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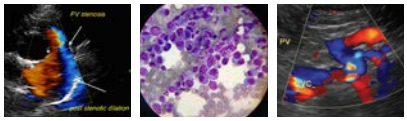

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DATE

1/4/22

PATIENT

Louie Jackson

SPECIES

Canine

BREED

Poodle

SEX

Neutered Male

AGE

9/29/10

WEIGHT

11.8 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Stephanie Pearce RDCS, RVT

HOSPITAL NAME

Homeward Bound VS

REFERRING VET

Dr. Vance

INVOICE

33964

PRESENTING CLINICAL SIGNS

History: Has had a hx of recurring severe leg infection. For the last month has been vomiting off and on, has gotten worse lately. X-rays show potential neoplasm in liver/pancreas.

Current Medications: Omeprazole, Cerenia.
Date of Previous IntraPet Ultrasound: No previous IntraPet scans.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

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 prostate is normal in size (1.3 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 (4.03 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.

The right kidney has a normal shape and size (4.31 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.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.59 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 0.61 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.

Liver

The liver is subjectively normal in size, and echogenicity with irregular shape. The parenchyma is homogenous echotexture. The visible portions of the vasculature and biliary tract appear normal. In the ventral portion of the liver, there is a small, rounded tip of a ventral liver lobe, creating somewhat of a nodular appearance. This lesion is isoechoic to the rest of the hepatic parenchyma and measures approximately 1.0 cm in diameter.

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.

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 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. Jejunum wall measured 0.32 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 hypoechoic as 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

- Prominent, hypoechoic pancreas – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.
- Irregular, rounded tip of the ventral liver lobe – This could be a normal irregularity for this patient, or could be consistent with a hepatic nodule (benign or malignant), and could be consistent with the lesion described on radiographs(?).
- 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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

An obvious GI lesion is not visualized to explain the off and on vomiting reported. The pancreas is somewhat prominent, but not overtly inflamed. This could be consistent with mild chronic pancreatitis or previous episode of pancreatitis. Consider a GI panel to Texas A&M for a qualitative PLI, TLI, cobalamin and folate to further evaluate the pancreas and small intestine.

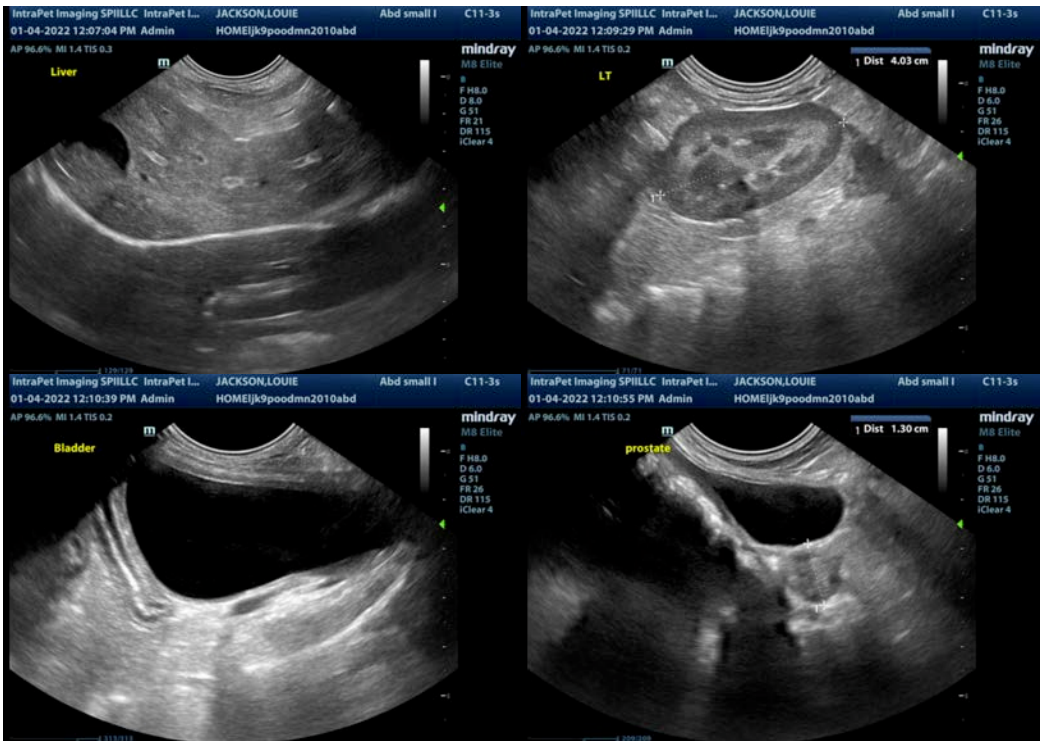
Unfortunately, it's possible to have GI signs with minimal ultrasonographic changes. A leg infection is described in the history. Consider side effects from any medications given. Recommend current blood work to look for possible metabolic causes. If this is normal, then possible primary GI diseases such as dietary sensitivity, IBD, less likely underlying neoplasia are possible. Consider symptomatic treatment for vomiting, a novel protein/hydrolyzed protein prescription diet, and thoracic radiographs to evaluate for possible

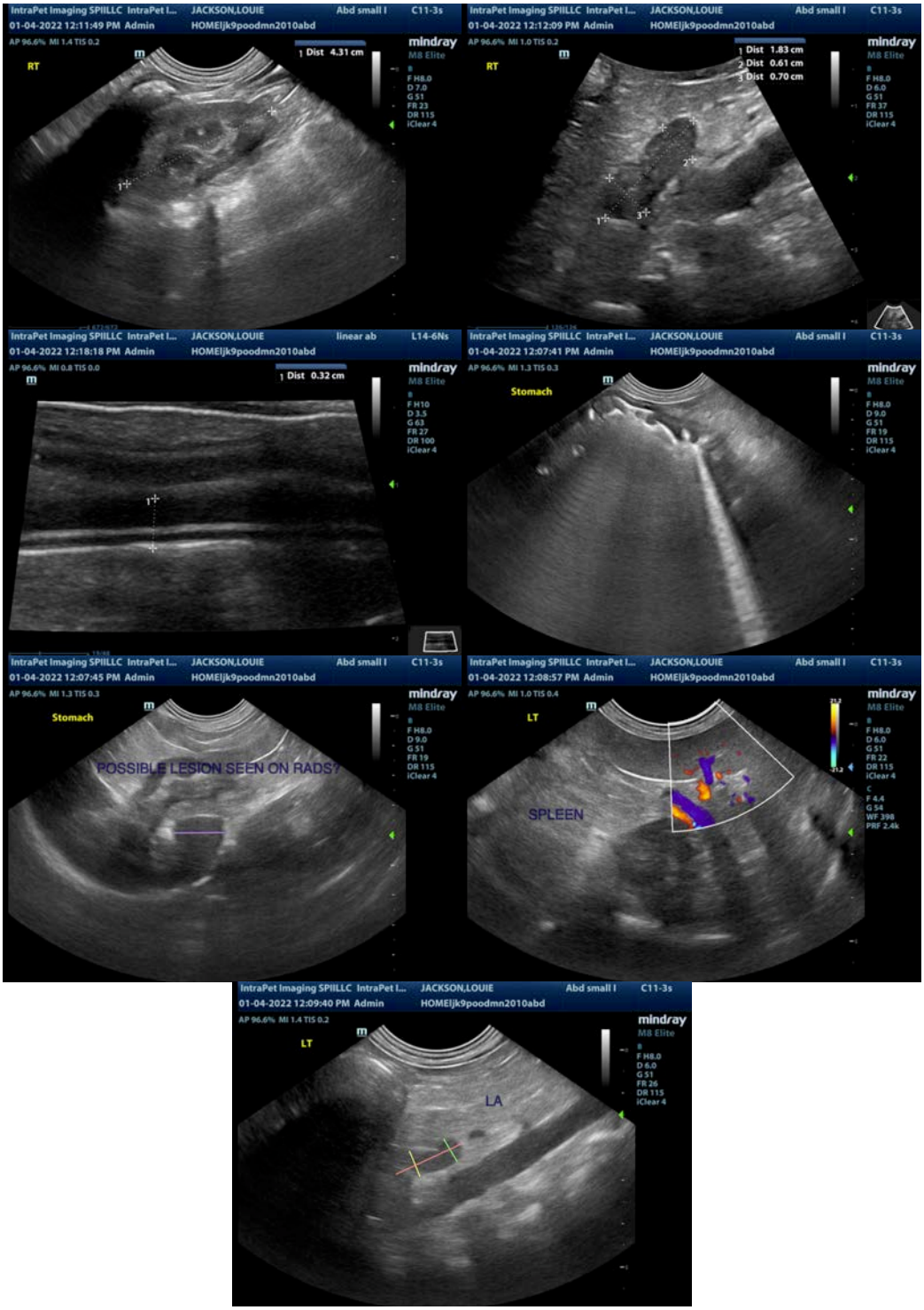
regurgitation and concurrent intrathoracic disease. If symptoms persist, GI biopsies may need to be considered.

Additionally, there is a radiology report describing a small mass effect (3.0 cm). An obvious lesion representing this described area is not visualized, although the ventral portion of the liver is somewhat irregular, and there is sometimes a silhouetting nodule-type effect, which appears smaller than that described in the radiographic report, so I am not sure if this could be the lesion described. Options for further evaluation of this area of liver would be:

- Contrast CT scan to further evaluate for a mass lesion in the liver and/or GI tract/pancreas.
- Consider a fine needle aspirate of the abnormal area of liver (this may or may not be possible).
- Consider continued monitoring with ultrasound.
- If GI biopsies are obtained, surgically consider further evaluation.

If there is concern for vomiting due to antibiotic use, dysbiosis, etc., consider probiotic therapy, nausea medications, and depending on the circumstances, a different antibiotic, or consider your options.

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LT
LA
mindray M8 Elite

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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