

**DATE PRESENTING CLINICAL SIGNS**

1/13/23

History: Chronic diarrhea for last month, with some occasional bouts of vomiting
 best response to prednisone so far; had skin and gingival lesions that resolved after prednisone treatment

PATIENT

Henri Locke

Current Medications: not currently on steroids at time of ultrasound.
 Lab Results: negative fecal, BW- (leukocytosis).

SPECIES

Canine

Date of Previous IntraPet Ultrasound: No previous.
 Sedation: Not required to complete full diagnostic ultrasound.

BREED

Standard Poodle

Stat Report: Not requested.
 Imaging Performed By: Rachel Brillhart, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**SEX**

Neutered Male

Urinary System

The urinary bladder is moderately distended with anechoic urine. The bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2.0 cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

AGE

47 Pounds

The visualized areas of prostate and surrounding tissue appear normal. Unfortunately, the prostate is not fully visualized likely due to its intrapelvic location. Correlate with rectal exam findings.

WEIGHT

9/19/21

The left kidney has a normal shape and size (6.83 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

INTERPRETED BY

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

The right kidney has a normal shape and size (5.87 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

HOSPITAL NAME

Festival VC

Adrenal Glands

The left adrenal gland is normal in size measuring 0.56 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.

REFERRING VET

Dr. Beron

The right adrenal gland is normal in size measuring 0.57 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.

INVOICE

20546

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.

Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed. The gall bladder lumen is moderately distended. The wall of the gall

bladder is not thickened and has a smooth mucosal surface. Luminal contents are primarily anechoic. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach appears moderately dilated with gas and some irregular shadowing material and fluid. It appears subjectively thickened (approximately 0.7 cm) with some variability due to the presence of rugal folds. Full evaluation of the gastric wall is challenging due to gas interference and likely panting. NO mass lesions are 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. The duodenum measured as normal (0.41 in wall thickness), and the jejunum measured as normal (0.33 cm). 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 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

There is no free fluid. There are prominent mesenteric lymph nodes visualized at the mesenteric root, measuring 0.69 cm, 0.61 cm, and 0.67 cm in diameter. Sublumbar lymph nodes are prominent, measuring 0.46 cm and 0.7 cm and there is a cranial abdominal lymph node, measuring 0.7 cm in diameter. The omentum is generally of normal echogenicity.

ULTRASONOGRAPHIC FINDINGS

- 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.
- Prominent, subjectively thickened gastric wall. Full evaluation of the gastric wall was challenging due to gas interference. Findings are most consistent with gastritis, although edema, infiltrative neoplasia, imaging artifact due to rugal folds, etc. are possible.
- Prominent mesenteric lymph nodes. The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

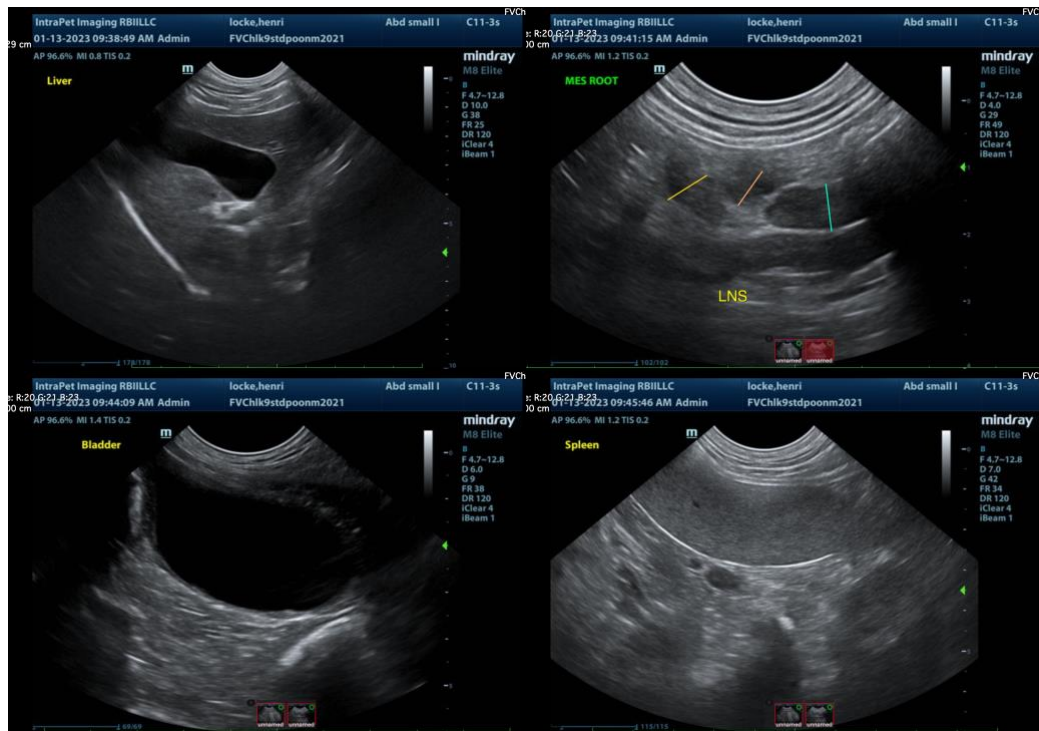
No prominent focal lesions are visualized associated with the gastrointestinal tract to explain the symptoms described. The gastric wall appears somewhat prominent, and the stomach could not be fully evaluated due to gas interference but correlate these findings with abdominal radiographs.

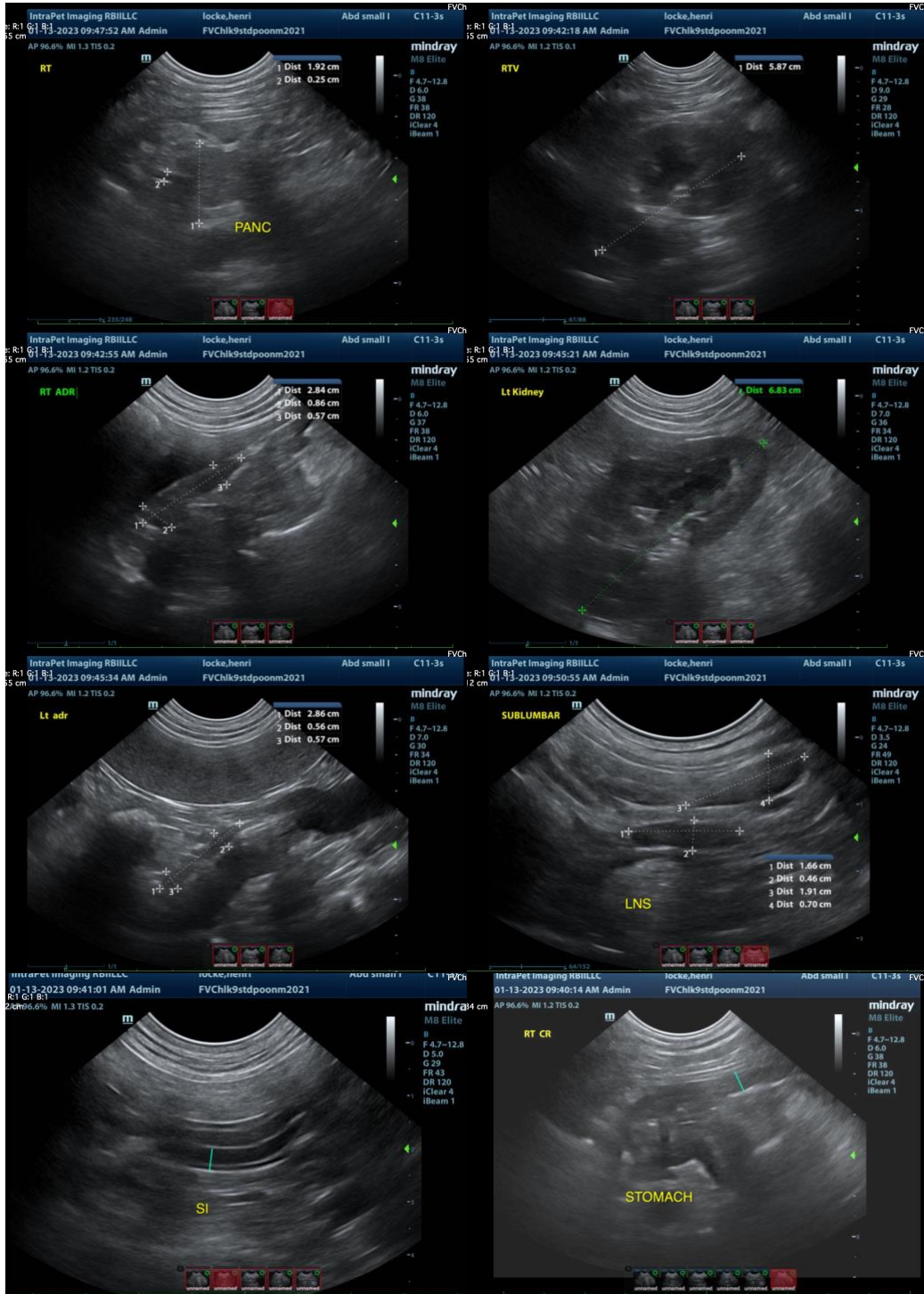
If not already done, recommend screening for Addisons disease, as there has been a response to steroids and blood work submitted shows eosinophilia, a borderline low albumin and a borderline low sodium.

If metabolic causes for vomiting are ruled out, then the most likely differentials for a young dog like this would be dietary indiscretion, food allergy/dietary intolerance, GI parasitism, or dysbiosis.

- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks)
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc. to further evaluate for pancreatic/small intestinal disease.
- Recommend screening for Addisons (must be off Prednisone)
- Recommend testing for GI parasites and empirical deworming, if not already done
- If there is a history of systemic antibiotic therapy with this individual, dysbiosis could be possible. I recommend chronic probiotic therapy. If dysbiosis is strongly suspected, consider a fecal transplant.

Although possible, this dog would be young for IBD, so consider other steroid responsive differentials. If symptoms persist, I recommend obtaining GI biopsies (off of steroids).





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.

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