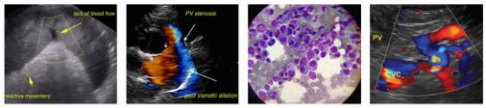


PATIENT

Bentley Simas

SPECIES

Canine

BREED

Dachshund

SEX

MN

AGE

9yr

WEIGHT

30lb

INTERPRETED BY

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

IMAGING PERFORMED BY

Pamela Harrigan, RDCS

HOSPITAL NAME

Rhode Island Animal Medical Center

REFERRING VET

Dr. Hart

INVOICE

11601ag

DATE

09/09/2022

PRESENTING CLINICAL SIGNS

Cough - Chronic bronchitis. Radiographs - Lower airway disease Current meds: Turbutaline 1.25 BID, Codeine 30mg 1/2 g 6-12 hrs, cerenia 16mg 1/4 SID, Cough tabs 1/2 tab 4-6 hrs, Prednisone 5mg SID.
Abnormal PE/Chem/CBC/UA Results: ALT 246, ALKP 1961, 66 TP 85, BUN/CreaRatio 30, Glu 42, POT 5.8, Amy 219, Prec. PSL 147, Lymph 8, urine protein 2+, WBC 2-3.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra exhibited normal tone. Mild nonuniform thickening of the urinary bladder wall was present. A solitary small dependent hyperechoic focal echogenicity with distal acoustic shadowing were present in the dependent lumen. An example of an echogenicity measured 0.66 cm diameter. Concurrent very minor particulate sediment was present.

Normal size and margination was 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 loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. Pinpoint to focal areas of medullary mineral were present. The left kidney measured 5.8 cm in length. The right kidney measured 6.1 cm in length.

The area of the aortic trifurcation was free of pathology.

The residual prostate was free of pathology measuring 0.98 cm in width.

Adrenal Glands

A small well-defined, hyperechoic nodule was present in the cranial pole of the left adrenal gland with mild associated symmetrical capsule expansion. The nodule did not exhibit signs of mineralization or vascular invasion. The nodule measured 0.47 cm x 0.3 cm. The left adrenal gland measured 0.50 cm width at the caudal pole and 0.53 cm width at the cranial pole.

The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.56 cm width at the caudal pole and 0.55 cm width at the cranial pole.

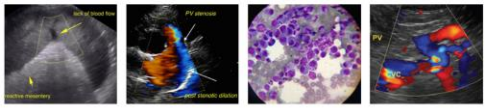
Spleen

The spleen exhibited mild parenchyma heterogeneity including a solitary discrete non-homogeneous to hypoechoic nodule measuring 1.0 cm in diameter. 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.

Liver

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. The gallbladder was non-distended in size with primarily anechoic luminal content and mild non-dependent echogenic luminal debris. The gallbladder walls were mildly prominent to hyperechoic in appearance with no evidence of peripheral inflammation. The cystic and common bile ducts were normal.

Gastrointestinal



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The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained mild to moderate retained anechoic fluid and echogenic non-shadowing ingesta/chyme with no signs of ileus, 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 was normal in size with areas of minor capsule asymmetry and mildly hyperechoic parenchyma. Mild pancreatic duct dilation was observed.

Free Abdomen

No omental masses, lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Benign hepatopathy
- Mild gallbladder debris, possible minor chronic cholecystitis
- Non-specific splenic nodule
- Age related kidney changes with pinpoint medullary mineral
- Solitary cystic calculus
- Small left adrenal nodule-suspect adenoma
- Hyperechoic pancreas-potential chronic pancreatitis or mild fibrosis owing to previous inflammatory episode

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A urine C/S to assess for underlying infection is recommended.

The appearance of the liver was nonspecific but most consistent with benign hepatopathy. Considerations for the liver may include benign vacuolar hepatopathy and minor cholestasis in light of the elevated ALP or inflammatory/infectious hepatobiliary process given the gallbladder debris and elevated ALT. Ultrasound guided FNA of the liver using a 25-gauge needle and assuming normal coagulation parameters would be warranted for screening cytology, primarily to assess for evidence of inflammatory cells and to rule out unlikely neoplasia. Hepatosupportive medications such as Denamarin or Vitamin E as well as Ursodiol due to its antioxidant and immunomodulatory effects within the liver would be warranted, although these medications may not result in decreased hepatic enzyme levels.

Potential etiologies for the discrete splenic nodule may include benign processes such as nodular hyperplasia, extramedullary hematopoiesis, hematoma, infection, infarction, or neoplasia. Ultrasound guided FNA of the nodule using 25-gauge needle and assuming normal coagulation parameters may be considered. Otherwise, sonographic monitoring of the splenic nodule for any changes in size or appearance with initial recheck in 3-4 weeks would be a more conservative approach.

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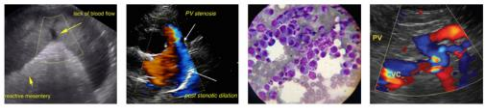

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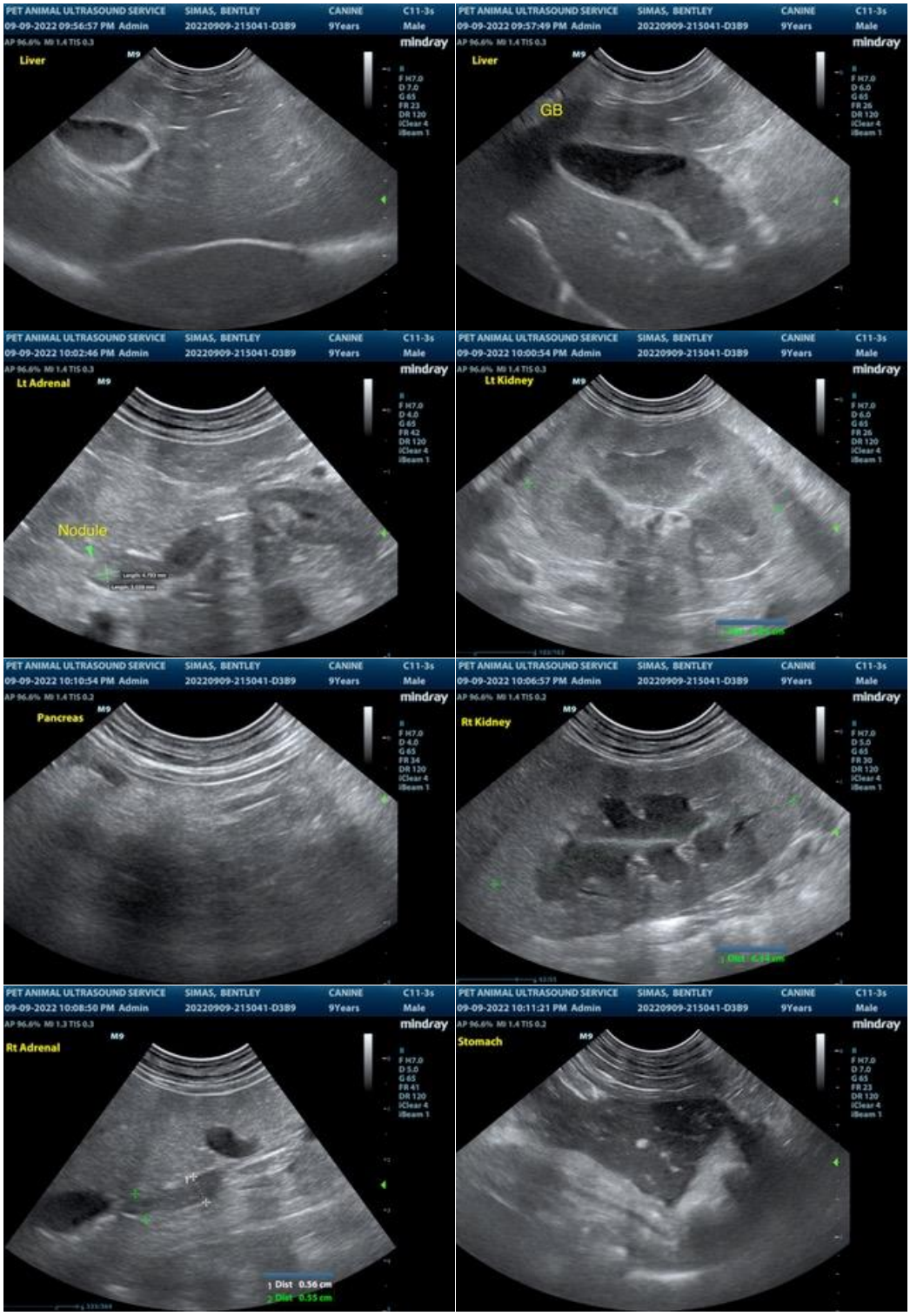

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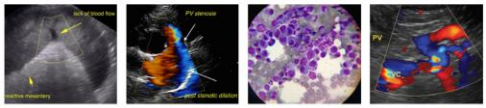

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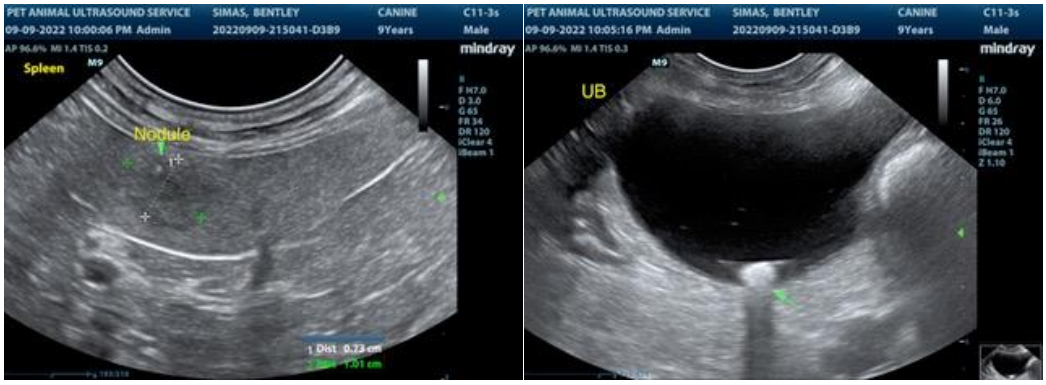

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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