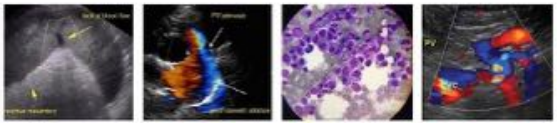


PATIENT

Winston Pakkala

SPECIES

Canine

BREED

Yorkie

SEX

Male, neutered

AGE

6 Yrs.

WEIGHT

3.13 kg.

INTERPRETED BY

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

IMAGING PERFORMED BY

Kelly REschny

HOSPITAL NAME

Preston AC

REFERRING VET

Dr. Karafilov

DATE

9/26/22

PRESENTING CLINICAL SIGNS

History: Dating back to May 2019, has had episodes of stumbling & reduced responsiveness followed by vomiting. Episodes used to happen once or twice per year but have been increasing in frequency (4 from January to July 2022). Episodes have also worsened in that sometimes will fall over & have frothing at mouth, and recently has been running wildly into walls/tables (not aware of surroundings). Bloodwork done in Feb 2020 showed elevated post-prandial bile acids at 66 (over 30 is considered significant). Owner declined referral / further work-up at that time. Presented again in Sept 2022; owner reports his appetite is sometimes decreased and has lost a bit of weight. Seems nauseous: pawing at mouth, asking to go outdoors to vomit. Bowel movements / drinking are normal. Started empirical treatment with Cerenia, gabapentin & switched to Gastro Low Fat - so far patient is responding well to this protocol meds: Hydroxyzine, Cerenia, gabapentin, Bravecto, Interceptor Plus
Abnormal PE/Chem/CBC/UA Results: Historical post- bile acid elevation (Feb 2020). Bloodwork repeated in Sept 2022 showed only mild elevation in random bile acid (16; 15-30 is considered mild) - but patient hadn't eaten much that day. spec CPL is abnormal at 859 (over 200 considered significant). Plan to do pre- & post-bile acid testing as well as folate/cobalamin testing when in for abdominal ultrasound

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder lumen is moderately distended with anechoic urine. No masses, inflammatory changes or calculi are observed. The region of the trigone is normal.

The prostate is not definitively visualized due to its pelvic location.

The left kidney is normal size (3.10 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (3.48 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

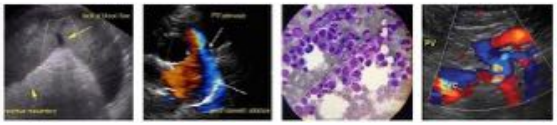
Adrenal Glands

The left adrenal gland is normal size (0.44 cm at cranial pole) (0.43 cm at caudal pole) (1.49 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.

The right adrenal gland is normal size (1.09 cm at cranial pole) (0.51 cm at caudal pole) (1.77 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 (0.75 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.



PATIENT
Winston Pakkala

SPECIES
Canine

BREED
Yorkie

SEX
Male, neutered

AGE
6 Yrs.

WEIGHT
3.13 kg.

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

IMAGING PERFORMED BY
Kelly REschny

HOSPITAL NAME
Preston AC

REFERRING VET
Dr. Karafilov

DATE
9/26/22

Liver

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed. The gall bladder lumen is moderately distended. The wall is thin and smooth. A moderate amount of aggregated echogenic partially dependent sludge 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 right limb of the pancreas is visible/prominent with minimal deviation from the normal peripheral contours. The parenchyma is hyperechoic relative to surrounding omental fat and subtly mottled in appearance. No distinct focal lesions are observed. The pancreatic duct is not overtly dilated.

Free Abdomen

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

ULTRASONOGRAPHIC FINDINGS

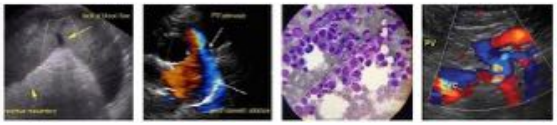
- The pancreatic changes are most consistent with age-related remodeling/fibrosis. Mild chronic pancreatitis may also be present, correlation with the patient's clinical history is recommended.
- Gallbladder sludge, non-mucocele.

*An obvious cause for the patient's clinical signs is not identified in this study.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Regarding the neurologic signs, a baseline blood pressure measurement is recommended along with a T4/free T4 by equilibrium dialysis. Ultimately, consultation with a board-certified neurologist may be warranted for further workup.
- Regarding the GI signs, consider the following:
  1. Thoracic radiographs to assess for occult esophageal disease.
  2. A fecal evaluation for ova/Giardia.
  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. Depending on the results of the above diagnostics as well as the pending B12/folate levels and serum bile acids, GI biopsies may be warranted.

SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com



THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 infoethefocalzone.com

PATIENT

Winston Pakkala

SPECIES

Canine

BREED

Yorkie

SEX

Male, neutered

AGE

6 Yrs.

WEIGHT

3.13 kg.

INTERPRETED BY

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

IMAGING PERFORMED BY

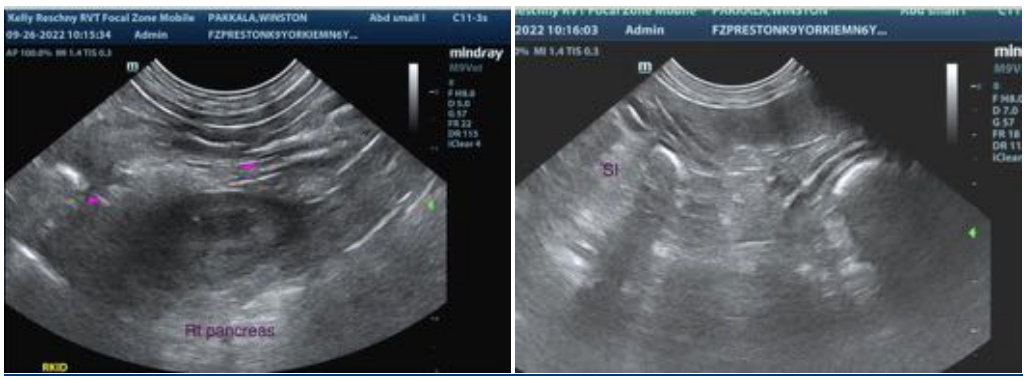
Kelly REschny

HOSPITAL NAME

Preston AC

REFERRING VET

Dr. Karafilov



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, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com

DATE
9/26/22