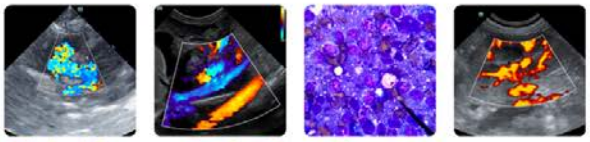

PATIENT

Autumn Kent

SPECIES

Canine

BREED

Yorkie x

SEX

Spayed Female

AGE

11 Years

WEIGHT

2.7 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Carlie Koltek, RVT

HOSPITAL NAME

Tuxedo Animal Hospital

REFERRING VET

Dr. Luke Pura

INVOICE

72584

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PRESENTING CLINICAL SIGNS

Lethargy, discomfort and decreased appetite past week. No vomiting, but some mucoid diarrhea. Not PUPD. Take metacam PRN (previous TPLO sx)

Abnormal PE/Chem/CBC/UA Results: T: 38.1 P: 90 R: normal MM:pink Grade 2/6 systolic murmur Tense and reactive on abdominal palpation Abdominal rads: concern for mass effect in cranial abdomen, decreased detail of cranial abdomen CBC: MCH 20.5 (21.2 - 25.9 pg L 19.7) MCHC 285 (320 - 379 g/L) Retic 146.1 (10.0 - 110.0 K/µL) Plat 126 (148 - 484 x10^9/L) CHEM: BUN 13.1 (2.5 - 9.6 mmol/L) ALKP 227 (23 - 212 U/L)

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, masses or cystic calculi.

The left kidney has a normal shape and size (3.06 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 (3.44 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 0.37 cm at the cranial pole and 0.49 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.

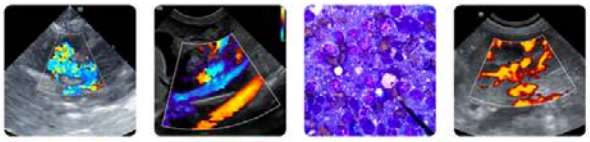
The right adrenal gland is normal in size measuring 0.57 cm at the cranial pole and 0.57 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size but slightly irregular in shape. The blood flow through the hilus and splenic parenchyma appears normal. There is a mixed echogenicity, hypoechoic, partially cavitated, slightly cystic nodule visualized in the head of the spleen measuring approximately 0.99 cm x 0.91 cm. Additionally, there are numerous hyperechoic peripheral irregular lesions most consistent with benign myelolipomas. An example at the hilus measures 0.50 cm x 0.35 cm.

Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is mildly heterogenous in echotexture with subtle, indistinct focal mottling. The visible



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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 mild and likely incidental at this time. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains moderate fluid. The gastric wall appears somewhat prominent, measuring at 0.65 cm, with intact wall layering. 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 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 measures 0.36 cm. Jejunum wall measures 0.24 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The colon contains non-formed fecal material. There is no observed focal or generalized colon wall thickening or loss of layering. Colon wall measures 0.17 cm.

Pancreas

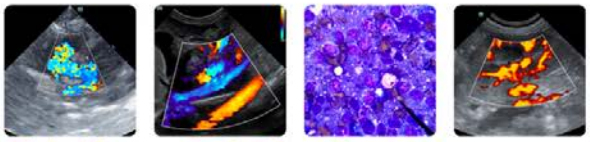
The pancreas is hyperechoic and mottled in the left limb. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

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

- Mixed echogenicity, hypoechoic nodule on the head of the spleen – There is a non-cavitated, hypoechoic splenic nodule visualized. Differentials include lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis.
- Hyperechoic, mottled left limb of the pancreas – Findings could be consistent with chronic pancreatic remodeling or chronic pancreatitis.
- Mildly heterogeneous liver – The appearance is most consistent with a mild vacuolar hepatopathy. Other hepatopathies are possible.
- Fluid distended stomach with a prominent wall with intact wall layering – Findings are suggestive of mild gastritis. A neoplastic process is less likely but cannot be ruled out.



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a mixed echogenicity, hypoechoic, slightly cystic nodule in the head of the spleen. This could represent a benign or early neoplastic lesion. Options moving forward would include a fine needle aspirate, continued monitoring with ultrasound, or even a splenectomy with samples submitted for histopathology. I suspect this is unrelated to the current symptoms but needs to be kept in mind.

The left limb of the pancreas is hyperechoic, possibly consistent with chronic pancreatitis or previous episodes of pancreatitis. Correlate with PLI level and consider empirical treatment for pancreatitis if clinically appropriate.

The stomach is fluid distended and subjectively mildly thickened. Correlate with feeding/drinking history. If the patient has been adequately fasted, this could represent delayed gastric emptying or similar. No evidence of an outflow tract was observed, but a partial obstruction cannot be definitively ruled out.

The colon appears distended with non-formed fecal material. No evidence of wall thickening observed.

Consider treatment for acute gastroenterocolitis and pancreatitis. If there is concern for a more chronic gastrointestinal condition, consider the following:

- Consider a hydrolyzed protein prescription diet.
- Some patients may benefit from the addition of insoluble fiber with the large bowel symptoms described.
- If not already done, recommend empirical deworming and parasite screening.
- 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 probiotic therapy.

If symptoms are persistent, you could consider repeat imaging, looking for the progression of today's lesion, as eventually biopsies of the GI tract (large bowel, small bowel and stomach) may be warranted.

Recommend recheck of the splenic lesion in 2-3 months if not further steps are taken (sooner if concerned).

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement (disregard if this has already been done).

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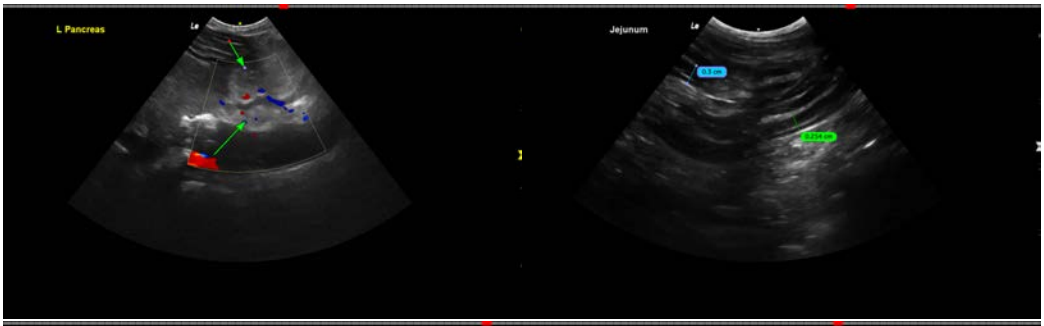

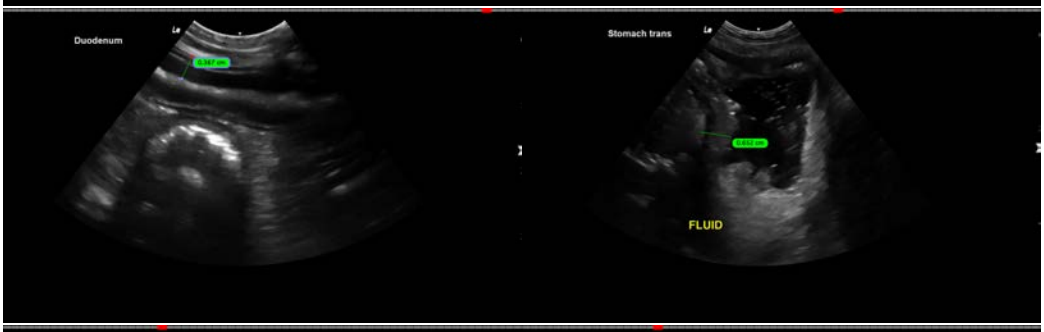

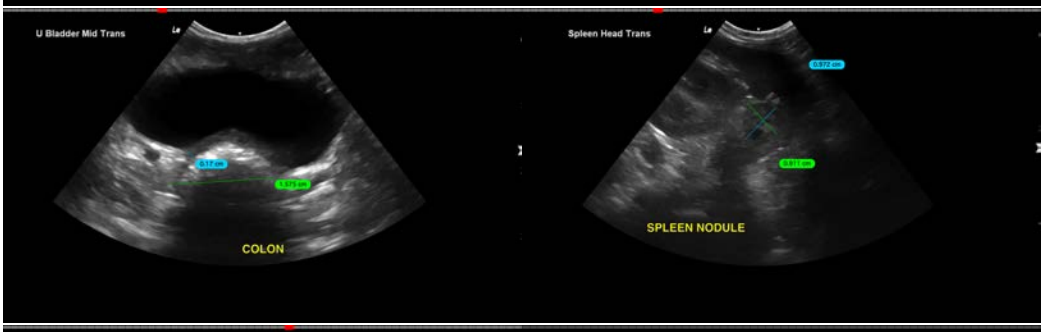

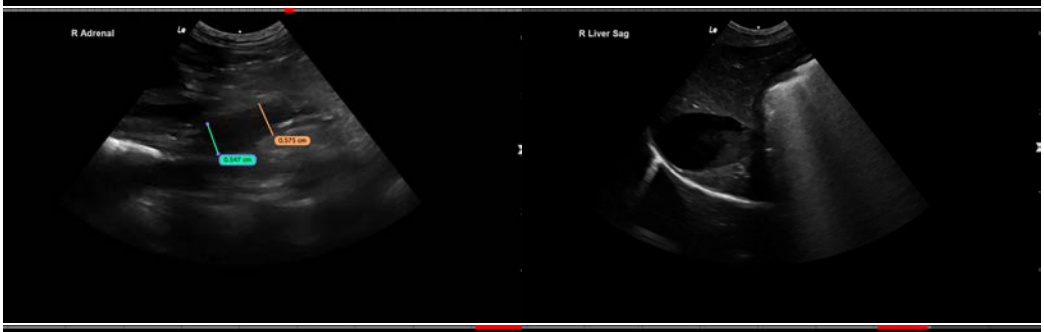

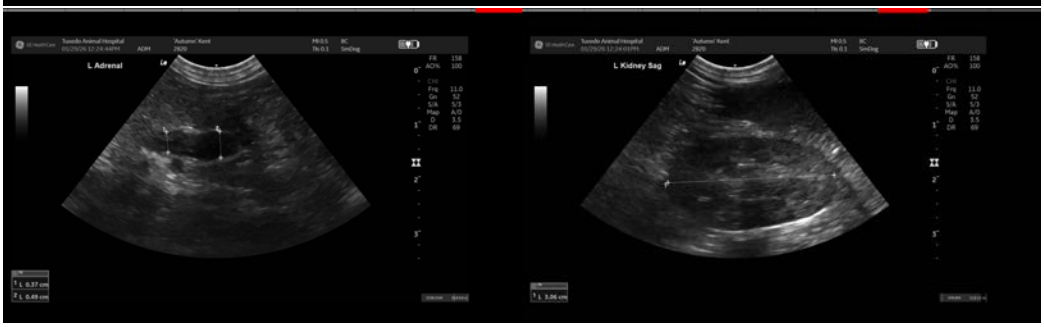

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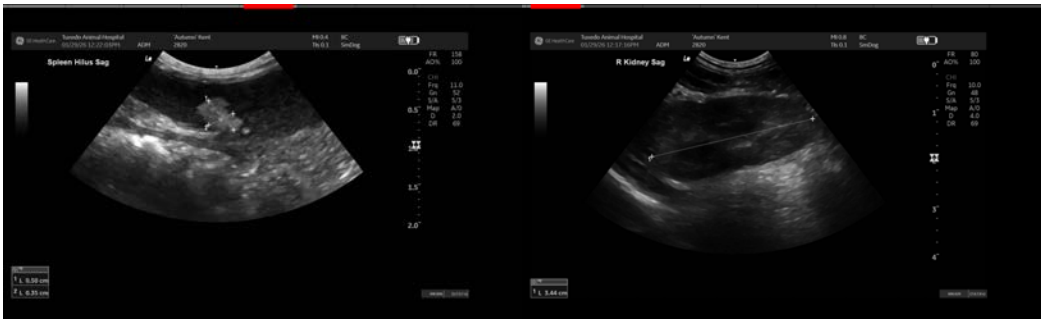

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@sonopath.com