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Clinical Sonography & Telecytology
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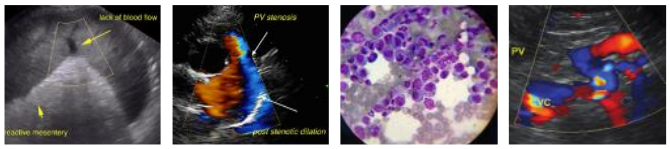

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Darla Goldberg

SPECIES

Canine

BREED

Golden Doodle

SEX

Spayed Female

AGE

9 Years

WEIGHT

42.6 Pounds

INTERPRETED BY

Tam Mengine, DVM, DABVP (canine/feline practice)

IMAGING PERFORMED BY

Dr. Tam Mengine

HOSPITAL NAME

Stoney CVH

REFERRING VET

Dr. Tam Mengine

INVOICE

17961

DATE

11/3/22

PRESENTING CLINICAL SIGNS

History: Patient has had ongoing wt loss with good appetite and no other clinical signs. First noted in 5/22 - had CBC / Chem / U/A, AUS, GI panel, resting cortisol - all normal except low coabalamin. Started hydrolyzed diet + cobalamin and increased amt fed - still losing weight. On 10/1/22 started pred - 0.7mg/kg BID - continued wt loss, and now ALT 484, ALP 542. Total weight loss of 15 pounds over ~ 8 months. Chest rads, bile acids pending

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine, and no luminal sediment is present. The ureteral papillae, trigone and pelvic urethra are of normal appearance, and the ureters are not visible (normal). No masses, calculi or mucosal irregularities are noted. Urethra visualized to 2.0 cm.

The kidneys are of normal size and shape and exhibit appropriate corticomedullary differentiation with a normal 1:3 cortex to medulla ratio. There is no evidence of nephrolithiasis, mineralization, pyelectasia, cystic change or hydronephrosis. The proximal ureter is not visible (normal). The left kidney is 6.1 cm in length. The right kidney is 6.4 cm in length.

Adrenal Glands

Both adrenal glands are subjectively decreased in size, with a flattened appearance to the poles. They have normal phrenic vasculature and are found in the normal location. The left adrenal gland height is 3.3 mm at the cranial pole and 3.3 mm at the caudal pole. The right adrenal gland height is 7.5 mm at the cranial pole and 3.8 mm at the caudal pole.

Spleen

The spleen is of appropriate size and has a normal, homogenous parenchyma with a smooth, continuous capsular surface. The splenic vasculature is normal with no evidence of congestion or thrombosis, and blood flow through the splenic hilus appears normal.

Liver

The liver is diffusely hyperechoic and subjectively enlarged. There are hypoechoic nodules present throughout the parenchyma, measuring up to 6.2 mm. The portal and hepatic vasculature are of normal size and appearance with no evidence of congestion or thrombosis.

The gallbladder is moderately distended with anechoic contents and a small amount of freely moveable echogenic sludge. The wall was thin and continuous with no focal lesions. The cystic and common bile ducts are normal / not visible.

Gastrointestinal

The stomach is mildly distended with anechoic fluid. The gastric wall is 4.0 mm with normal deviations due to rugal folds and exhibits appropriate wall layering. The pylorus is of normal appearance.

The visualized portions of the duodenum, jejunum, and ileum are of normal thickness with intact wall layering that exhibits the appropriate 1:3 muscularis to mucosa ratio. The duodenal wall measures 4.4 mm. The jejunal wall measures up to 3.4 mm. Intestinal motility appears normal.

The visible portions of the colon are of normal thickness, up to 1.0 mm, with intact wall layering. The ileocecal junction is visualized and appears normal.

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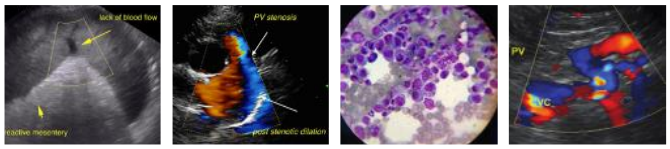

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Pancreas

The areas of the limbs and body of the pancreas are isoechoic to the surrounding mesenteric fat, with normal capsular appearance. There is no evidence of peripancreatic inflammation. The pancreatic duct appears normal.

Free Abdomen

There is no evidence of free fluid within the peritoneal cavity. The omentum and intra-abdominal fat are of appropriate echogenicity. Enlarged abdominal lymph nodes are not observed. The aortic trifurcation has normal blood flow with no evidence of thrombosis.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

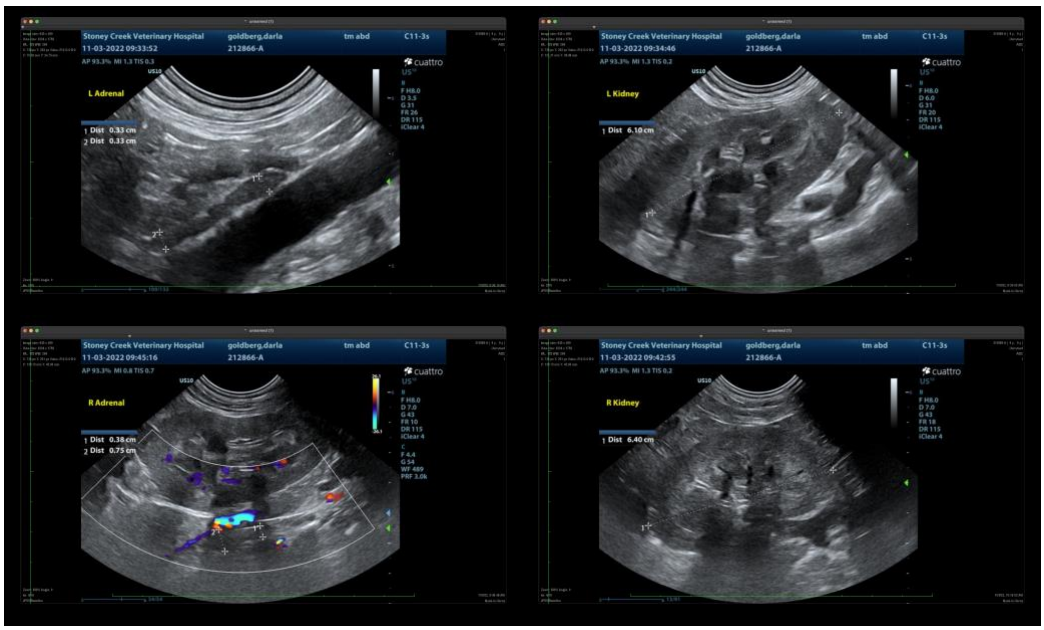
- A reactive hepatopathy with hypoechoic nodules

Secondary Findings

- Small adrenal glands, consistent with corticosteroid use

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes in the liver may be due to a steroid hepatopathy, however, the possibility of infiltrative neoplasia cannot be ruled out, and might explain the ongoing history of weight loss. Fine needle aspirate or alternately laparoscopic biopsies should be considered for a definitive diagnosis. Bile acid testing is also recommended to further assess severity of hepatic disease. If the bile acids are normal, but the ALT is increased, then initiation of liver support therapies, such as SAM-e, vitamin E, and Ursodiol would be recommended. Additional diagnostics for weight loss would include chest radiographs, and gastrointestinal biopsies.



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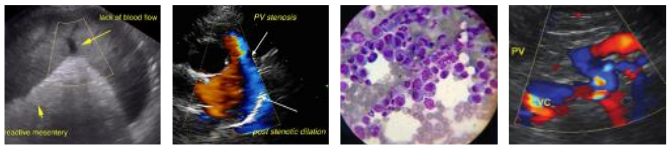

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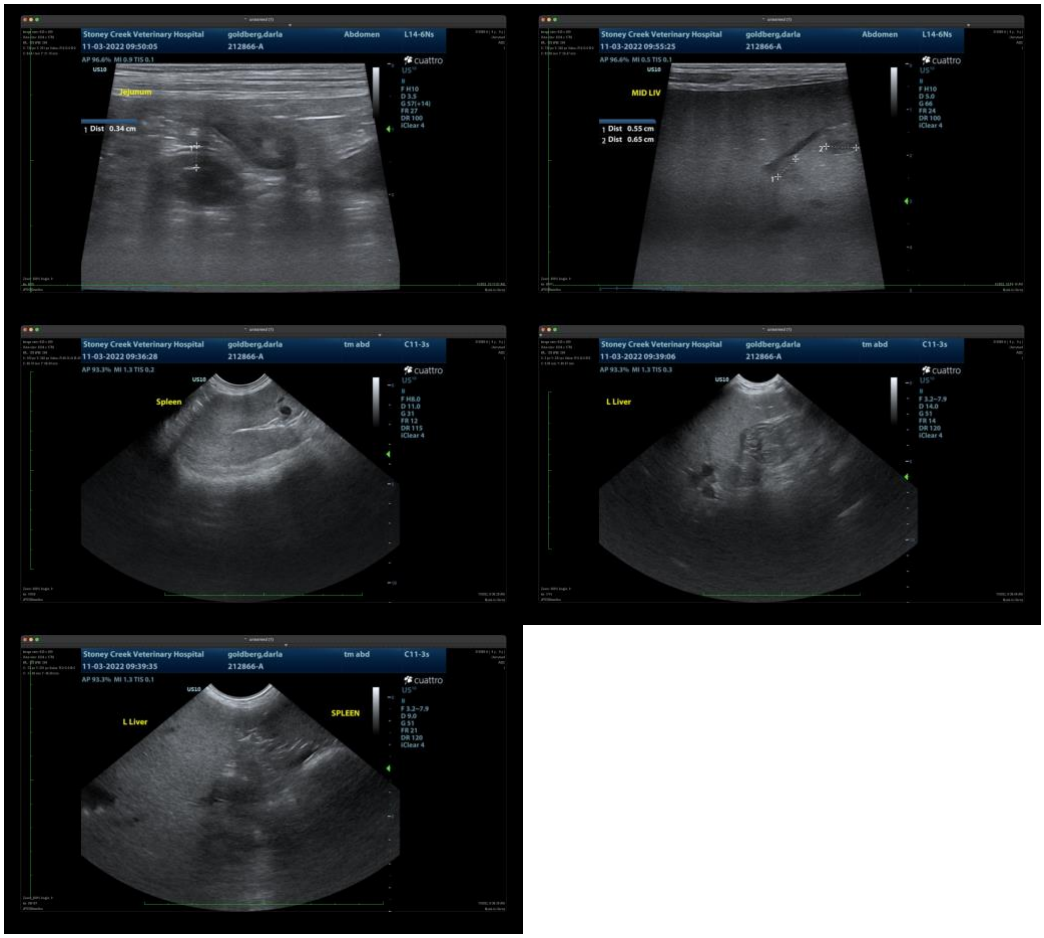

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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