



PATIENT

Pennie Kittilson

SPECIES

Canine

BREED

Miniature Golden Retriever

SEX

Spayed Female

AGE

7 Years 1 Month

WEIGHT

15.8 Pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Raul Casas-Dolz

HOSPITAL NAME

State Ave Vet Clinic

REFERRING VET

Dr. Raul Casas-Dolz

INVOICE

40142

DATE

8/4/22

PRESENTING CLINICAL SIGNS

Diabetic with history of Pancreatitis. Lethargic, not wanting to cuddle, secluding herself Not eating right/well, noticed a couple weeks ago. Within the last 3-4 days, she has not wanted to eat her regular food No V, but has diarrhea (has been ongoing for some time) Current meds: Insulin 4 1/2 units AM, 4 units PM, no longer have Cerenia or Metronidazole O believes she might possibly painful because she won't jump onto the bed or in the car currently O believes this could be a Pancreatitis flair-up Visited SD at the end of July, no HW prevention or Flea/Tick prevention curenly No other concerns at this time BAR; p/sl tacky mm; CRT 2s; no mur/arrh; no abn lung sounds; no abd dist; sl tense during abd palp; sl uncomfortable with abd palp; ambulating normally; dried feces on hairs around anus; eyes, ears, LNs WNL SpG: 1.054

Abnormal PE/Chem/CBC/UA Results: CBC MPV 11.6+ Chem. ALP 379 BUN 29 GLU 257 GLOB 2.3

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 (5.0 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. A hyperechoic band parallel to the corticomedullary border is present.

The left kidney is normal in size (4.8 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. A hyperechoic band parallel to the corticomedullary border is present.

Adrenal Glands

The adrenal glands are unable to be well visualized in these images.

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

Liver is subjectively enlarged (swollen contour) without disruption of architecture. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen and falciform fat. 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.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta.



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There is no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

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The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease.

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

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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.

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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

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- **Hyperechoic hepatomegaly** - This appearance is non-specific and most consistent with a benign steroid (endocrine) or vacuolar hepatopathy or reactive or idiopathic hepatopathy. Inflammatory and/or infiltrative disease (such as round cell neoplasia) are also possible, but considered less likely.

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- **Medullary rim sign** - This finding is of unknown clinical significance and can be a normal variant, often idiopathic. Medullary rim sign can be present with renal disease including FIP, lymphoma, hypercalcemic nephropathy, Leptospirosis, tubular disease, other and should be interpreted in combination with other more specific indications of kidney disease such as isosthenuria, proteinuria, azotemia, etc. This is a common incidental finding in patients with diabetes mellitus.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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These findings are all consistent with the reported history of diabetes mellitus. There is no ultrasonographically visible indication of pancreatitis at this time.

REFERRING VET

Dr. Raul Casas-Dolz

To rule out possible ketosis as the cause of the decreased appetite, 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 ration is recommended.

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Given the chronic diarrhea, 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.

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

Given this patient's reluctance to jump in the car, and seemingly being painful, further evaluation for possible orthopedic and/or neurologic (cervical or spinal) pain is recommended, given the lack of ultrasonographically visible cause for pain in the abdomen.



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In the meantime, supportive/symptomatic medical management of the acute gastrointestinal signs is recommended with antiemetics, gastroprotectants, appetite stimulants, and a probiotic, etc. while awaiting results of the above recommended diagnostics.

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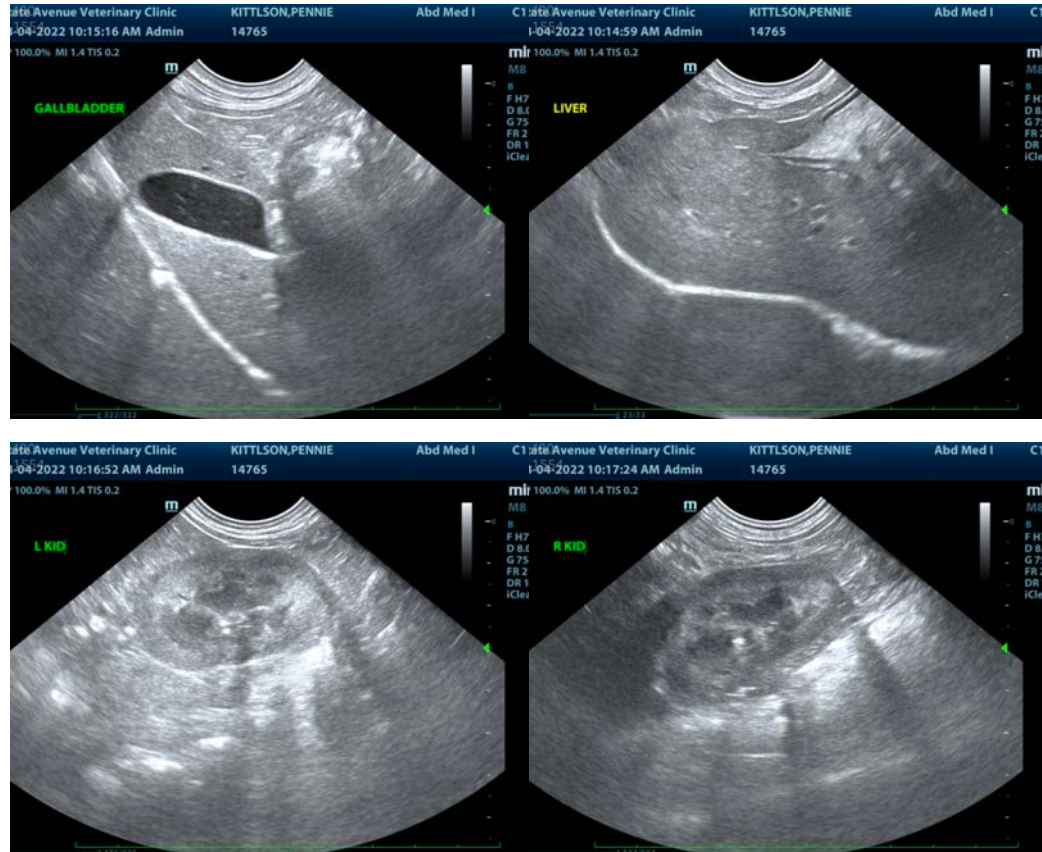
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
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