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Clinical Sonography & Telecytology
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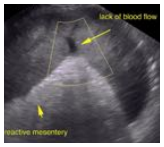
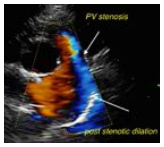
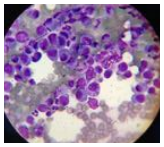
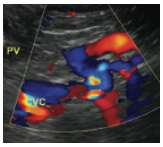

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1-800-838-4268 info@sonopath.com

**PATIENT**
Lucy Firlinger

**SPECIES**
Canine

**BREED**
Cocker Spaniel

**SEX**
Spayed female

**AGE**
14 years

**WEIGHT**
33.2 lbs

**INTERPRETED BY**
Dr Brittany Sinclair, BVSc(hons), DACVECC

**IMAGING PERFORMED BY**
M Kermendy CVT

**HOSPITAL NAME**
Wauwatosa Vet

**REFERRING VET**
Dr. Haynes

**INVOICE**
42881

**DATE**
2/20/23

## PRESENTING CLINICAL SIGNS

History: Several month history of elevated lipase and spec CPL despite low fat diet (Royal Canin Gastrointestinal low fat). Patient clinically doing well. No vomiting, hyporexia, or diarrhea. Screening for GI tract/pancreatic disease.
Abnormal PE/Chem/CBC/UA Results: Spec CPL = 1341 (0-200

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder, trigone, and visible pelvic urethra were of normal thickness. The ureters were not visible which is normal. There was normal wall layering with no masses, uroliths or abnormal thickening visualized. Urine was anechoic. No evidence of inflammatory or neoplastic changes were noted.

The kidneys have a smooth capsule and with hazing of corticomedullary definition to the point of inability to determine cortical/medullary ratio. No evidence of pelvic dilation was present. The left kidney measured 4.41 cm.

### *Adrenal Glands*

Both adrenal glands were visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The left adrenal gland measured 1.84 cm in length and 0.52 cm at the cranial pole and 0.63 cm at the caudal pole. The right adrenal gland measured 1.66 cm in length x 0.54 cm at the cranial pole and 0.58 cm at the caudal pole.

### *Spleen*

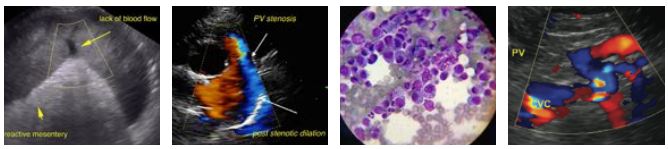
The spleen was normal with a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma and smooth capsule, with normal splenic vasculature with no signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarct changes were noted.

### *Liver*

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed. The gall bladder is moderately distended with anechoic fluid, with hyperechoic non-shadowing debris present. There is no surrounding free fluid or signs of active inflammation.

### *Gastrointestinal*

The stomach contains minimal luminal contents. It measures at a normal thickness of with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and

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there is no impression of reduced peristaltic activity. No masses or focal lesions were observed. The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed. The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

### *Pancreas*

The base and limbs of the pancreas were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour and parenchyma were normal. No overt evidence of active inflammatory or neoplastic disease was noted.

### *Lymph Nodes*

No clinically significant lymphadenopathy or abnormalities noted.

### *Free Abdomen*

No masses or free fluid were noted.

## ULTRASONOGRAPHIC FINDINGS

### Primary Findings

1. Normal pancreas
2. Normal GI tract
3. Degenerative renal changes
4. Gall bladder debris

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

GI tract and pancreas are normal. In the absence of clinical signs or ultrasonographic changes associated with elevated specCPLi, discontinuation of monitoring is responsible. Persistently elevated PLi values after clinical recovery of pancreatitis is reported. Treatment for pancreatitis is supportive and in the absence of clinical signs, no specific treatment is necessary. Continuation of low fat diet is recommended.

Gall bladder debris is likely an incidental finding and is often subclinical and often does not warrant specific treatment or further investigation. Correlate clinical significance with bloodwork findings and clinical signs. Serial imaging for monitoring could be considered especially if liver enzymes subsequently become elevated. If otherwise clinically indicated, investigation for endocrinopathy such as hyperadrenocorticism or hypothyroidism could be considered as an underlying cause predisposing to gall bladder debris accumulation.

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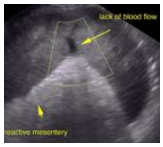
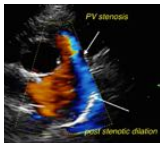
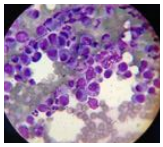
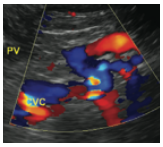

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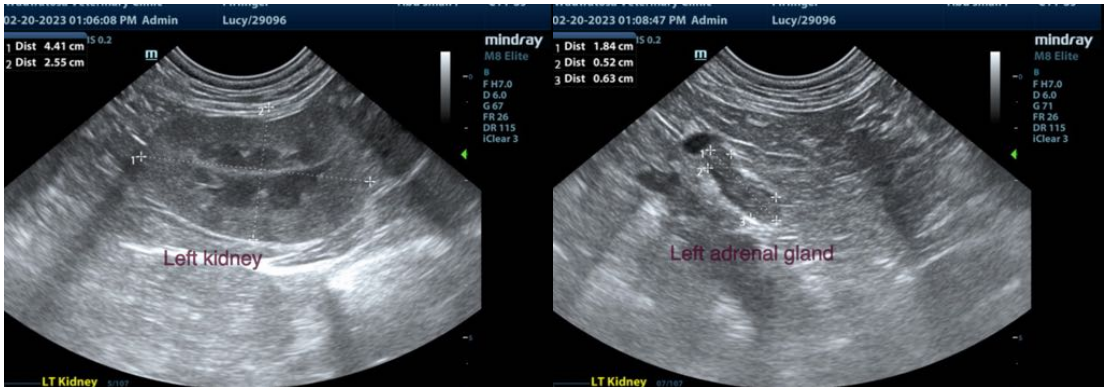
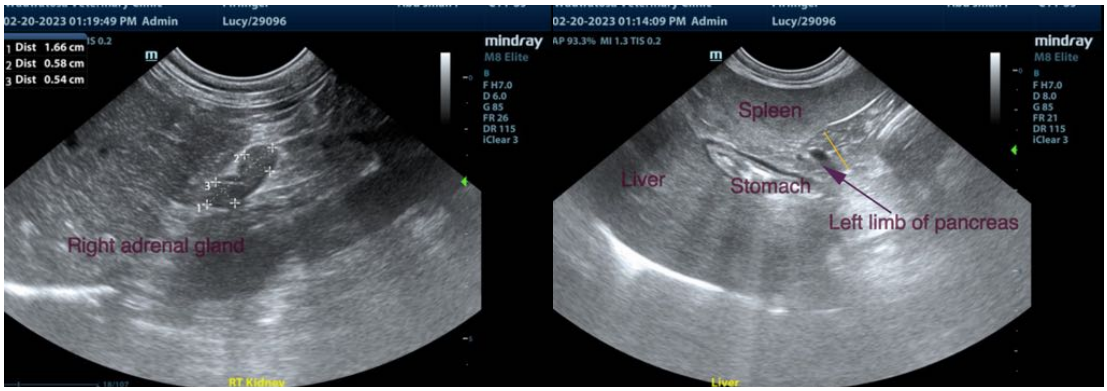
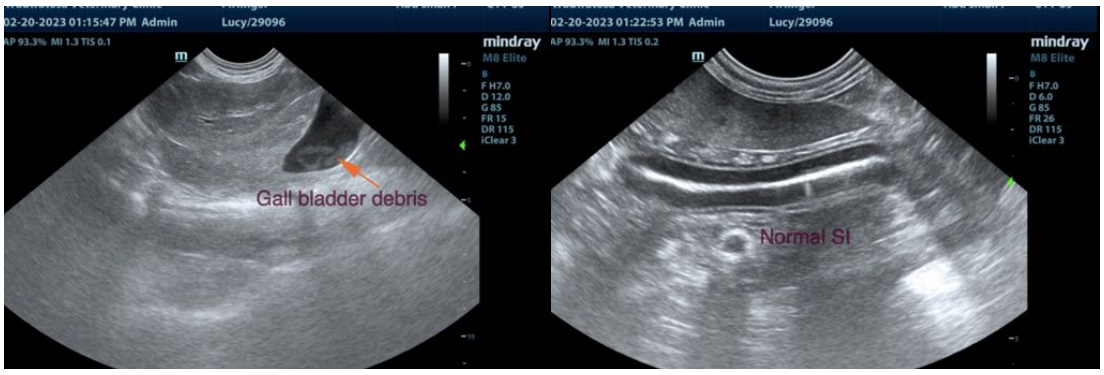
Renal changes are likely age related degeneration. Correlate clinical significance with blood work/urinalysis findings and clinical signs.



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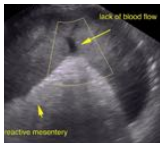
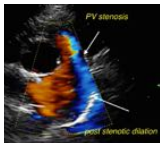
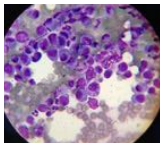
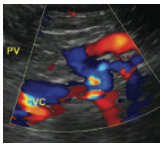

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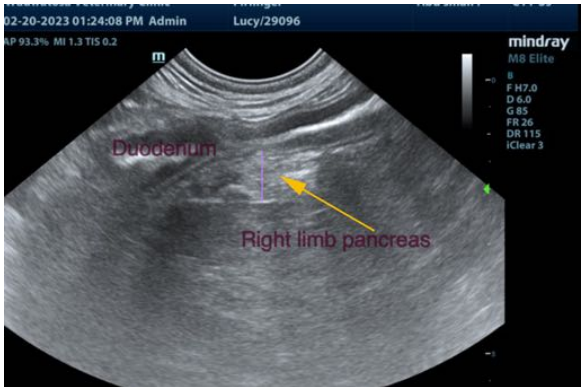


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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.

Dr Brittany Sinclair, BVSc(hons), DACVECC
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