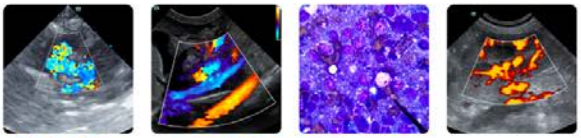


PATIENT

Tiki Faulkner

SPECIES

Canine

BREED

Treeing Walker Coonhound

SEX

Spayed Female

AGE

12 Years

WEIGHT

63.8 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Meghan Morse, LVT, CVT

HOSPITAL NAME

Rondout Valley Veterinary Associates

REFERRING VET

Dr. Hartelius

INVOICE

72023

DATE

1/7/26

PRESENTING CLINICAL SIGNS

Episodic cranial abdominal pain, occasional regurgitation, splints abdomen with palpation, licks lips with palpation Current meds: Carprofen 50mg BID, Gabapentin 300mg BID, Amantadine 10mg daily, Incurin 1mg daily.

Abnormal PE/Chem/CBC/UA Results: ALKP 186, BUN/Creat 34:1, USG 1.060, urine protein +

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall appears slightly diffusely thickened and irregular, measuring at 0.55 cm. The region of the trigone, ureteral papillae and proximal urethra appear free of any mass lesions or calculi.

The left kidney has a normal shape and size (6.72 cm). There are numerous pinpoint cortical mineralizations most consistent with mild dystrophic mineralization. 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, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (7.09 cm). There are numerous pinpoint cortical mineralizations most consistent with mild dystrophic mineralization. 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, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is large, measuring 0.96 cm at the cranial pole and 0.96 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.

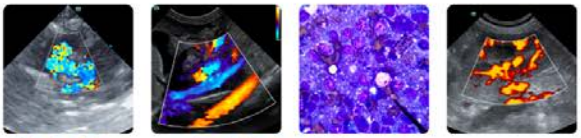
The right adrenal gland is normal in size measuring 1.15 cm at the cranial pole and 0.90 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of 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. There is a hyperechoic nodule visualized within the parenchyma measuring 0.86 cm, most consistent with a benign myelolipoma.

Liver

The liver is subjectively normal in size, and 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. There is a hyperechoic nodule visualized adjacent to the gallbladder measuring 2.85 cm x 2.4 cm.



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

Gastrointestinal

The stomach contains a large amount of fluid and shadowing ingesta. 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. Full evaluation of the stomach including the outflow tract is obscured by the intraluminal material.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal to mild 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 0.49 cm. Jejunum wall measures 0.37 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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 right limb of 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

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.

PRIMARY FINDINGS

- Diffusely thickened/irregular 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.

- Bilateral adrenomegaly – The bilateral adrenomegaly could be consistent with bilateral hyperplasia (e.g., secondary to pituitary-dependent hyperadrenocorticism), bilateral infiltrative neoplasia, inflammatory adrenal disease, other. Correlation with clinical findings is recommended.

- Prominent, mottled right limb of the pancreas – Findings are most consistent with chronic pancreatic remodeling +/- mild pancreatitis.

- Heterogeneous liver with hyperechoic nodule visualized adjacent to the gallbladder – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy. The appearance of the hyperechoic lesion is most consistent with a benign lesion (adenoma, other). An early neoplastic lesion cannot be ruled out.

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- Fluid/ingesta distended stomach – Correlate with feeding history. If the patient was adequately fasted, this could represent delayed gastric emptying, partial outflow tract obstruction, etc.
- Minimal to mild fluid distention of the small intestine – Findings could be consistent with mild ileus, a post-prandial patient, etc.

SECONDARY FINDINGS

- Small splenic myelolipomas.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The stomach is significantly distended with fluid and some shadowing ingesta. This interferes with full evaluation, and the pylorus is not clearly visualized. This could represent delayed gastric emptying or partial outflow tract obstruction. Additionally, if the patient was not fasted this could be a normal post-prandial patient. There is some fluid visualized within the small intestine as well, possibly consistent with mild ileus or post-prandial patient.

The majority of the pancreas appears normal. There is a small area in the right cranial limb that is more mottled and hypoechoic. This could represent focal remodeling or mild active inflammation. Correlate with a PLI level.

Both adrenals measure as enlarged. Correlate with clinical signs. If Cushing's is suspected, you could consider adrenal function in the future once symptoms resolve.

An obvious cause for the regurgitation and vomiting is not observed. Recommend 3-view thoracic radiographs to evaluate the lungs and the esophagus for any potential distal lesions, etc. If there is no response to symptomatic treatment for esophagitis/gastroenteritis, then consider upper GI endoscopy to evaluate the esophagus, cardia, and gastric outflow tract. Additionally, you could consider repeat imaging with a more prolonged fast to reassess the region of the pylorus. Correlate findings with abdominal radiographs as well.

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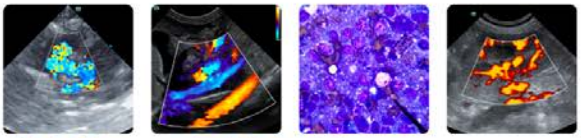

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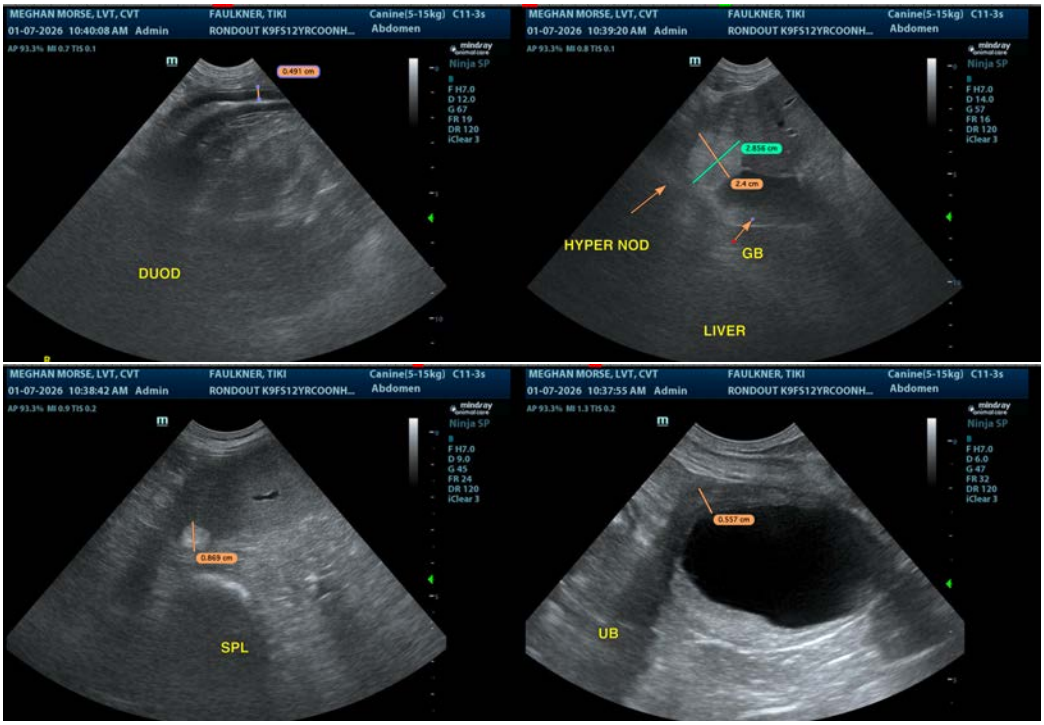

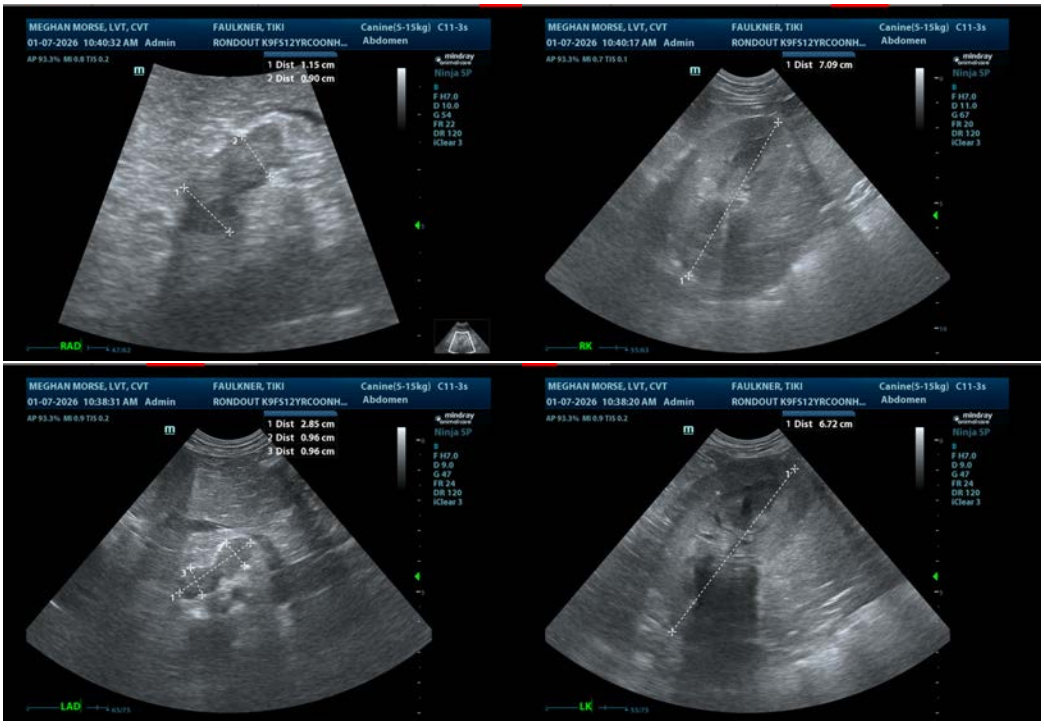

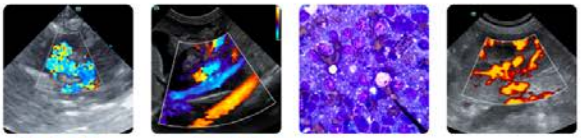

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

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