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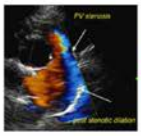
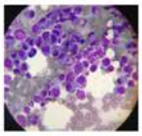
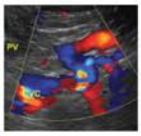

SonoPath
Clinical Sonography & Telecytology
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PATIENT

Shaun Scott

SPECIES

Canine

BREED

Miniature Schnauzer

SEX

Neutered Male

AGE

9 Years 6 Months

WEIGHT

6.4 kg

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Tracy Lasarge

HOSPITAL NAME

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REFERRING VET

Madions VS – Dr. Graham

INVOICE

44137

DATE

1/12/23

PRESENTING CLINICAL SIGNS

Shaun presented to the MVS Emergency Services yesterday for dyspnea. He came back today for AUS. No major changes since yesterday. Since late November Shaun has had episodes of open mouth breathing that last about 20-30 minutes that have recently increased in frequency. He also has had episodes of crying out and has been reluctant to jump on or off furniture. He was seen by his primary care who suspected neck pain and was treated with rimadyl which made no difference. X-rays were WNL. Blood work performed in December and normal. He was started on steroids, gabapentin, and methocarbamol. Owner reports that Shaun only want to wat canned food and has had a harder time chewing on his hard treat. She also feels like his has pain on opening his mouth. Current medications: Prednisolone 5mg bid, Gabapentin tid, Methocarbamol tid, Trazodone sid

Abnormal PE/Chem/CBC/UA Results: ALB: 4.1 ALT: 323 ALKP: 393

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, or masses. There are occasional small hyperechoic foci visualized within the urinary bladder. One such structure is visualized in the proximal urethra measuring 0.13 cm and is consistent with either hyperechoic mildly echogenic debris or a small stone.

The prostate is normal in size (0.54 cm) and shape for this neutered male dog. The parenchyma is homogenous, and the external margins are smooth. The prostatic urethra appears normal with no evidence of irregularity, invasion, mass effect or calculi.

The left kidney has a normal shape and size (4.65 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.45 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.38 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.41 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size, echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

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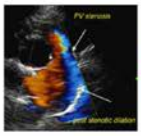
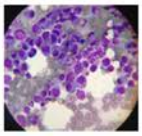
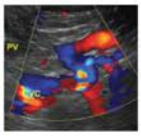

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Liver

The liver is large in size, and hyperechoic with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gall bladder lumen is significantly distended. Some areas of the wall appear mildly thickened (0.20 cm) with adherent debris. There is a large amount of primarily non-organized echogenic debris. There is no evidence of bile duct dilation.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.7cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and 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 uniform diameter with minimal fluid distension. Wall appears subjectively, mildly increased. Bowel loops follow a typical curvilinear path with distinct wall layering. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed. Duodenum wall measures 0.52 cm. Jejunum wall measures 0.40 cm.

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 pancreas is prominent and mottled compared to the surrounding isoechoic mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Small amount of echogenic debris visualized in the proximal urethra – This could represent a stone or small debris. Correlate with urinalysis and culture.
- Prominent, mottled pancreas – The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Large, heterogeneous, hyperechoic liver – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy.
- Large gallbladder debris – A large amount of debris is evident in the gall bladder with no evidence of a mucocele or associated inflammation at this time. This could represent an early mucocele or cholestasis, with minimal evidence of associated inflammation at this time. Continued monitoring of labwork and ultrasound are warranted for progression of this lesion. Ursodiol therapy could be considered.

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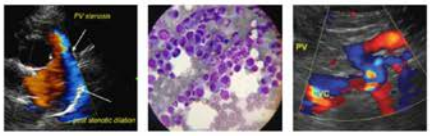

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- Subjectively thickened small intestine – The mild small intestinal wall changes may be a normal variant in this patient or could be consistent with an inflammatory process (e.g., inflammatory bowel disease).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

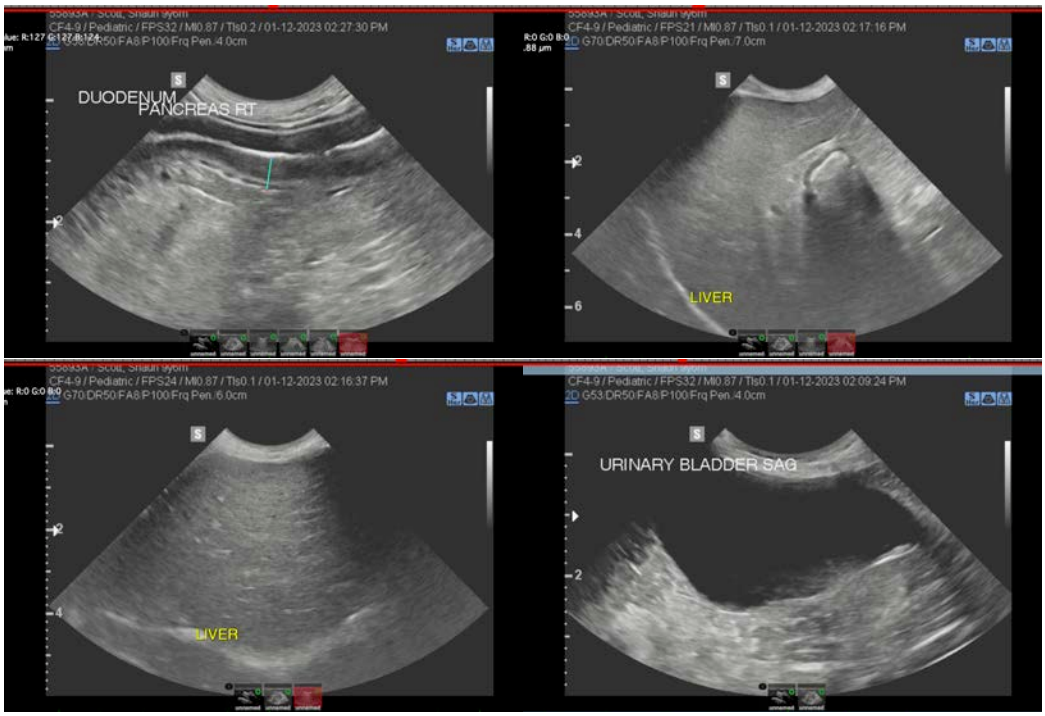
The changes observed on today's scan are relatively mild and commonly seen in older Schnauzers. There is a small amount of echogenic debris in the proximal urethra. Recommend continued monitoring for lower urinary tract signs, urinalysis and culture.

The liver is large, heterogeneous, and hyperechoic. This is a non-specific finding but could be somewhat related to the Prednisone use. Additionally, Schnauzers can commonly have a vacuolar hepatopathy. If the steroids are not effective, I would consider tapering them off, reevaluating liver enzymes, and performing a liver function test +/- fine needle aspirate of the liver.

There is a large amount of debris in the gallbladder with early organization and a prominent wall. Consider starting chronic Ursodiol therapy and continued monitoring of the gallbladder and liver enzymes.

The pancreas is somewhat visible/mottled, and the small intestine is subjectively thickened. If this patient is not having significant GI signs, both findings could be within normal limits for this individual.

An obvious cause for the open mouth breathing and pain episodes is not observed on today's scan. If the patient appears hypoxic, consider a pulmonary thromboembolism, pain reaction, etc.



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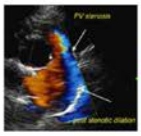
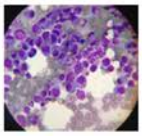
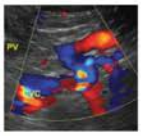

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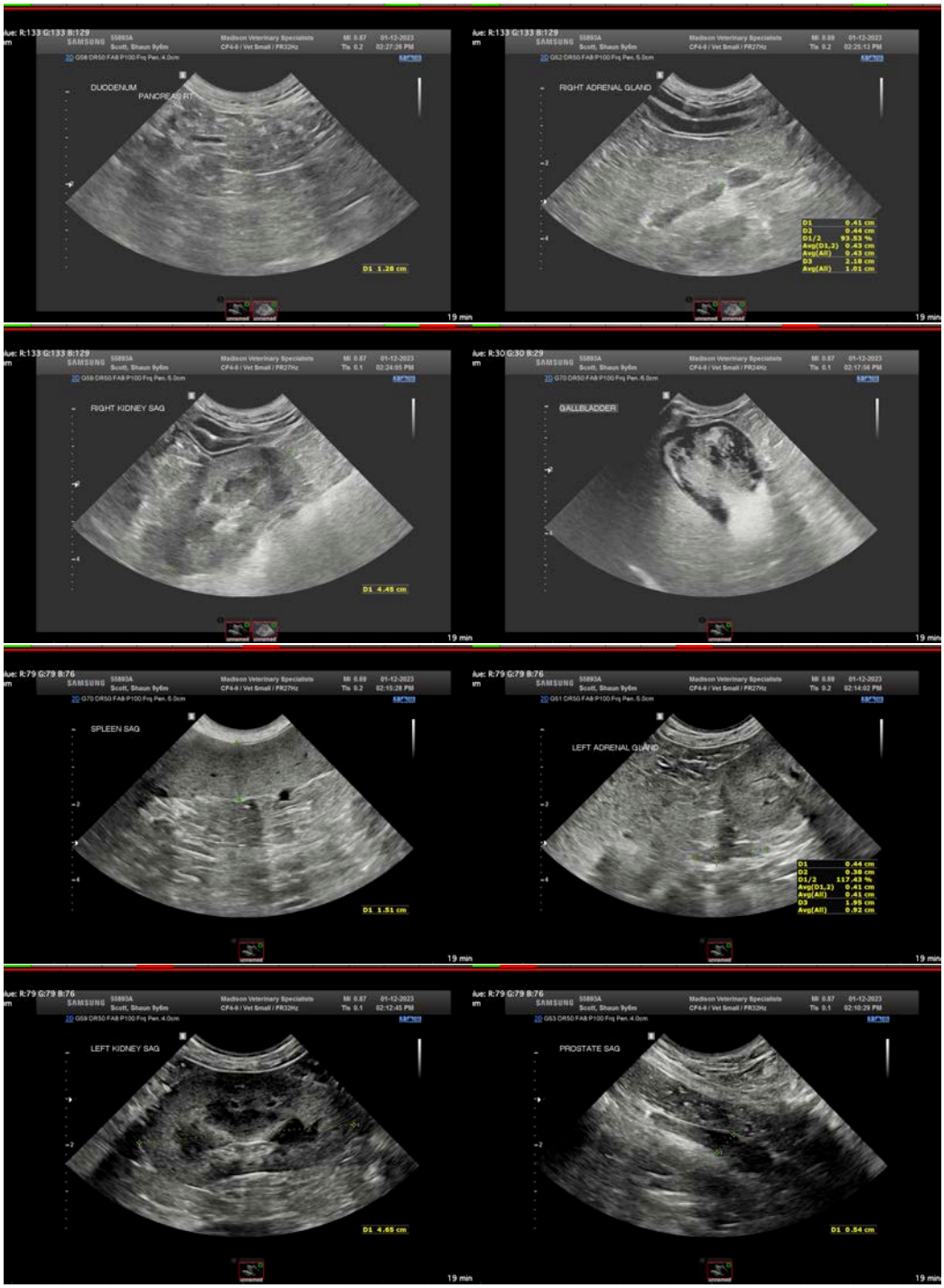

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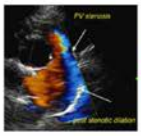
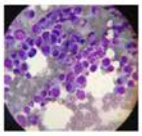
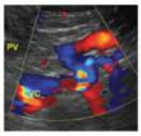

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)

kathleen.sennello@sonopath.com