



**PATIENT**

Rocky Corregio

**SPECIES**

Canine

**BREED**

Dachshund

**SEX**

Neutered Male

**AGE**

15 Years

**WEIGHT**

25.5 Pounds

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

**IMAGING PERFORMED BY**

Kelly Vazquez

**HOSPITAL NAME**

Animal General on  
Hudson

**REFERRING VET**

Dr. Daniel Tierney

**INVOICE**

17203

**DATE**

9/7/22

**PRESENTING CLINICAL SIGNS**

History: Patient with history of splenectomy in 2019 (lymphoid nodular hyperplasia with developing hematoma), presents for new grade 3/6 heart murmur.

Abnormal PE/Chem/CBC/UA Results: ALP 258, PLTs 805, monos 1098.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

Urinary bladder is adequately 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.

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

Left kidney is normal is size (4.55 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.

Right kidney is normal is size (4.4 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.

**Adrenal Glands**

Left adrenal gland is normal in size (2.0 cm long x 0.5 cm at cranial pole and 0.53 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (1.97 cm long x 1.1 cm at cranial pole and 0.64 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

**Spleen**

Spleen has been previously removed. There is no pathology evident in the area.

**Liver**

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 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 empty with 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 empty with no evidence of obstruction, foreign material or infiltrative disease.

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The visible colon is normal in wall thickness and layering. Contents are consistent with normal formed feces and gas.

**Pancreas**

**BREED**

Dachshund

The area of the pancreas contains irregular hyperechoic pancreatic remodeling.

**Free Abdomen**

**SEX**

Neutered Male

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

**ULTRASONOGRAPHIC FINDINGS**

**AGE**

15 Years

- 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 patients spleen has been previously removed

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

**WEIGHT**

25.5 Pounds

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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There is no ultrasonographically visible explanation for this patients thrombocytosis and monocytosis, etc. Further diagnostic considerations could include investigation for a chronic infectious disease and/or inflammatory disease elsewhere in the body.

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Additionally, if clinical signs of hyperadrenocorticism are present, testing for hyperadrenocorticism could be considered in the form of a low dose dexamethasone suppression test, however, testing is not indicated without supporting clinical signs.

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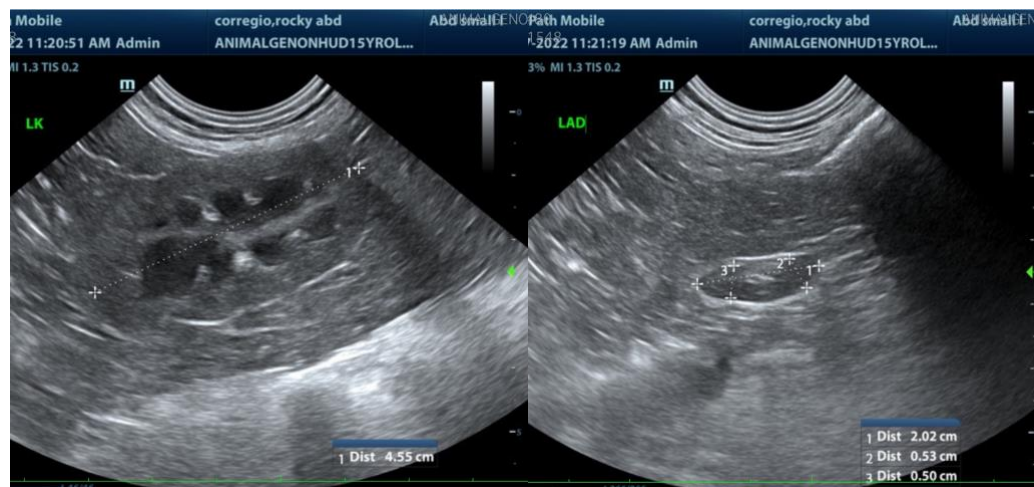
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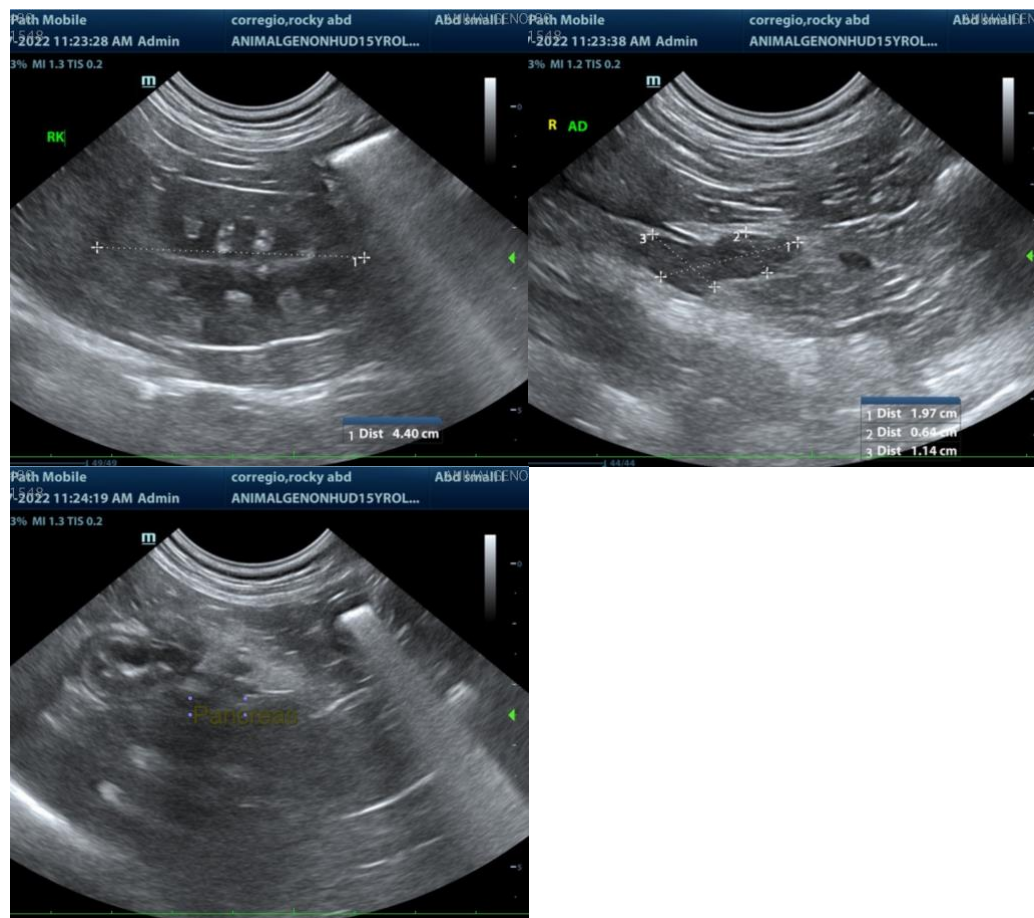
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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