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Clinical Sonography & Telecytology
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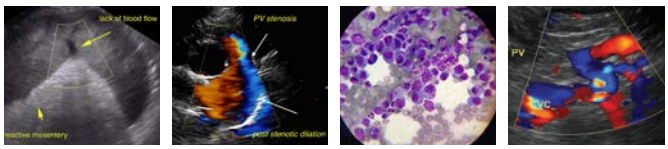

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1-800-838-4268 info@sonopath.com

PATIENT
Bo Coleman

SPECIES
Canine

BREED
Yorkshire Terrier X

SEX
Neutered Male

AGE
7 Years

WEIGHT
8.5 Pounds

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

IMAGING PERFORMED BY
Jack Reese

HOSPITAL NAME
Willow Run VC

REFERRING VET
Dr. Anna Leppien

INVOICE
43942

DATE
1/4/23

PRESENTING CLINICAL SIGNS

Weight loss; Owner reports posturing at home abnormally, concern for discomfort. Owner feels Bo is urinating more frequently at home. No pain or discomfort noted on exam, slight discomfort possible on cranial abdominal palpation

Abnormal PE/Chem/CBC/UA Results: CBC - nsf Chem - nsf 4dx - neg x 4

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 (0.73 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 (3.55 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 (3.54 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 0.52 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 0.42 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 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 gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and primarily anechoic. The cystic and common bile ducts are normal/not visible.

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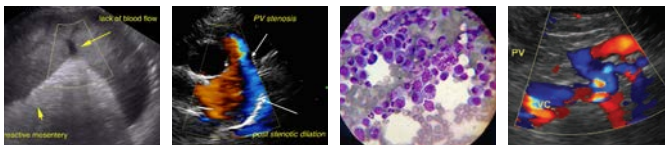

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Gastrointestinal

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.

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 measures 0.23 cm. Duodenum wall measures 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 area of 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. There is an ill-defined focal region of hyperechoic tissue associated with the small bowel. I cannot exclude this being of pancreatic origin, but no correlation with pancreatic tissue is visualized.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is no lymphadenopathy but there is an ill-defined hyperechoic region measuring approximately 2.2 cm x 2.66 cm, which is initially visualized medial to the spleen and appears associated with a section of small intestine. This could represent focal inflammation, an ill-defined hyperechoic mass effect, scar, or fatty tissue. A neoplastic lesion is thought less likely. The omentum is generally of normal echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Moderate gastric ingesta – Correlate with feeding history. If the patient was adequately fasted then consider possible differentials such as delayed gastric emptying or partial outflow tract obstruction, etc. (none observed).
- Ill-defined hyperechoic structure associated with the small bowel – Possible differentials include focal inflammation, inflammation/scar tissue, less likely pancreatic tissue, etc.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Today's scan appears relatively normal. The stomach appears dilated with a moderate to small amount of ingesta. Correlate with feeding history and abdominal radiographs.

There is an irregular, poorly defined, hyperechoic region associated with the small bowel. There is no obvious invasion or effect that this lesion is having on the associated bowel. It could represent focal inflammation, adhesions, scar tissue, adipose tissue, or less likely a true mass effect, pancreas, etc. Consider a fine needle aspirate of this hyperechoic region to try and further evaluate. Consider correlation with quantitative cPLI, looking for evidence of pancreatic inflammation. If symptoms are persistent and thought to be abdominal in origin, consider reevaluation of this lesion or a contrast CT scan for better resolution.

Additionally, consider the possibility of referred abdominal pain due to spinal pain, neck pain, etc.

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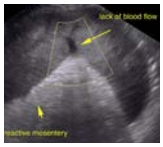
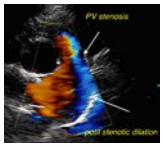
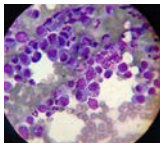
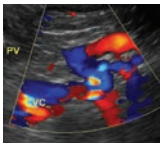

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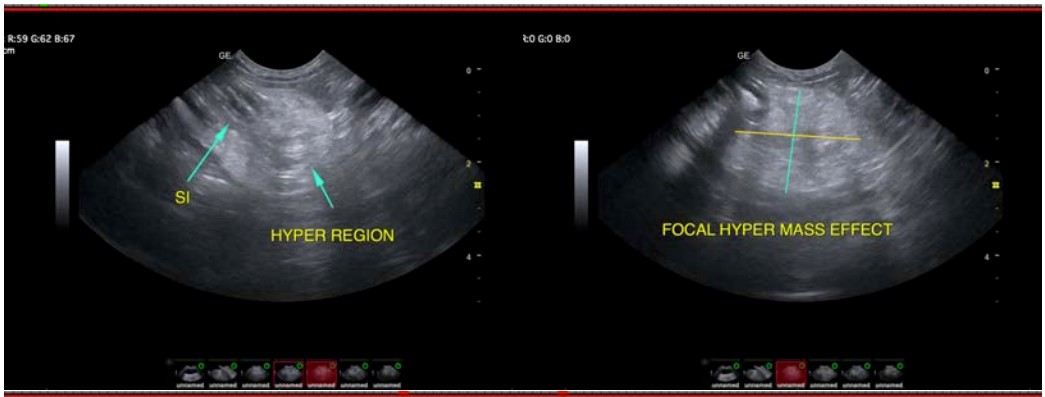
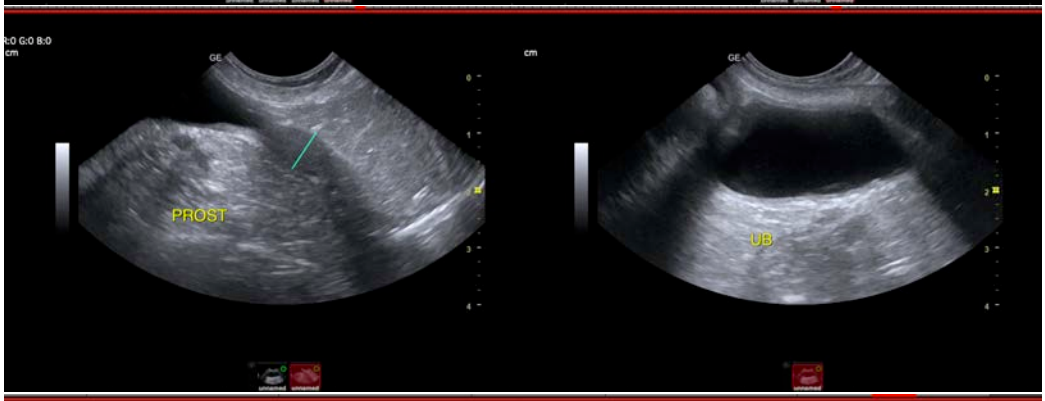
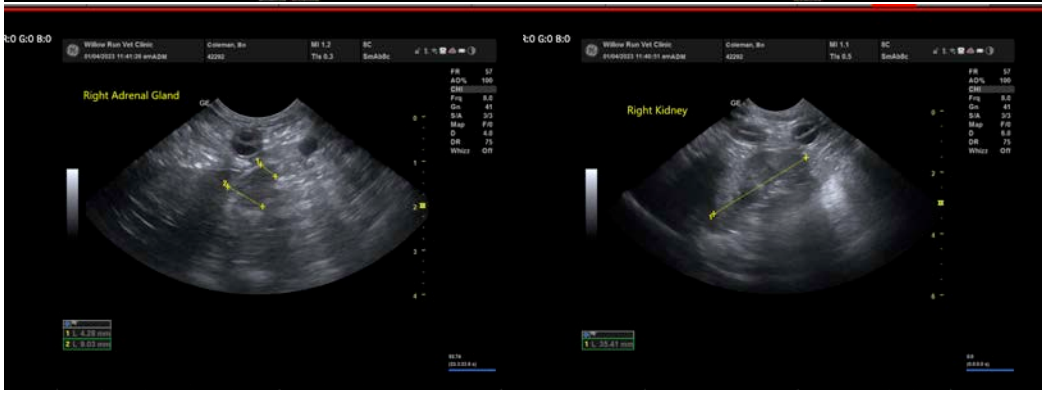
Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.







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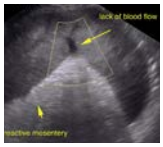
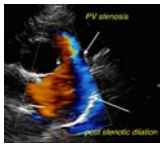
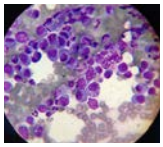
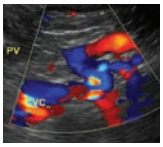

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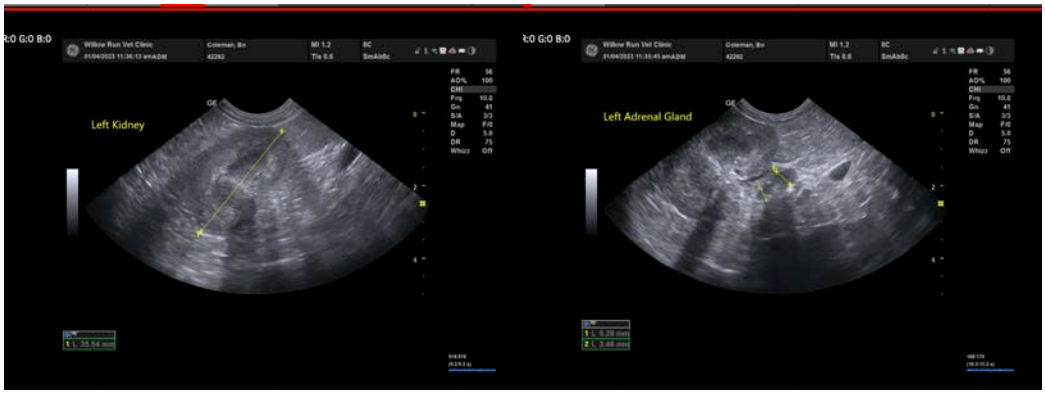

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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