea. Losing weight for several weeks. Febrile on presentation. Non-painful on abdominal palpation Non-regenerative anemia and neutrophilia, monocytosis, and lymphocytosis on CBC. Mildly elevated globulins and ALP. Normal cPL. Significant rods, cocci, and WBC on UA. Current therapies: IV fluids at maintenance (decreased from 2x maintenance when new murmur noted) Metacam, 0.2 mg/kg SQ ampicillin metronidazole cerenia pantoprazole methadone
Abnormal PE/Chem/CBC/UA Results: 8/31/2022: ALKP = 311 U/L (23 - 212) GLOB = 49 g/L (25 - 45) WBC = 68.91 x10^9/L (5.05 - 16.76) LYMPHS * * 8.72 x10^9/L (1.05 - 5.10) MONOS * * 5.42 x10^9/L (0.16 - 1.12) NEUT **54.64 x10^9/L (2.95 - 11.64) HCT = 32.1 % (37.3 - 61.7) UA: Large # rods, cocci noted. 24 WBC/hpf with 5 RBC/hpf

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder was mildly distended in size exhibiting normal tone. The urinary bladder walls were sonographically normal without evidence of inflammatory or neoplastic criteria. Anechoic urine with moderate nondependent particulate sediment along with mild dependent hyperechoic sand was present. The urethra exhibited normal structure and tone to a depth of 3.0 cm.

The residual prostate was free of pathology, measuring 1.1 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 mild to moderate loss of corticomedullary symmetry and definition expected for the age of the patient. Mild bilateral pyelectasia was present. Pinpoint to focal areas of medullary mineral were noted. The left kidney measured 4.1 cm in length. The right kidney measured 4.3 cm in length.

Adrenal Glands

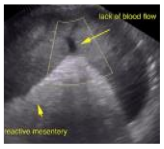
The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 1.4 cm length x 0.50 cm width at the caudal pole. The right adrenal gland was mildly enlarged in size exhibiting variably echogenic nodular parenchyma. The overall right adrenal gland measured 2.2 cm length x 1.1 cm width. An area of nodular right adrenal parenchyma measured 1.7 cm x 1.0 cm. No obvious evidence of vascular Invasion was noted.

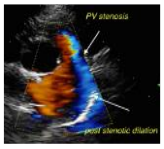
Spleen

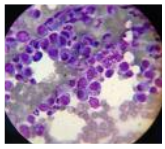
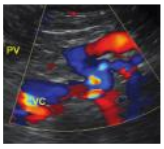
The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver/ Gallbladder

The liver presented normal 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





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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 containing mild, nondependent, mildly hyperechoic gallbladder debris. No evidence of gallbladder or peripheral gallbladder inflammatory criteria 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 pylorus wall width measured 0.37 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 0.43 cm width. The jejunum wall measured 0.33 cm width.

The colon was empty. Mildly prominent yet intact descending colon wall was noted measuring 0.34 cm width.

Pancreas

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 were evident.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Urinary bladder moderate nondependent sediment with mild dependent sand
- Bilateral chronic renal changes with minor medullary mineral and mild bilateral pyelectasia
- Mild reactive / vacuolar hepatopathy pattern - subjectively benign
- Minor gallbladder debris (non-mucocele)
- Irregular to nodular right adrenal gland
- Suspect mild gastroenterocolitis

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The bilateral pyelectasia may be secondary to chronic renal changes, pelvic scarring possibly secondary to previous mineral passage, or IV fluid therapy. Potential for low-grade pyelonephritis cannot be definitively excluded. Full urinary work up including urinalysis and C/S is recommended if not done.

Considerations for the irregular to nodular right adrenal gland may include functional vs. nonfunctional adenoma, benign hyperplasia, emerging neoplasia such as pheochromocytoma, adenocarcinoma, or other. Screening blood pressure is recommended to assess for evidence of hypertension which may allude to a right pheochromocytoma. Sonographic monitoring of the right adrenal gland for evidence of progression +/- urine catecholamine levels if documented hypertension, is recommended.

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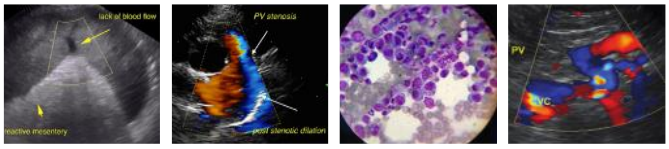

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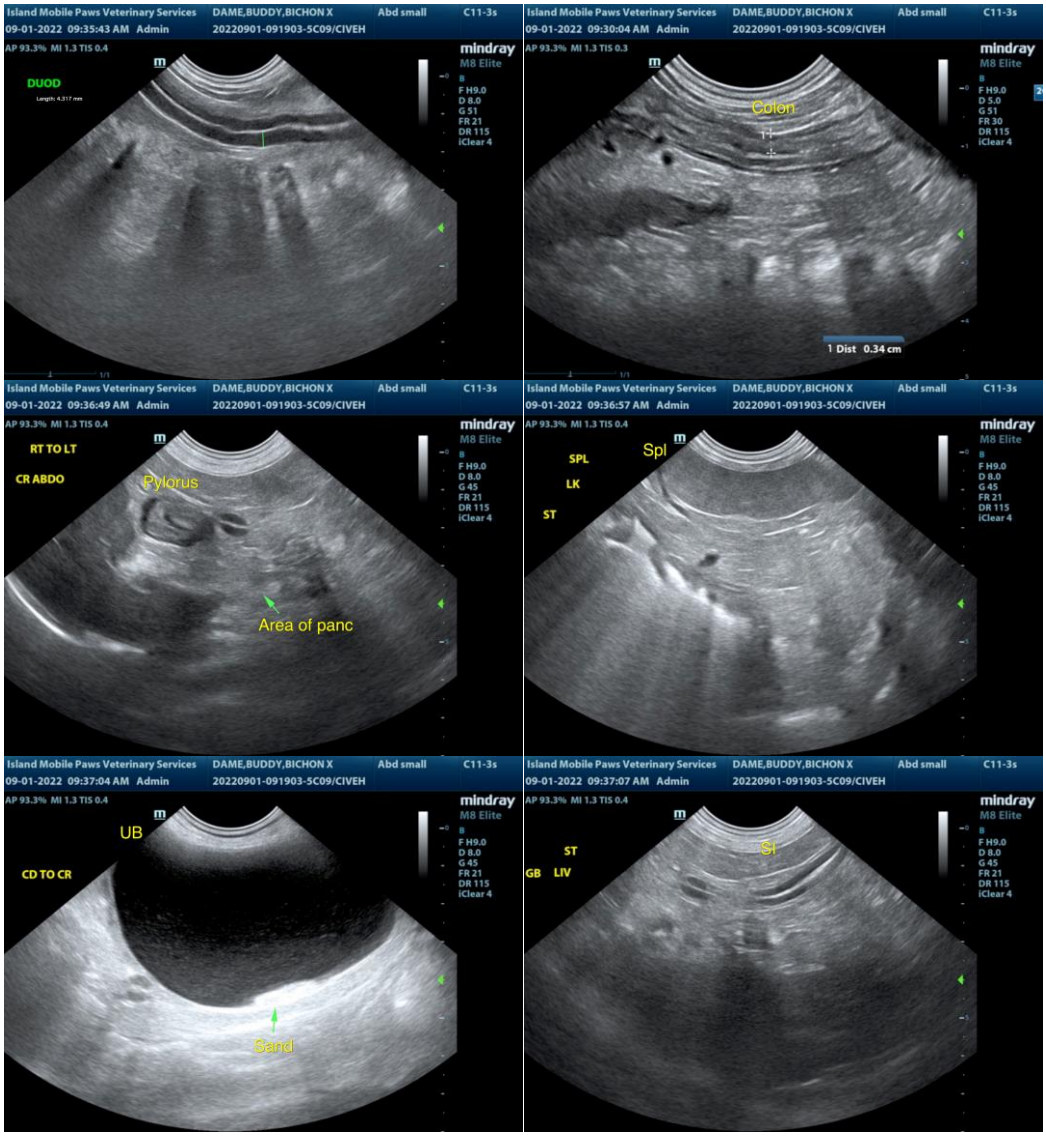
Dietary intolerance / food allergy, infectious gastroenterocolitis, dysbiosis, occult parasitism, IBD, or infiltrative intestinal neoplasia is possible. As-needed GI support, hydrolyzed diet trial with potential long-term dietary therapy, prophylactic deworming, high colony count probiotic such as Proviable, and / or antibiotic trial, given the fever and CBC abnormalities, would be reasonable. A GI panel to include PLI/TLI/Cobalamin/Folate as well as three-view chest radiographs to rule out occult thoracic pathology are recommended given the patient's weight loss. CBC pathology review is recommended.



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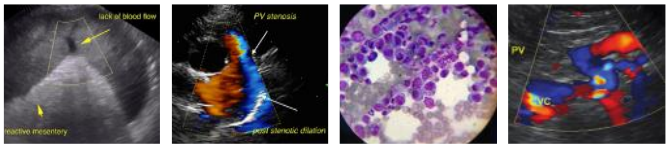

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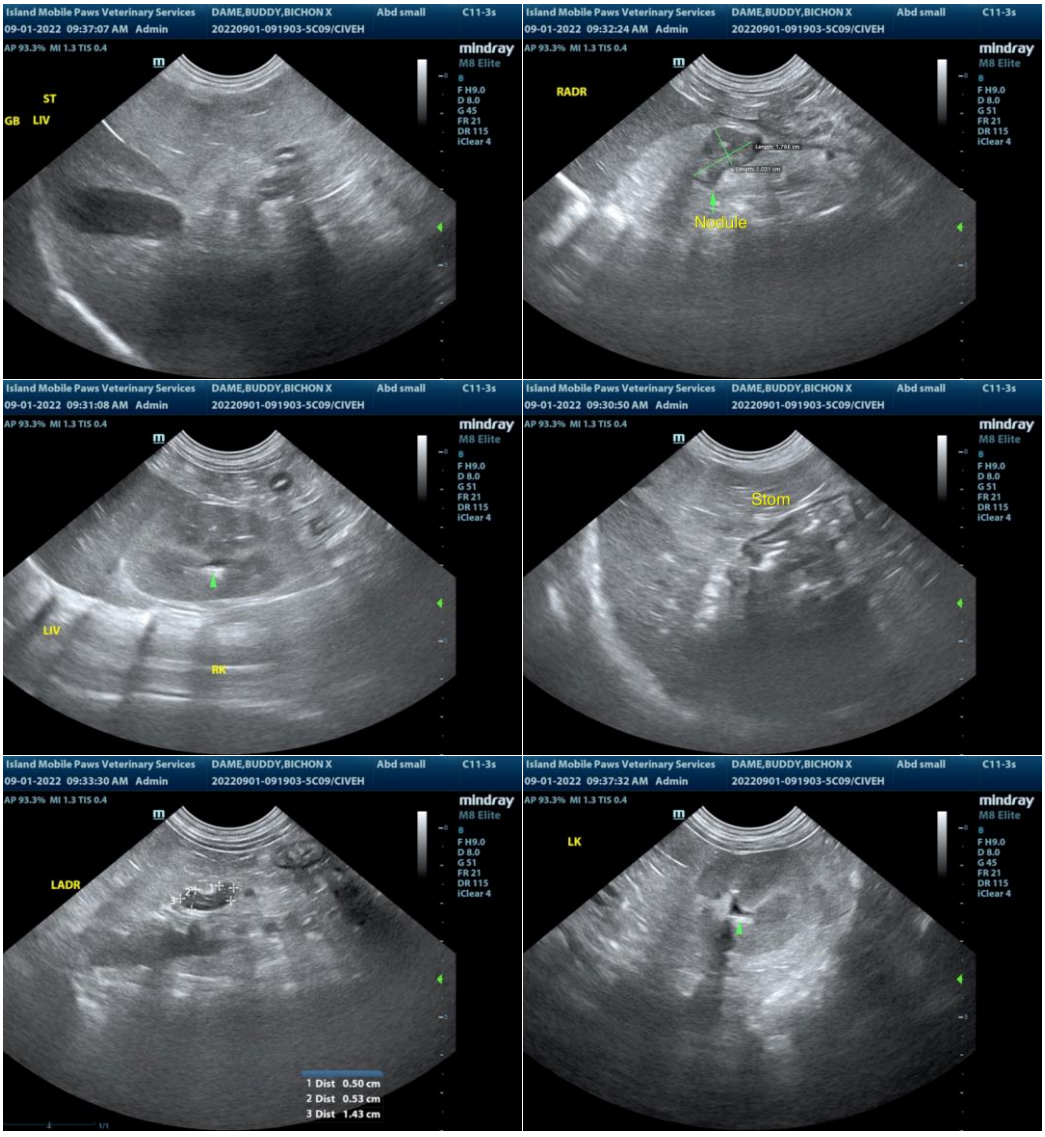

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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