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Clinical Sonography & Telecytology
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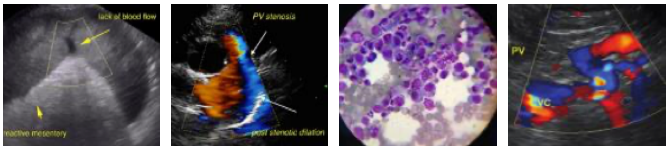

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Mary Jane Tiersch

SPECIES
Canine

BREED
Beagle

SEX
Female, spayed

AGE
10 Yrs.

WEIGHT
26 lbs.

INTERPRETED BY
Andrea Nicastro, DVM, Diplomate ACVIM (*Small Animal Internal Medicine*)

IMAGING PERFORMED BY
Sorbo

HOSPITAL NAME
Back Bay VC

REFERRING VET
Dr. Wheeler

INVOICE
12959

DATE
2/7/22

PRESENTING CLINICAL SIGNS

History: Acute nausea 2/5: hypersalivation, excessive licking and then vomiting (4x within 1 hour). Gave Cerenia, 1/2 60mg tablet PO. Symptoms subsided for a few hours but then hypersalivation, licking, nausea returned. No further vomiting. . Energy, appetite, stools WNL. CBC/Chem 2/6: ALP 458, remainder WNL. Fasted (12+h) rads 2/6: soft tissue opacity in gastric lumen, fluid/gas distended intestines, no obstruction, suspect ileus. Hepatomegaly. Nodular structure associated w caudal ventral margin of liver. Admitted for 8h IVF, IV Cerenia and offered bland diet. Initially did well yesterday afternoon but nausea, licking, hypersalivation returned overnight w new lethargy. Repeat AXR 2/7 consistent w normal gastric emptying. Chronic hx: Sensitive GI since 2019, mostly diarrhea. GI symptoms will flare (diarrhea, no vomiting) when new foods would be introduced (anything other than GI diet). Course of Metronidazole typically helped symptoms.
Abnormal PE/Chem/CBC/UA Results: Soft, NP abdomen, chronic moderate abdominal distension wo obvious organomegaly, masses or fluid. MM pink, sl tacky, CRT <2.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder and visible portion of the pelvic urethra are normal for the degree of luminal distension. The urine is anechoic with no evidence of debris. Cystic calculi and discrete masses are not observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The left kidney is normal size (xxx cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. Hyperechoic shadowing diverticular foci are visualized. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (5.33 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. Hyperechoic shadowing diverticular foci are visualized. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.70 cm at cranial pole) (0.59 cm at caudal pole); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.98 cm at cranial pole) (0.57 cm at caudal pole) (2.14 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (1.54 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

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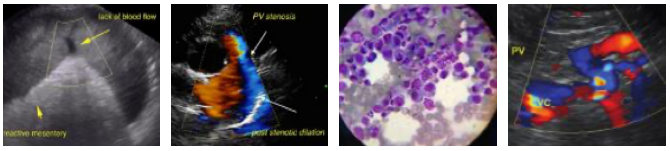

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Liver

The liver is subjectively enlarged with slightly swollen peripheral contours. The parenchyma is isoechoic relative to the spleen with a few ill-defined hypoechoic areas, the largest measuring 1.98 cm in diameter. At least one small hyperechoic nodule is also seen. Vascular and biliary tracts are of normal volume with no evidence of congestion. The gall bladder lumen is moderately distended. The wall is normal in thickness. A moderate to large amount of aggregated echogenic suspended sludge in a partially stellate pattern is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. No obstructive disease is noted.

Pancreas

The base of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely isoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Free Abdomen

The peritoneal cavity is normal. There is no evidence of inflammation or effusion. The abdominal lymph nodes are normal/not visible.

Other

A uterine stump is visible (0.46 cm in width). No obvious pathology is observed.

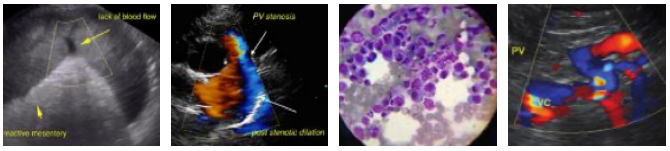
ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The gallbladder changes are consistent with a developing mucocele. The changes appear to have progressed since the previous sonogram.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory and infiltrative disease are considered less likely. Changes are similar to the previous sonogram.

Secondary Findings:

- Minor age-related renal changes with dystrophic mineralization.
- Visible uterine stump- incidental.



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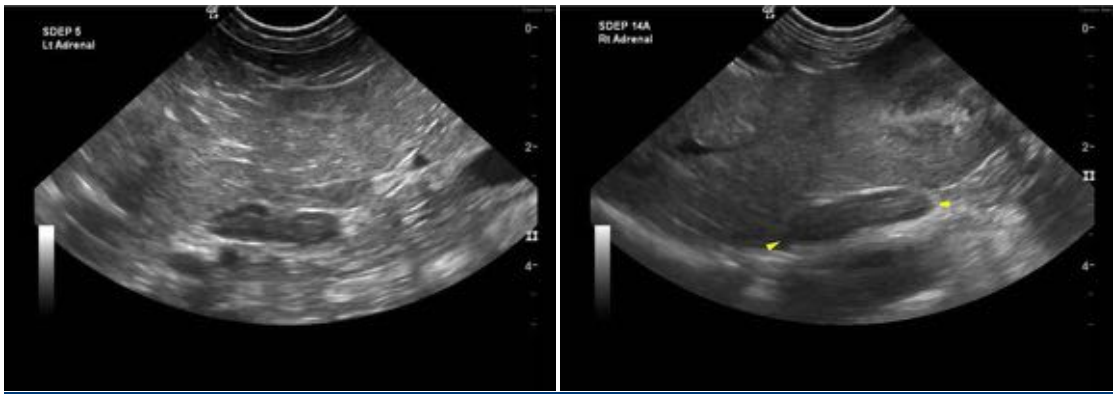
*An obvious cause for the patient's clinical signs is not identified in this study. Considerations include low-grade pancreatitis, microscopic gastrointestinal disease (i.e., gastroenteritis, infectious/parasitic, intestinal dysbiosis), occult cholecystitis (i.e., secondary to a developing mucocele), other metabolic issue.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Baseline labwork including a CBC chemistry panel, urinalysis and T4 is recommended, if not already performed.
- Given the gall bladder changes, Ursodeoxycholic acid (Ursodiol) at 10-15 mg/kg once a day is recommended. Serial sonographic monitoring (e.g., every 6-8 weeks) of the gall bladder is recommended to assess for progression to a fully-formed mucocele.
- Regarding the vomiting, consider the following:

1. A fecal evaluation for ova/Giardia
2. GI panel including serum cobalamin, folate, TLI and PLI
3. A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended
4. Consider three-view thoracic radiographs to assess for occult esophageal disease.
5. If clinical signs persist despite supportive measures, endoscopic or surgical gastrointestinal biopsies may be necessary to get a definitive diagnosis. If surgery is pursued, evaluation of the gall bladder +/- cholecystectomy should be considered.



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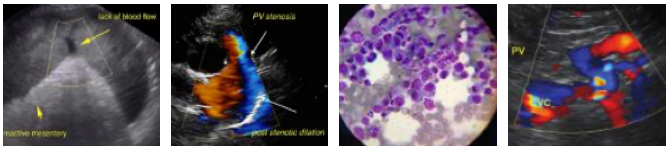

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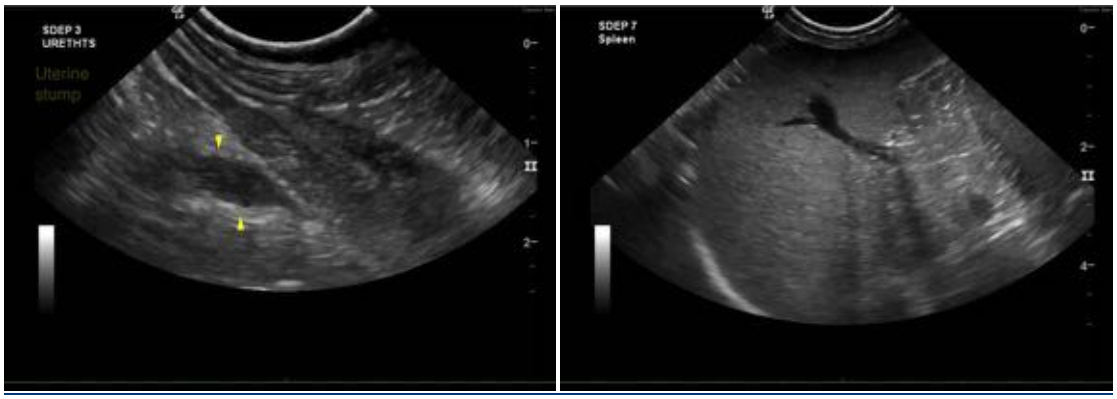

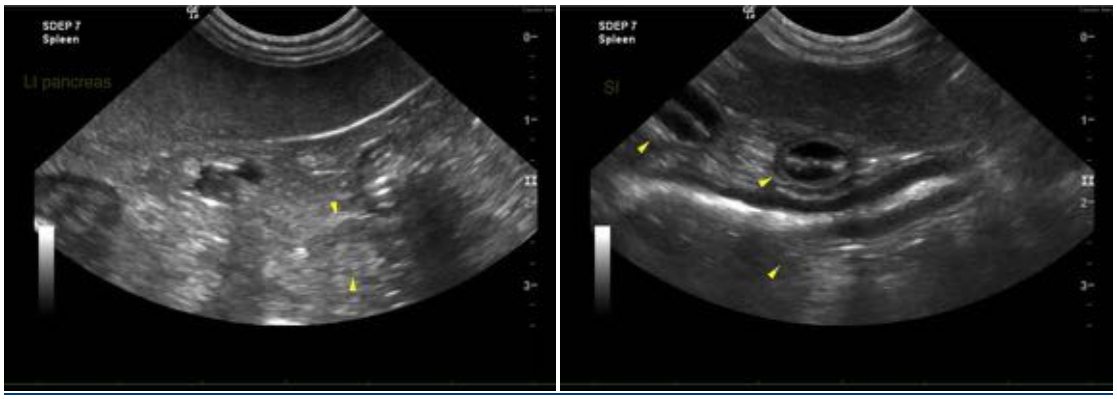

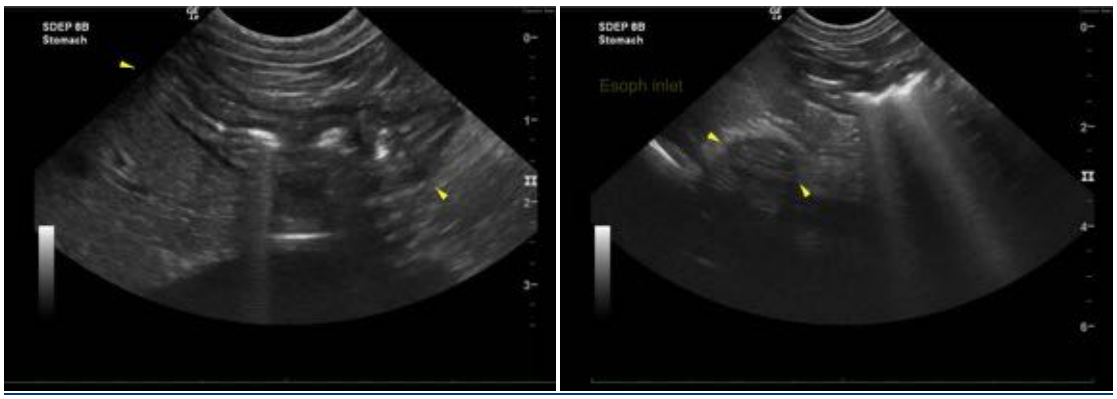

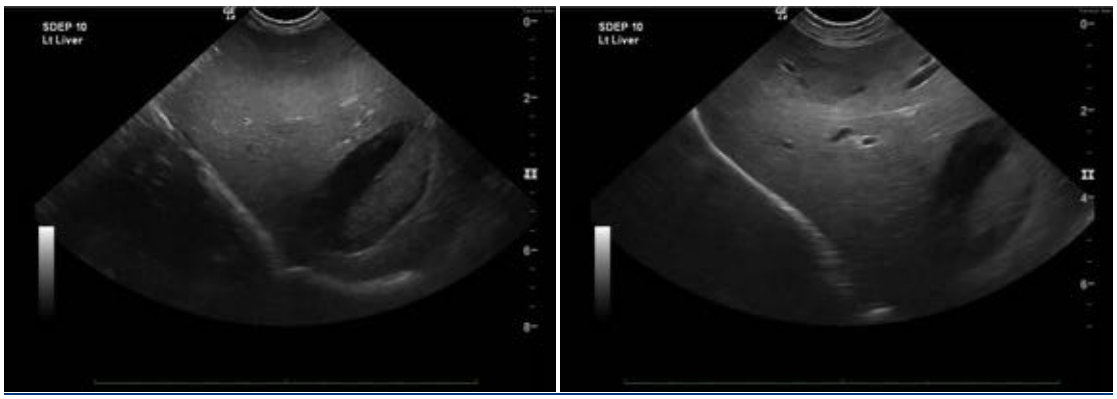

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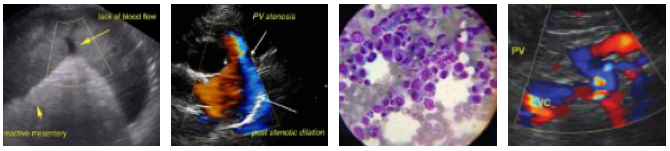

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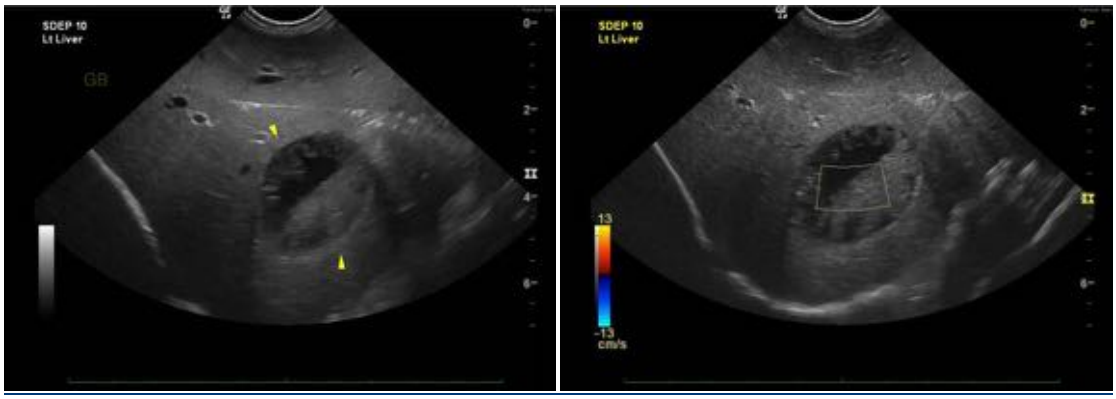

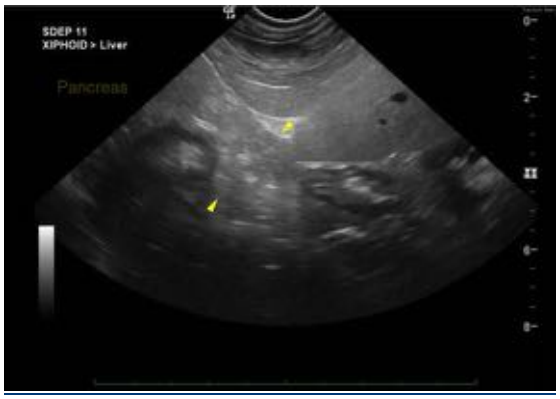

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, DVM, Diplomate ACVIM (*Small Animal Internal Medicine*)

Andrea.nicastro@sonopath.com