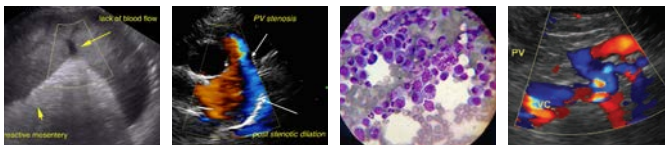
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Milley Rizzitello

SPECIES

Canine

BREED

Dachshund

SEX

Spayed Female

AGE

13 Years

WEIGHT

N/A

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Kelly Vazquez

HOSPITAL NAME

Westwood Regional

REFERRING VET

Dr. Hartwick

INVOICE

45149

DATE

2/15/23

PRESENTING CLINICAL SIGNS

Previous history of gall bladder sludge vs. polyp, etc. PLE: History of occasional vomiting, stools relatively normal, weight stable. After AUS 7/6/22: dewormed Panacur x 7 days, TLI/Cobalamin/Folate= TLI > 50, all else WNL. SBA 2/7/23= WNL. Albumin/glob. below normal. Looking for treatment options (steroids? steroids?). Current eds: Tylan 1/16 tsp SID, famotidine 5 mgs SID, Z/D diet.

Abnormal PE/Chem/CBC/UA Results: 2/1/23: TP 3.9, Alb. 2.4, Glob. 1.5, Alk. Phos. 632. U/A= negative for protein.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended with primarily anechoic contents and occasional echogenic non-shadowing debris. Apical urinary bladder wall is diffusely thick (0.35 cm). Mucosa is hyperechoic and irregular. No masses are observed. A small 0.20 cm cystoliths is noted. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface.

The right kidney is normal in size (cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal in size (4.12 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia or infarcts observed. A small non-obstructive nephrolith is visualized.

Adrenal Glands

Adrenal glands are plump/swollen in size (3.75 cm). Normal shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. The right adrenal gland measures 1.91 cm long x 1.09 cm at the cranial pole and 0.71 cm at the caudal pole. The left adrenal gland measures 2.1 cm long x 0.47 cm at the cranial pole and 0.62 cm at the caudal pole.

Spleen

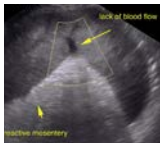
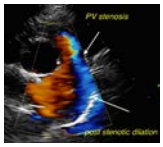
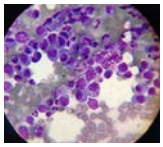
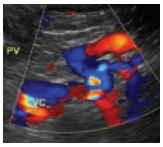
The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. A homogeneous, non-cystic, hyperechoic mass is noted in the superficial left liver measuring 1.8 cm x 3.2 cm in size. Visible vasculature and biliary tree appear normal without distension or congestion.

The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. Near the neck of the gallbladder, there is a 1.2 cm x 0.90 cm echogenic density without evident shadow. There is no evidence of cystic or common bile duct dilation.

SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

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

PATIENT
Milley Rizzitello

SPECIES
Canine

BREED
Dachshund

SEX
Spayed Female

AGE
13 Years

WEIGHT
N/A

INTERPRETED BY
Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY
Kelly Vazquez

HOSPITAL NAME
Westwood Regional

REFERRING VET
Dr. Hartwick

INVOICE
45149

DATE
2/15/23

Gastrointestinal

Fundic mucosal hypertrophy with hyperechoic mucosa and some mucosal remodeling is noted. There is no loss of mural detail. Layering is normal. There is mild luminal fluid accumulation. No evidence of masses/nodules or foreign material present.

The visible small intestines are normal in wall thickness and layering. Subtle hyperechoic mucosal fogging or speckling is noted. Small intestinal motility appears adequate (1-3 contractions per min). The lumen is empty with no evidence of obstruction or foreign material.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

Pancreas is prominent (enlarged) in size and mildly irregular in shape with a slightly undulating contour. Parenchyma is coarse in echotexture and heterogenous to hypoechoic in echogenicity.

Free Abdomen

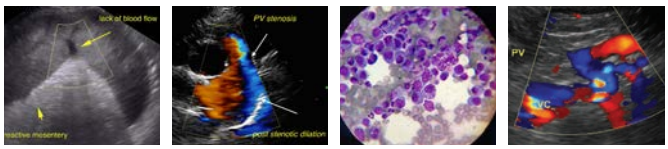
There is no evidence of free peritoneal effusion noted in these images.

There is no apparent lymphadenopathy noted in these images.

In the cranial abdomen, caudal to the stomach in the area of the pancreas, there is mildly enhanced hyperechoic mesenteric fat noted.

PRIMARY FINDINGS

- **Liver nodule/mass** – Differentials include both benign changes such as a myelolipoma or lipoma, nodular hyperplasia, fibrosis of an old hematoma, granuloma, etc. However, while considered slightly less likely, primary well differentiated hepatic neoplasia or even infiltrative round cell or metastatic neoplasia can mimic benign lesions and cannot be definitively ruled out.
- The gallbladder density may represent a benign nodule or polyp, or some accumulated debris. It is not likely of clinical significance.
- **Subtle mucosal speckling –** Mucosal speckling is often present with inflammatory bowel disease (IBD). It is not specific for type or severity of disease. Mild speckling change can occur as a normal patient variant in the post-prandial state.
- **Gastritis –** Consistent with irritation secondary to dietary indiscretion or intolerance, infection (bacterial, viral, other), parasitic or protozoal disease, toxin, other metabolic disease such as pancreatitis, other. Microulceration cannot be ruled out.
- **Chronic active pancreatitis** – However, given the enhanced mesenteric fat in the area, an acute on chronic smoldering pancreatitis may be present and resulting in the described gastric changes/gastric stasis/ileus.
- **Chronic Cystitis with small cystolith noted** - Urinary bladder wall changes are most consistent with chronic cystitis. Infiltrative neoplasia cannot be ruled out but is considered less likely give the location and diffuse nature of the changes.



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

PATIENT

Milley Rizzitello

SPECIES

Canine

BREED

Dachshund

SEX

Spayed Female

AGE

13 Years

WEIGHT

N/A

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Kelly Vazquez

HOSPITAL NAME

Westwood Regional

REFERRING VET

Dr. Hartwick

INVOICE

45149

DATE

2/15/23

- **Bilateral adrenomegaly –** consistent with adrenal hyperplasia secondary to pituitary dependent hyperadrenocorticism vs stress or normal variant. Interpret in combination with clinical signs of hyperadrenocorticism.

SECONDARY FINDINGS

- Small non-obstructive nephrolith in the left kidney

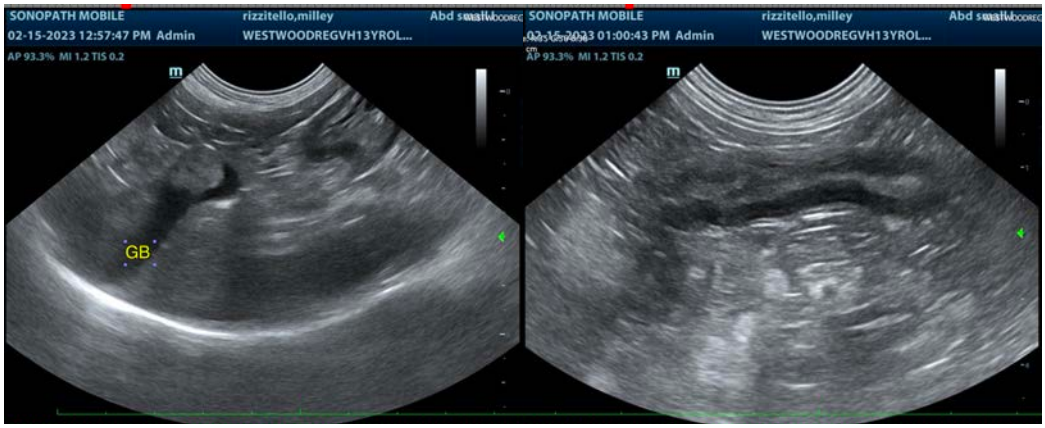
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given this patient's reported history of protein losing enteropathy but normal stool and stable weight, the continued vomiting may be secondary to some chronic smoldering pancreatitis. Therefore, for both protein losing enteropathy as well as chronic pancreatitis, a low-fat diet may be beneficial. Therefore, transition (if tolerated) to an ultra-low-fat diet is recommended at the same time as a supportive/symptomatic course of therapy for gastritis, including antiemetics, gastroprotectants, and empirical deworming with a 5-day course of Panacur.

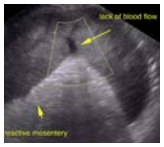
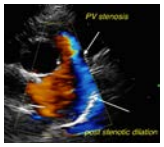
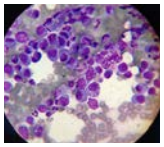
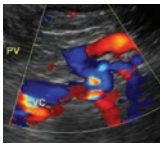
A fine needle aspirate of the liver nodule/mass is recommended if patient's coagulation status is appropriate.

If not recently evaluated, Urinalysis and, if indicated based on urinalysis results, urine culture are recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ratio is recommended.

Additionally, if this patient has clinical signs of hyperadrenocorticism, once the gastrointestinal signs are managed, further testing in the form of a low-dose Dexamethasone suppression test may be warranted. However, further evaluation of hyperadrenocorticism is not indicated without supporting clinical signs and/or while concurrent ongoing illness is present elsewhere.



SonoPath
Clinical Sonography & Telecytology

EDUCATIONAL TELECONSULTATION SERVICES™

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

PATIENT

Milley Rizzitello

SPECIES

Canine

BREED

Dachshund

SEX

Spayed Female

AGE

13 Years

WEIGHT

N/A

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Kelly Vazquez

HOSPITAL NAME

Westwood Regional

REFERRING VET

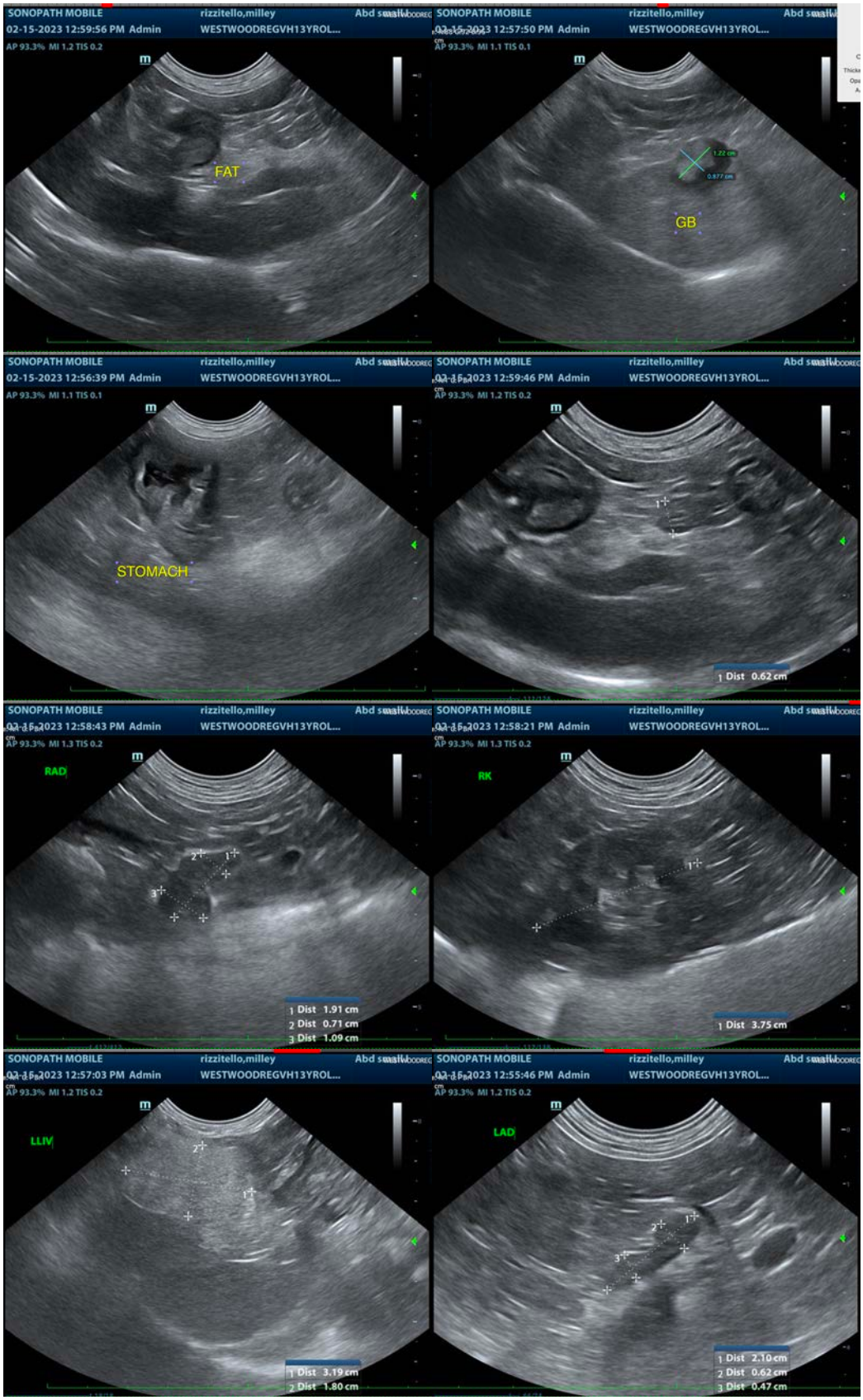
Dr. Hartwick

INVOICE

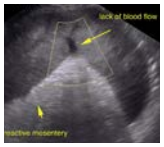
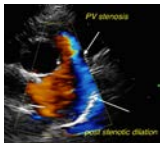
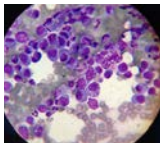
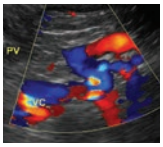
45149

DATE

2/15/23



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

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

PATIENT

Milley Rizzitello

SPECIES

Canine

BREED

Dachshund

SEX

Spayed Female

AGE

13 Years

WEIGHT

N/A

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Kelly Vazquez

HOSPITAL NAME

Westwood Regional

REFERRING VET

Dr. Hartwick

INVOICE

45149

DATE

2/15/23

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.

Beth Johnson, DVM, DACVIM
Beth.Johnson@sonopath.com