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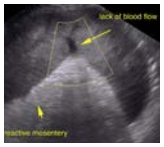
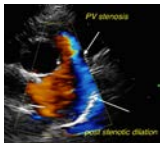
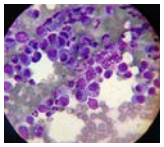
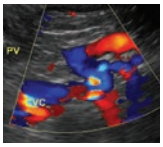

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1-800-838-4268 info@sonopath.com

**PATIENT**

Milley Rizzitiello

**SPECIES**

Canine

**BREED**

Dachshund

**SEX**

Spayed Female

**AGE**

13 Years

**WEIGHT**

16.62 Pounds

**INTERPRETED BY**

Beth Johnson, DVM DACVIM

**IMAGING PERFORMED BY**

Kelly Vazquez

**HOSPITAL NAME**

Westwood Regional

**REFERRING VET**

Dr. Hartwick

**INVOICE**

47265

**DATE**

5/9/23

## PRESENTING CLINICAL SIGNS

Patient with previous history of suspect PLE/IBD/chronic pancreatitis, and gall bladder sludge vs. polyp, etc., presents for vomiting, inappetence, diarrhea, and depressed attitude. + CPLI, low albumin. R/O emerging disease vs. other.

Abnormal PE/Chem/CBC/UA Results: Current treatments: IVFs, B12 injections (now Q 2 weeks before tapering), Tylan, RC HP diet (lowest fat hydrolyzed option). 5/8/23: Chem: TP 4.9, albumin 2.0, T. bili 1.1. CBC: WNL except mild neutrophilia. U/A: pH 7.0, all negative sediment, USG 1.018.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder is moderately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The right kidney is normal in size (3.52 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 (4.39 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. Punctate non-obstructive nephroliths are noted.

### *Adrenal Glands*

The right adrenal gland is normal in size (1.6 cm long x 0.55 cm at the cranial pole and 0.41 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (2.14 cm long x 0.45 cm at the cranial pole and 0.88 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

### *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). At the head of the spleen, a 1.2 cm x 1.6 cm, mildly heterogeneous, primarily hypoechoic nodule is noted resulting in mild capsular bulge. 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. No focal lesions are observed. 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 except for a hyperechoic irregular pedunculated 1.3 cm x 1.0 cm polyp/mass with some vascular uptake in the neck of the gallbladder. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

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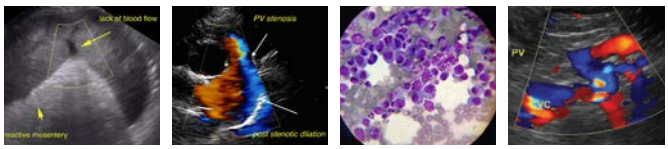

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### *Gastrointestinal*

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with very echogenic reverberation artifact from intraluminal gas. There is no evidence of obstruction, foreign material or infiltrative disease; however, complete visualization of far wall is partially inhibited by gas. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering. 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. In the caudal abdomen, there are several mildly fluid dilated loops of small bowel that are difficult to trace to origin or end point in these images. e

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

### *Pancreas*

The area of the pancreas contains irregular hyperechoic pancreatic remodeling. Additionally, there is some enhanced hyperechoic mesenteric fat in the area of the pancreas.

### *Free Abdomen*

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

There is no apparent lymphadenopathy noted in these images.

### ULTRASONOGRAPHIC FINDINGS

- **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. The loops of dilated small bowel in the caudal abdomen are most consistent with ileus/gastroenteritis secondary to the underlying gastrointestinal disease. However, it is difficult to trace them in these images, and the partial obstruction cannot be definitively ruled out.

- **Hyperechoic pancreas –** This finding is suggestive of pancreatic fibrosis, possibly secondary to chronic pancreatitis. A TLI is recommended to rule out exocrine pancreatic insufficiency (EPI), especially if clinical signs (weight loss, diarrhea, etc.) are present. The area surrounding the pancreas is concerning for possible acute or acute on chronic smoldering inflammatory process involving the pancreas.

- The vascular tissue density in the neck of the gallbladder is most consistent with a benign polyp, especially given the static appearance and lack of progression from previous ultrasound. Infiltrative neoplasia can't be ruled out but is considered less likely.

- The mildly heterogeneous, primarily hypoechoic splenic nodule trends in appearance towards benign, as is seen with hematoma, nodular hyperplasia, extramedullary hematopoiesis, etc. However, while considered less likely, infiltrative neoplasia can mimic benign lesions and cannot be ruled out.

- Non-obstructive nephroliths in the left kidney

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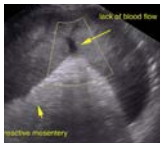
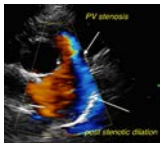
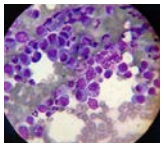
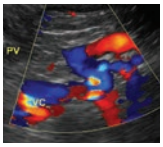

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## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This patient's acute flare up of gastrointestinal signs could be secondary to an acute episode or acute on chronic episode of pancreatitis, or an exacerbation or acute flare up of the previously suspected protein losing enteropathy. If not recently evaluated:

A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

Additionally, if not recently evaluated, looking for other contributing parasitic/infectious/other diseases could be considered with a fecal exam.

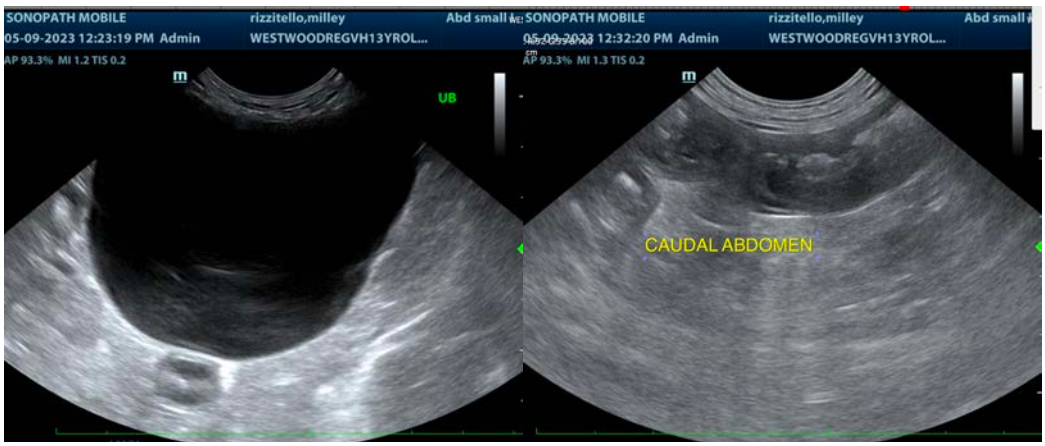
A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease.

In the meantime, medical management of pancreatitis with anti-emetics, gastroprotectants, appetite stimulants or nutritional support as needed, pain management, broad spectrum antibiotics, and fluid therapy is recommended.

Ultimately biopsies of the GI tract would be recommended to definitively diagnose and therefore potentially manage the suspected infiltrative bowel process and minimize flare ups.

However, if biopsies cannot be obtained safely due to low albumin or patient stability, etc., empirical therapies could include diet change to an ultra-low fat diet, empirical deworming with a 5 day course of Panacur, cobalamin supplementation (unless cobalamin level is evaluated and supplementation is not warranted) a probiotic and prednisolone (if not contraindicated based on patient contraindications, co-morbidities, etc.). Calcium monitoring, and supplementation if necessary, is also recommended.

If gastrointestinal signs persist, recheck imaging of the dilated bowel loops in the caudal abdomen may be warranted.



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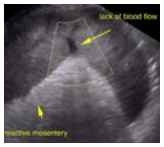
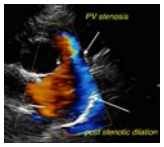
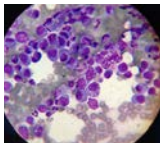
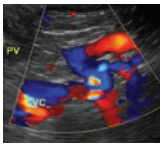

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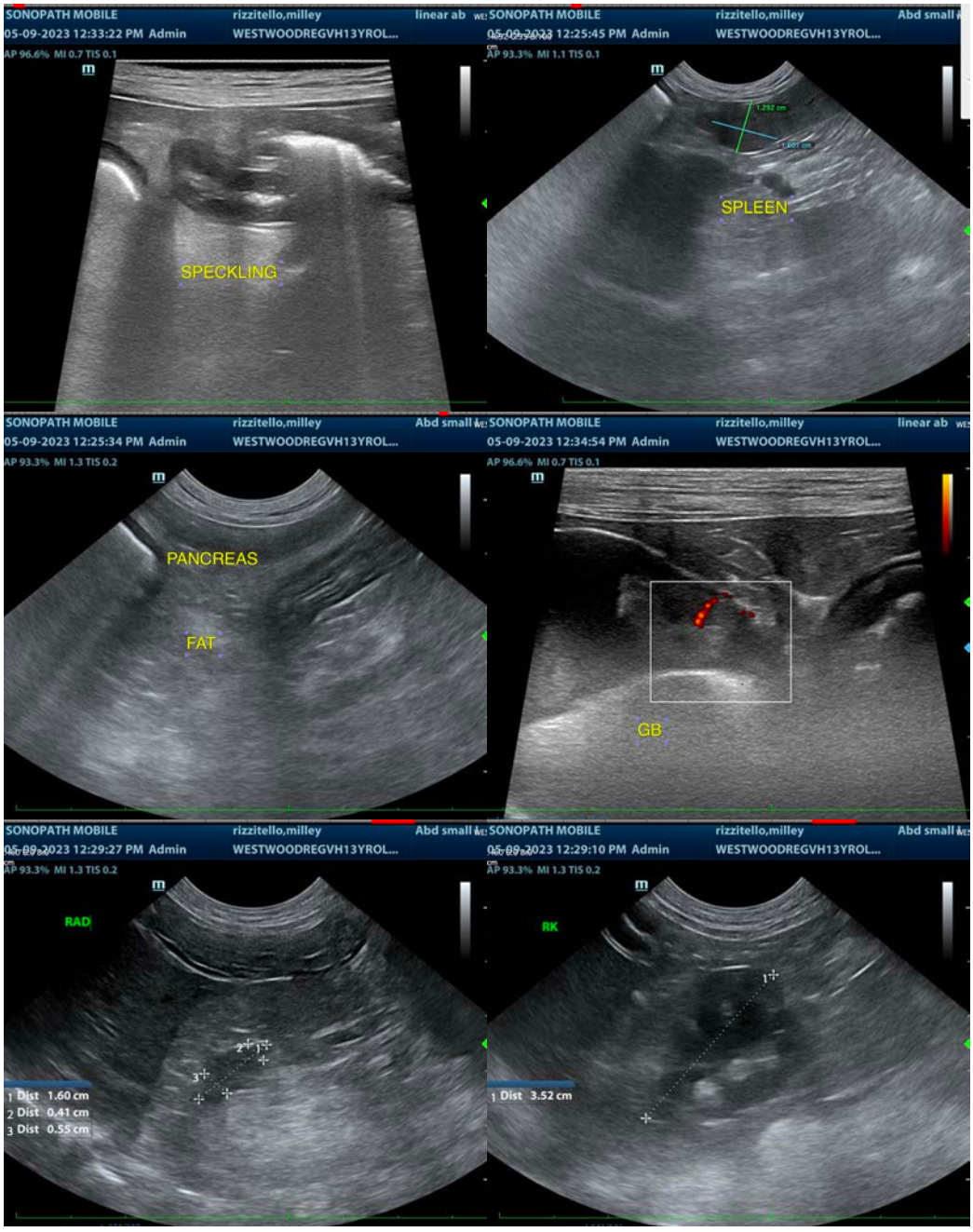

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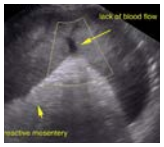
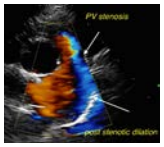
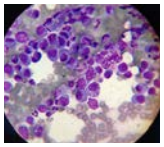
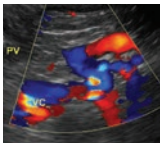

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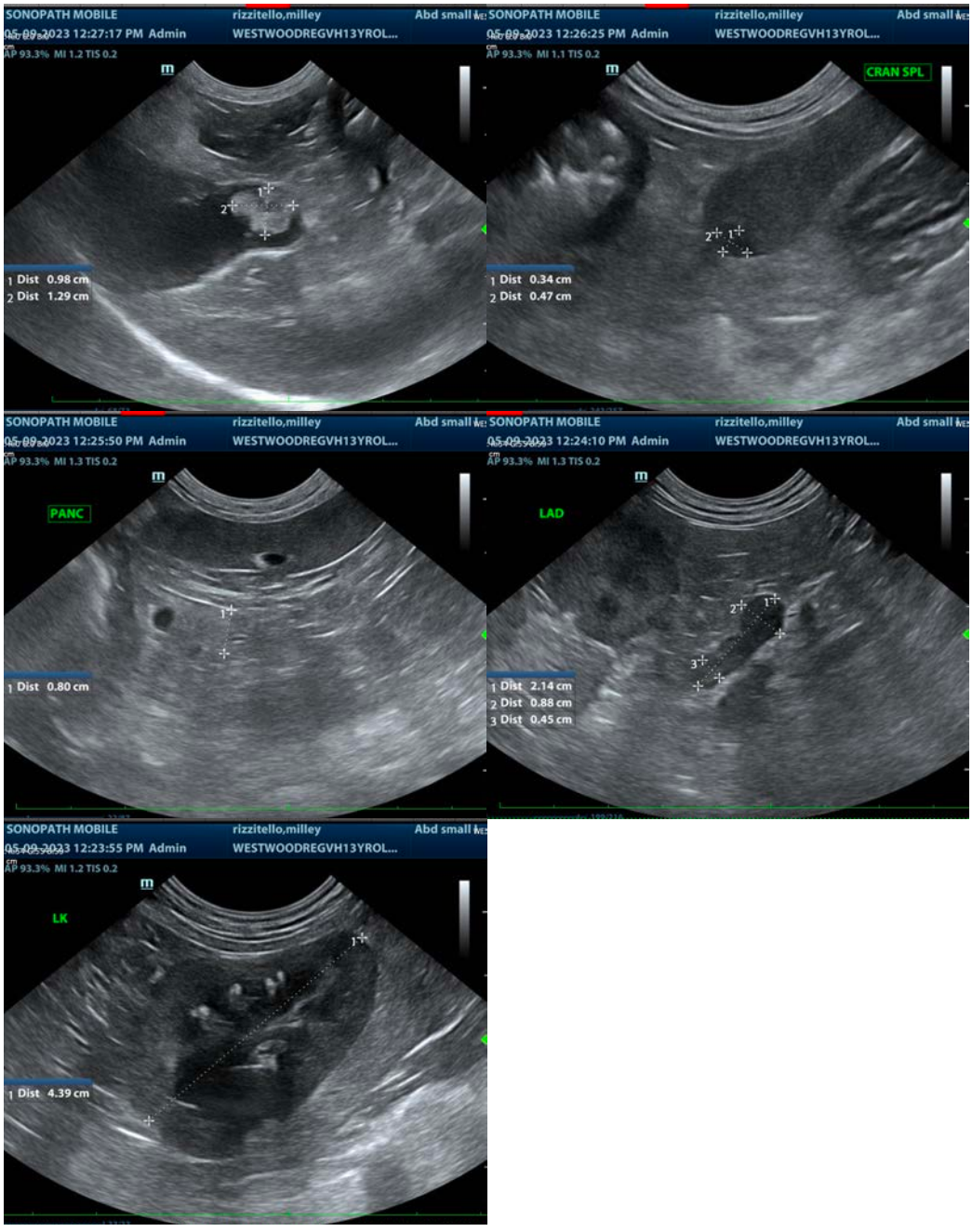


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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.

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