



PATIENT

Auggie Tarpley

SPECIES

Canine

BREED

Terrier X

SEX

Neutered Male

AGE

12.5 Years

WEIGHT

32 Pounds

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

Dr. Judy Schroeder

HOSPITAL NAME

Animal Health
Associates

REFERRING VET

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DATE

1/21/22

PRESENTING CLINICAL SIGNS

Well controlled diabetic. Past month has been acting lethargic, vomiting intermittently, usually in the am and when stressed. Blood testing shows normal Spec cPL, elevated ALT >>>ALP, elevated AST, GGT, BUN, cholesterol. All values were normal in July of 21. Weight loss, gradual. Due to diabetes patient was given small meal this am.

Abnormal PE/Chem/CBC/UA Results: ALT 791 U/l AST 369 U/l ALP 295 U/l GGT 33 U/l bilirubin 0.3 mg/dl Spec cPL normal 81 ug/l BUN 38 mg/dl, all other renal parameters normal. USG 1.060 (glucosuria) CBC unremarkable.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall appears diffusely mildly thickened and irregular, measuring 0.50 cm in width. The area of the trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear relatively normal with no evidence of mass effect or cystic calculi. Findings are most consistent with diffuse cystitis, but underlying neoplastic change cannot be excluded as a possibility.

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.

The left kidney has a normal shape and size (6.14 cm). Overall echogenicity is slightly hyperechoic with poor 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.

The right kidney has a normal shape and size (5.73 cm). Overall echogenicity is slightly hyperechoic with poor 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.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.53 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 0.60 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 and the echotexture is homogenous. The splenic capsule is smooth with no visible irregularities. Rare discrete focal hyperechoic, perivascular parenchymal abnormalities are present. The appearance of these lesions is most consistent with benign splenic myelolipomas. One focal hyperechoic nodule is visualized measuring 0.46 cm. While this has the appearance of a benign lesion, an underlying neoplastic process cannot be excluded. The blood flow through the hilus and splenic parenchyma appears normal.



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Liver

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The liver is large in size, and normal in echogenicity 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.

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The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a moderate amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.

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Gastrointestinal

The stomach is moderately dilated with fluid and irregular shadowing material most consistent with normal ingesta and gas. 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 layering is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

SEX

Neutered Male

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. Duodenum wall measured 0.37 cm. Jejunum wall measured 0.30 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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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.

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Pancreas

The pancreas is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

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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.

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ULTRASONOGRAPHIC FINDINGS

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- Mildly irregular/thickened urinary bladder wall – The bladder mucosal changes could be consistent with cystitis or artifactual due to lack of adequate luminal distension. Bladder neoplasia cannot be ruled out but is considered unlikely in this patient.
- Decreased corticomedullary distinction in both kidneys – The bilateral renal findings are consistent with age-related change.
- Hyperechoic splenic nodule – The appearance of this nodule is most consistent with a benign lesion, but an underlying neoplastic process cannot be excluded. Recommend continued monitoring.

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- Large, heterogeneous liver – The diffuse hepatic changes are non-specific and could be consistent with diabetic hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy. This is most likely consistent with a vacuolar

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hepatopathy.

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- Moderate gallbladder sludge – The significance of the aggregated gallbladder sludge is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal lesions were visualized to explain the elevation in ALT reported. It is common to get a diabetic hepatopathy, but these typically have higher ALPs than ALTs, so this is not 100% typical.

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- Consider close evaluation of history for possible toxic changes examine medications, diet, dietary indiscretion etc...

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- Consider PCR on urine/serum for leptospirosis (if not on antibiotics)/serology if recent antibiotic history

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- If not already done, consider pre and post prandial bile acids to evaluate liver function
- Consider Fine needle aspirate if round cell neoplasia is on your differential list (25 g needle, normal coags)
- If no response to supportive care (denamarin, fluids, antibiotics,+/- ursodiol etc...) Consider liver biopsy with samples obtained for histopathology, culture, and copper levels.

WEIGHT

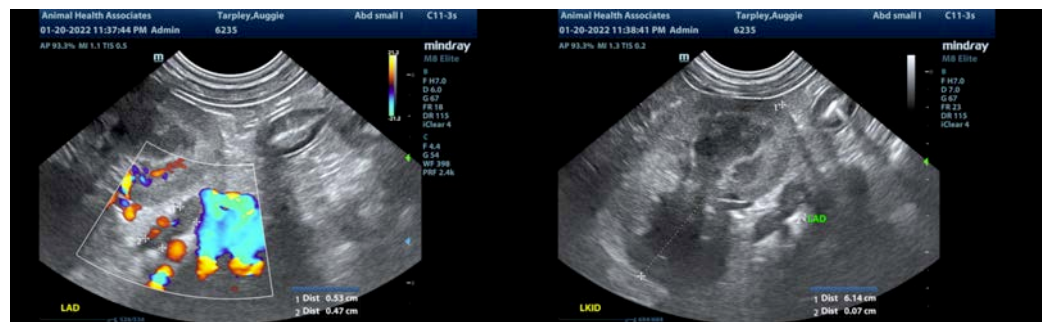
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Cholangiohepatitis can be relatively common in diabetics, so I feel a trial with Ursodiol, Denamarin and antibiotics is warranted.

The urinary bladder changes are most consistent with cystitis. Recommend urinalysis and culture.

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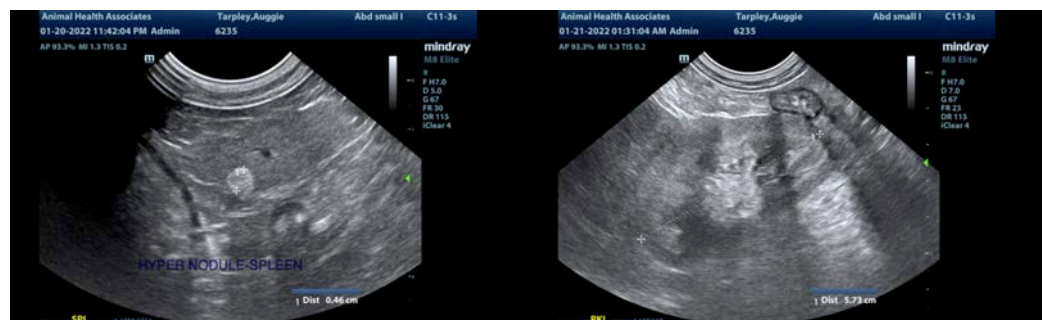


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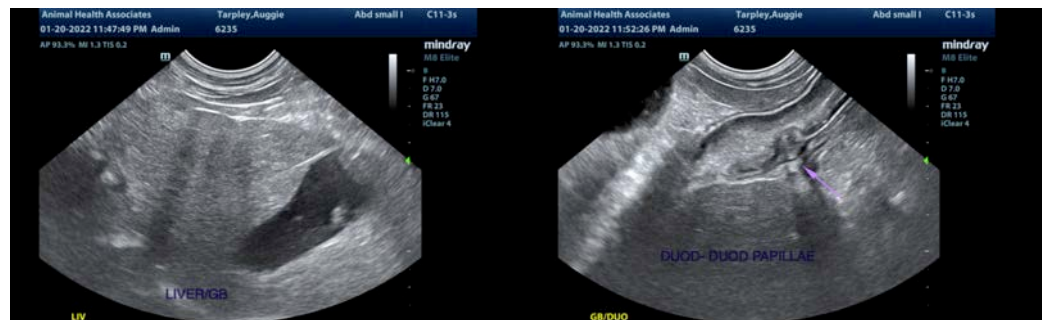
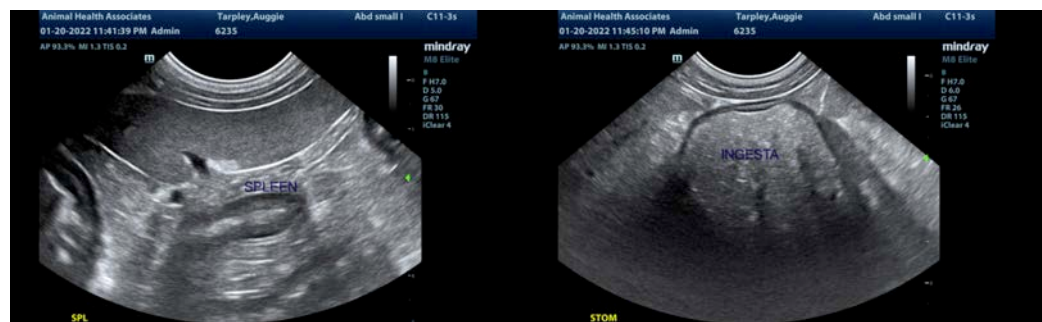
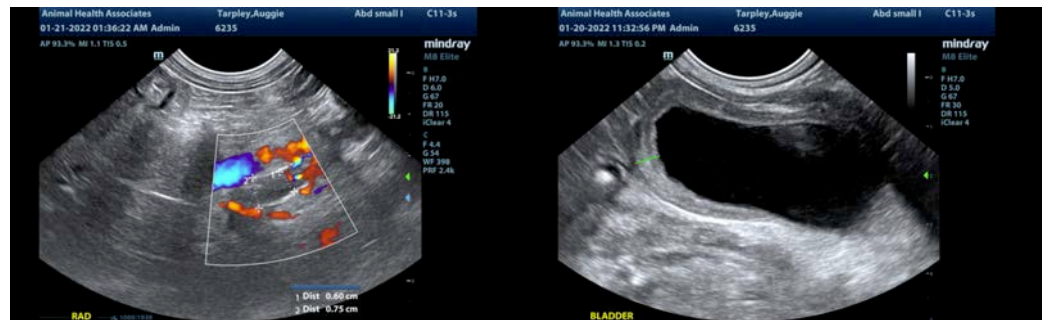
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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