SonoPath
Clinical Sonography & Telecytology
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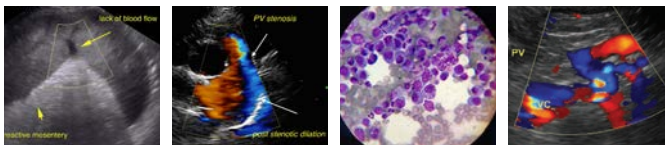


SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Simon Dudeck

SPECIES
Canine

BREED
Border Terrier

SEX
Neutered Male

AGE
14 Years

WEIGHT
15.2 Pounds

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Dr. Susan Lincoski

HOSPITAL NAME
University Drive VH

REFERRING VET
Dr. Susan Lincoski

INVOICE
41280

DATE
9/13/22

PRESENTING CLINICAL SIGNS

Chronic loose stool/diarrhea. Eating more, but stable weight. No vomit and good energy. Diarrhea panel and fecals negative.

Abnormal PE/Chem/CBC/UA Results: GGT=14, otherwise all WNL.

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 (0.4 cm). 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.

The area of the prostate is examined without evident pathology.

Kidneys are overall normal in size 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 cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. The left kidney measures 4.34 cm. The right kidney measures 4.7 cm.

Adrenal Glands

The area of the right adrenal gland is examined without evident pathology.

The left adrenal gland is normal in size (0.96 cm at the cranial pole and 0.40 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

The area of the spleen is examined without evident pathology, but the screen cannot be discretely visualized in these images.

Liver

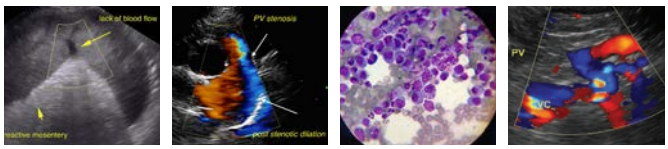
The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

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 intestine demonstrates areas of thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and



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hyperechoic, without evident loss of layering appreciated. 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

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.

PRIMARY FINDINGS

- **Inflammatory bowel disease (IBD) pattern –** Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No aggressive lymphadenopathy, loss of layering, etc. is noted to make lymphoma more probable, but lymphoma cannot be definitively ruled out without tissue sampling.

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.

- **Gallbladder debris -** 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. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

- Age related kidney changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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.

Ideally, biopsies of the GI tract, being sure to include ileum, if possible, are recommended to definitively diagnose and therefore manage the suspected infiltrative bowel disease.

In the meantime, empirical deworming with a 5-day course of Panacur is recommended as well as probiotic if not already in place, as well as a trial-and-error of diets until a helpful diet is discovered with options including a hydrolyzed protein diet or potentially a higher fiber diet, or potentially a bland, easy to digest diet as possible categories to begin with.

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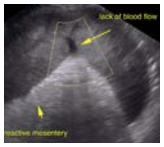
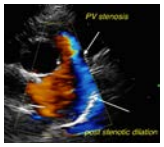
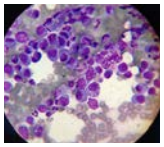
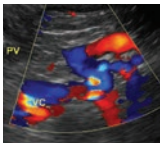

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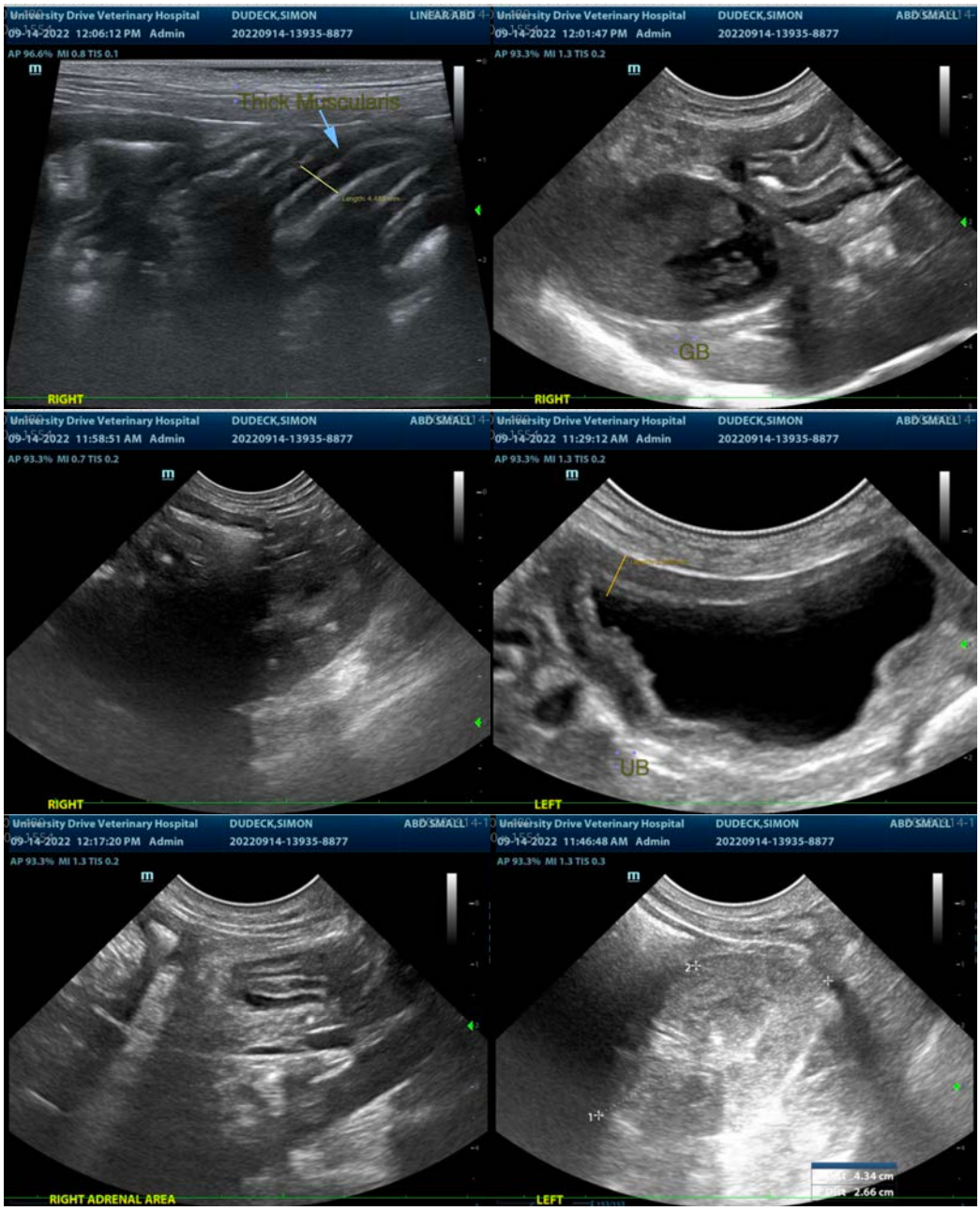

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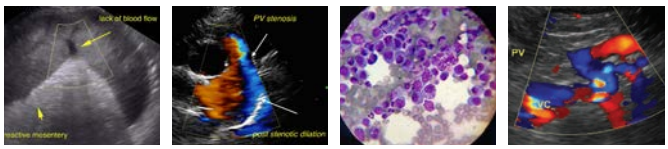

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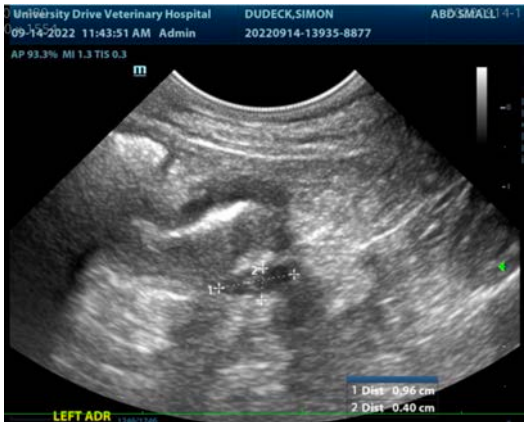

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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