

**DATE PRESENTING CLINICAL SIGNS**

8/31/22 Weight gain with decreased appetite, blood coming from rectum prior to stools. History of intermittent bloody stool. Possibly enlarged spleen.

PATIENT

Gabby Celestini

Current Medications: None listed.

Lab Results: Elevated ALP, SDMA and BUN. Decreased T4.

Date of Previous IntraPet Ultrasound: No previous.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

SPECIES

Canine

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**BREED**

Boxer X

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.

SEX

Spayed Female

Kidneys are normal in size but mildly irregular and diffusely echogenic with mildly decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted and no mineral is observed. The left kidney measures 6.06 cm. The right kidney measures 7.55 cm.

AGE

11/19/10

Adrenal Glands

The right adrenal gland is normal in size (3.2 cm long x 1.0 cm at the cranial pole and 0.98 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

WEIGHT

59 Pounds

The left adrenal gland is normal in size (3.0 cm long x 0.68 cm at the cranial pole and 0.89 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

INTERPRETED BYBeth Johnson, DVM
DACVIM**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.

IMAGING PERFORMED BY

Rachel Brilhart RDMS

Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion.

HOSPITAL NAME

Mount Airy AH

REFERRING VET

Dr. Atchley

Gallbladder is mildly overdistended with a moderate amount of non-dependent, mildly aggregated/inspissated sludge. Hypo to anechoic cystic areas are noted between the gallbladder sludge and luminal wall. The wall is otherwise smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion.

INVOICE

40925

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. 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 free peritoneal effusion noted in these images.

There is no apparent lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- **Heterogenous Liver** – These changes are most consistent with benign processes such as nodular hyperplasia, steroid (vacuolar) hepatopathy, extramedullary hematopoiesis or possibly chronic inflammatory disease and less commonly infiltrative round cell or metastatic neoplasia.
- **Emerging mucocele** – Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. The non-dependent nature of this sludge combined with the cystic areas are suggestive, however, of possible emerging cystic mucosal hyperplasia or early gallbladder mucocele.
- **Chronic Kidney Disease** – This appearance of the kidneys is consistent with chronic kidney disease such as chronic glomerular or interstitial nephritis, chronic pyelonephritis, etc.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

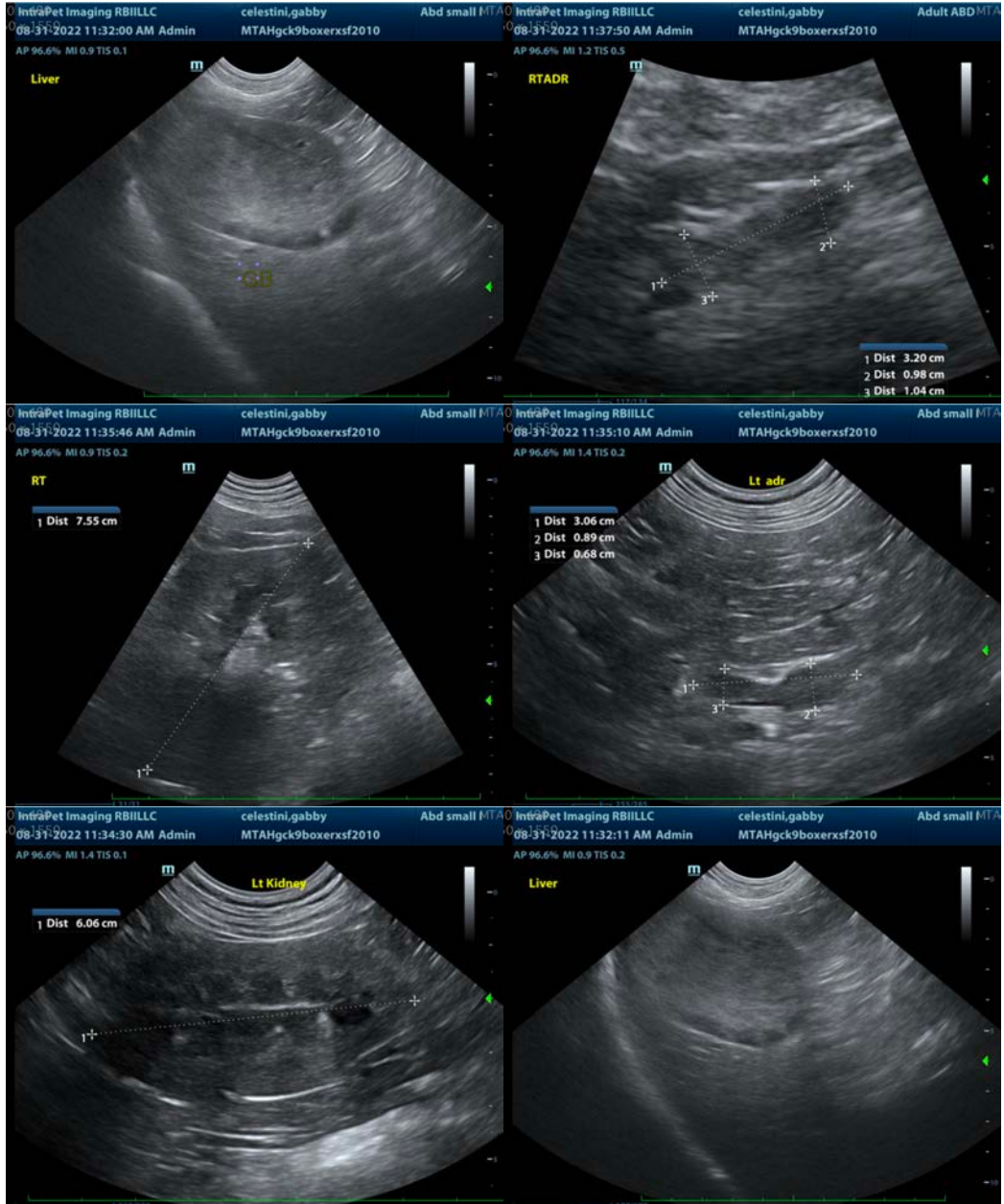
Given this patient's reported weight gain, despite a decreased appetite, hypothyroidism is considered a top differential. Therefore, given the reportedly low T4, medical management of hypothyroidism is recommended.

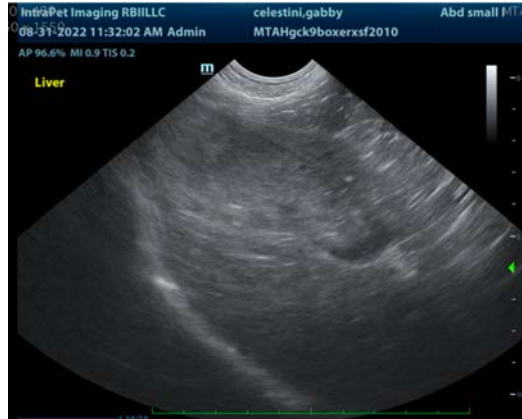
The emerging gallbladder mucocele may also be contributing to decreased appetite, and therefore should continue to be monitored depending on patient's response to management of hypothyroidism. In the meantime, empirical therapy with Ursodiol could be considered. If clinical signs are consistent with an emerging mucocele contributing to decreased appetite such as cranial abdominal pain, nausea, changes in liver enzymes, etc., then a cholecystectomy could be considered alternatively.

Give the reported hematochezia, 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.

A fecal exam and fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Empirical deworming with a 5-day course of Panacur is recommended, as well as potential transition to a higher fiber or colitis diet, or the addition of fiber to the current diet, as well as probiotic +/- Metronidazole or Tylosin could all be considered.

Ultimately, if the gastrointestinal signs persist, colonoscopy may be warranted for further infestation.





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.

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