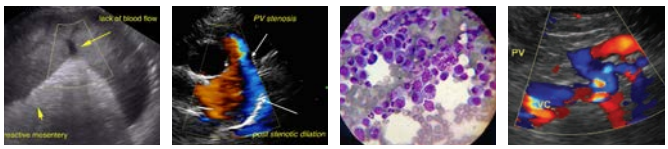
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Silvio Dennis

SPECIES
Canine

BREED
Pit Bull Terrier

SEX
Neutered Male

AGE
15 Years

WEIGHT
59 Pounds

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Kelly Vazquez

HOSPITAL NAME
The Venturing Vet

REFERRING VET
Dr. Marisa Herzog

INVOICE
38791

DATE
6/16/22

PRESENTING CLINICAL SIGNS

Patient with history of significant arthritis presents for discomfort after eating, bloating - lasting about 2-3 hours. No vomiting or diarrhea. Current meds: Tramadol for arthritis and pain after eating. A Pepcid trial did not help symptoms.
Abnormal PE/Chem/CBC/UA Results: Blood work from 8/2021: Alk. Phos. 1287, BUN 38, BUN/Creat. ratio 42, PrecisionPSL 367. Current bloods pending.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is mildly to moderately distended with anechoic contents. Apical urinary bladder wall is diffusely thick (0.56 cm thick). Mucosa is hyperechoic and irregular. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface.

Prostate (neutered) is normal in size, echotexture and echogenicity for a neutered male.

The right kidney is normal in size (6.4 cm) and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased echogenicity and mild loss of corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal in size (6.73 cm) and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased echogenicity and mild loss of corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed. A cortical cyst is present in the left kidney.

Adrenal Glands

The right adrenal gland is normal in size (1.84 cm long x 1.1 cm at the cranial pole and 0.76 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 (1.97 cm long x 0.68 cm at the cranial pole and 0.60 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

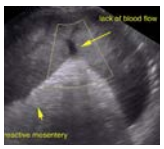
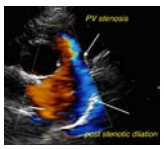
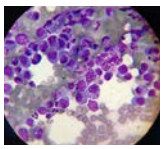
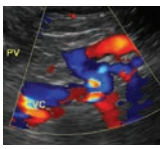
Spleen

The spleen is subjectively large in size with a normal smooth margins. Parenchyma is diffusely coarse/mottled, containing multifocal, poorly defined, hypoechoic nodules of varying sizes that do not disrupt the splenic capsule, as well as multifocal, well demarcated, hyperechoic, homogeneous nodules. 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. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

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Gastrointestinal

The stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. However, the muscularis in the ileum is mildly thick relative to the other layers. Contents are consistent with normal formed feces and gas.

Pancreas

The pancreatic parenchyma is appropriately isoechoic to surrounding tissue. Visible capsule is smooth and normal in contour. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is no evidence of peritoneal effusion. There is no apparent lymphadenopathy.

PRIMARY FINDINGS

- Coarse, nodular spleen – Differentials include benign conditions such as extramedullary hematopoiesis or lymphoid hyperplasia, as well as infiltrative neoplastic disease such as round cell neoplasia. The hyperechoic nodules are most consistent with benign myelolipomas. Other differentials such as fibrosis or calcification caused by old hematomas or infarct, chronic inflammation, granulomatous disease, metastatic disease, etc. cannot be ruled out, but are considered less likely.

- Thick muscularis layer in the ileum – suggestive of infiltrative inflammatory bowel disease versus normal patient variant. No evidence of neoplasia. However, infiltrative neoplasia such as lymphoma cannot be ruled out.

SECONDARY FINDINGS

- Chronic Cystitis – 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.

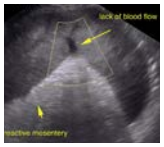
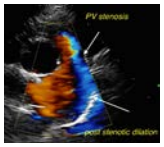
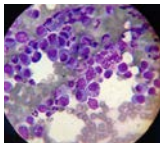
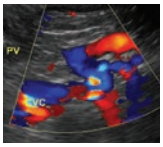
- Age related kidney change – This finding is expected/consistent with age-related mild degenerative disease and should be interpreted clinically in combination with laboratory changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Fine needle aspirate of the spleen is recommended if patient's coagulation status is appropriate.

3-view thoracic radiographs are recommended for further evaluation of possible metastatic disease, if not recently evaluated.

Given the reported gastrointestinal signs combined with the thick muscularis layer in the ileum, further evaluation for an infiltrative gastrointestinal disease +/- maldigestion is indicated, beginning with a

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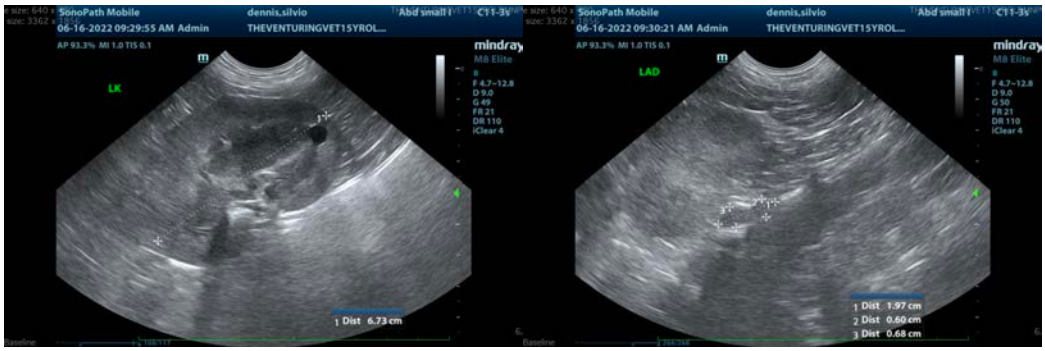
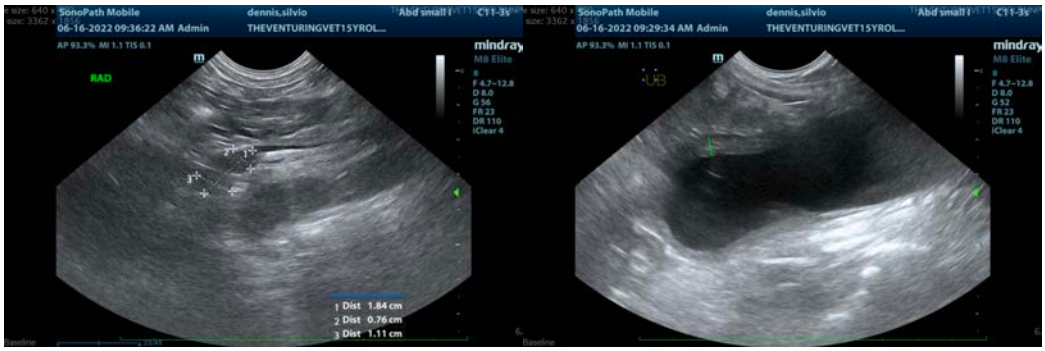
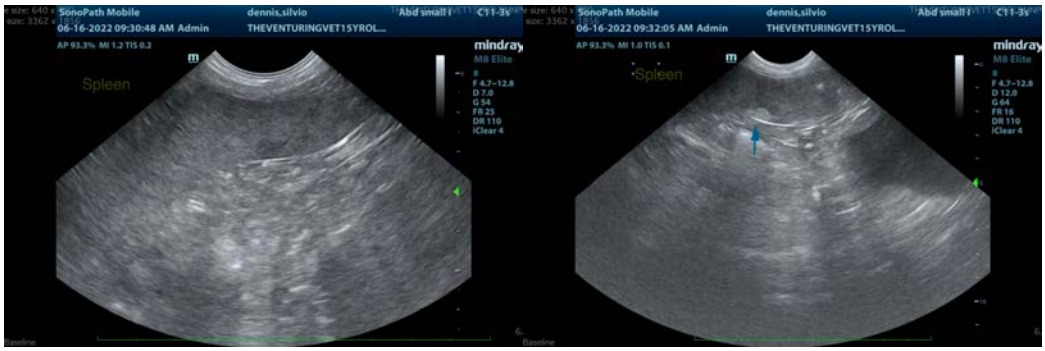
malabsorption panel to include TLI, PLI, folate and cobalamin to Texas A&M GI laboratory.

Urinalysis with follow up urine culture, if indicated based on urinalysis results, is recommended, given the urinary bladder wall changes.

Ultimately, pending results of the aforementioned diagnostics, biopsies of the bowel, being sure to include the ileum, may be necessary to definitively diagnose and therefore manage the cause of this patient's discomfort after eating and gastrointestinal signs. However, in the meantime, empirical deworming with a 5-day course of Panacur, transition in diet to different diets using a trial and error basis, potentially beginning with a novel or hydrolyzed protein diet, then perhaps progressing to a high fiber diet if the first one is not successful would be recommended. A daily probiotic may also be beneficial.







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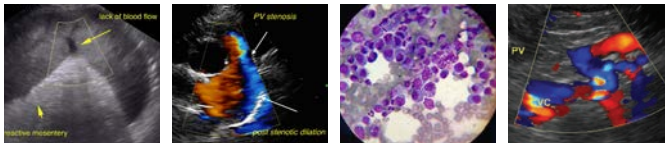

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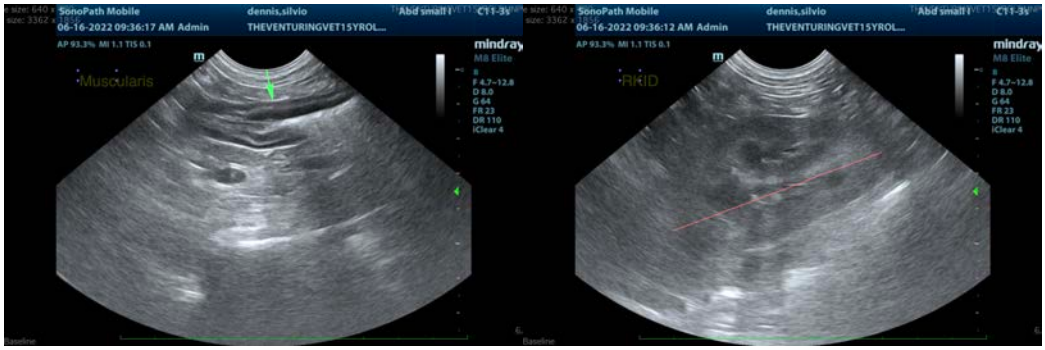

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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