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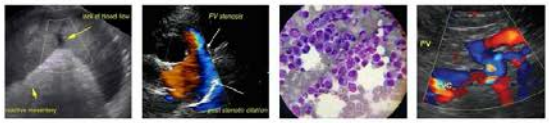

IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Lily Teichner

SPECIES

Canine

BREED

Golden Retriever

SEX

Spayed Female

AGE

10 Years 2 Months

WEIGHT

88 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT

HOSPITAL NAME

MountainView AH

REFERRING VET

Dr. Sarah Kalivoda

INVOICE

26308

DATE

10/14/21

PRESENTING CLINICAL SIGNS

PAWS Request Form: Chief Concern / Provisional Diagnosis: Concern for Hyperadrenocorticism with delayed gastric emptying. Relevant Medical History and Physical Exam findings: Lily presented for initial examination on 9/27 and was found to be BAR, anxious with a BCS 9/9. She has severe crepitus of the stifles with medial buttressing (previous TPLO surgery). Abdominal distension that was turgid (unclear whether it was simply fat) but lacked a fluid wave. Opthalmic examination was performed due to cataracts and conjunctival hyperemia with chemosis and was unremarkable (STT, Tono, Flourescein). CBC/Chem/UA/T4/fecal were performed and pertinent result found below. Concern for hyperadrenocorticism with symptoms of panting, weight gain and fat redistribution, non specific GI signs. Recommended LDDS test +/- AUS. Prior to diagnostics, Lily present to urgent care for evaluation of extreme anxiousness and anorexia. CXR and Abdominal Radiographs were performed and Lily was found to have an extremely large amount of food in her stomach with gas distension pattern. Concern for over feeding with delayed gastric emptying. Treated with cerenia and pepcid. LDDS test to be performed same day as ultrasound. Recent Diagnostics: Relevant Labratory Results / Abnormalities: CBC: HCT 52.6% (N), MCH 20.9 (L), MCHC 31.5 (L), Retic 23.9 (L), Lymph 728 (L) CHEM: BUN 37 (H), Creat 1.1 (N), SDMA 6 (N), ALP 466 (H), CK 230 (H) UA: USG 1.038, Prot - neg T4: 2.6 (N) Current medications (include full name, dosage and frequency): ~~ Kan Damp Heat Derma Relief - 2.5 tab BID Animax: apply to elbows as needed for bleeding hygroma Neopolydex ointment: OU BID 7 days Nexgard once - possible demodex on face Truprofen 75mg SID Lactulose 10-15ml q8-12 hours Pepcid 20mg SID-BID Tumeric Cosequin Adequan Probiotic Dr. Mercola's mushrooms Relevant Radiograph Findings(email radiographs if available): CXR - significant soft tissue opacity in the cranial lung field consistent with fat. Cardiac silhoutte is appropriate in size and shape. Mild interstitial pattern throughout. ABXR - Enlarged, very full stomach present for a patient that has not eaten in 12 hours. Gas distended colon and bowel loops. Hepatomegaly. Staples present which are consistent with previous liver lobe torsion surgery in 2017.

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 (6.67 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 (7.27 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/borderline enlarged in size measuring 0.94 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/borderline enlarged in size measuring 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.

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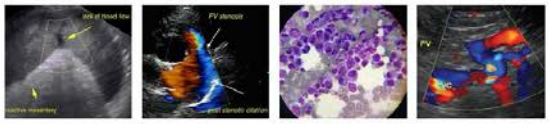

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Spleen

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 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.

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

Gastrointestinal

The stomach contains minimal luminal contents. Most of the gastric wall 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. At the junction of the pylorus and duodenum, there is some prominent and thickened tissue. This area often appears somewhat thickened due to the sphincter and increased muscular layer. Recommend continued monitoring.

The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal fluid distension. Wall appears subjectively, mildly increased. Bowel loops follow a typical curvilinear path with distinct wall layering. Duodenum wall measured 0.46 cm. Jejunum wall measured 0.38 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 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.

Free Abdomen

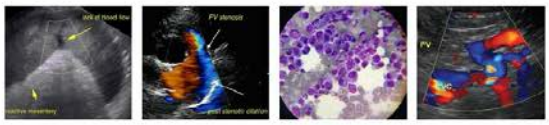
Evaluation of the peritoneal cavity did not reveal any evidence of effusion. No significant lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is generally of increased echogenicity in some areas around the small intestine.

Other

No significant pericardial effusion.

PRIMARY FINDINGS

- Heterogeneous liver – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease,



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fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy.

- Subjectively thickened small intestine with surrounding hyperechoic omentum – The mild small intestinal wall changes may be a normal variant in this patient or could be consistent with an inflammatory process (e.g., inflammatory bowel disease).
- Borderline 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.

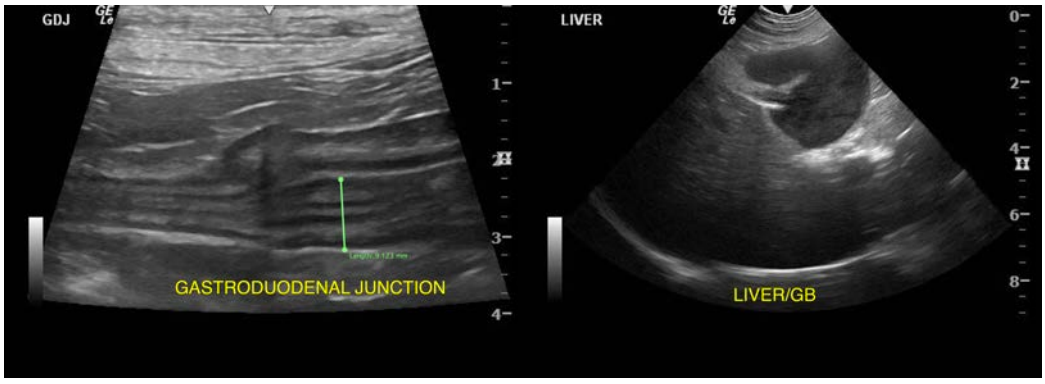
SECONDARY FINDINGS

- Prominent gastroduodenal junction – This is a subjective finding and could be consistent with normal anatomic variation or early hyperplasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

An obivoius cause for the recent acute anorexia is not identified. The small intestine appears subjectively thickened and there is some mesenteric inflammation, so my strongest suspicion would be acute gastroenteritis. Additionally, the gastroduodenal junction is prominent. This area has a prominent muscular layer and can appear thickened normally, but if symptoms are progressing, consider reevaluation for an early lesion in this area.

The adrenal glands are borderline enlarged, and the findings in this ultrasound could be consistent with Cushing's disease if clinical signs are present. This is difficult to assess currently, as this pet is not feeling well, so consider adrenal function testing in light of this increased stress. Recommend symptomatic treatment for gastroenteritis. If symptoms are persisting, consider upper GI endoscopy. You could also consider a barium swallow and cranial abdominal study to asses gastric outflow.



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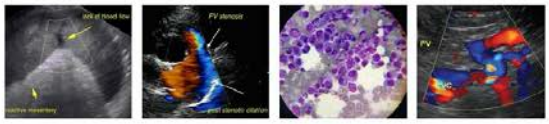

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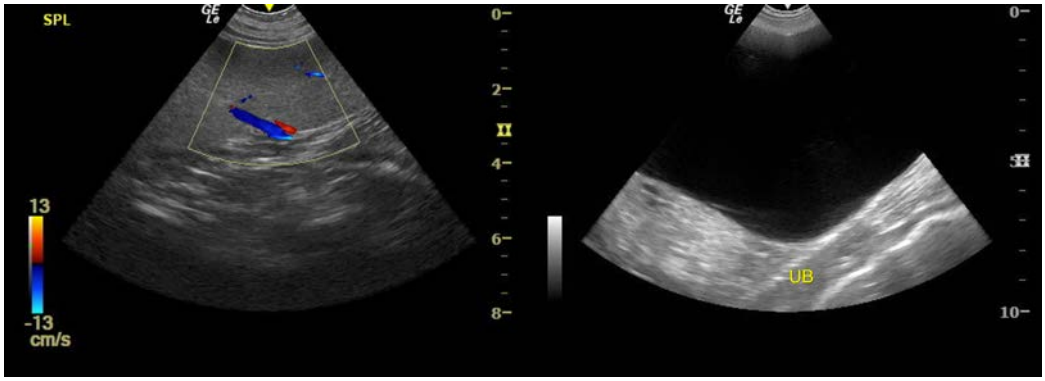

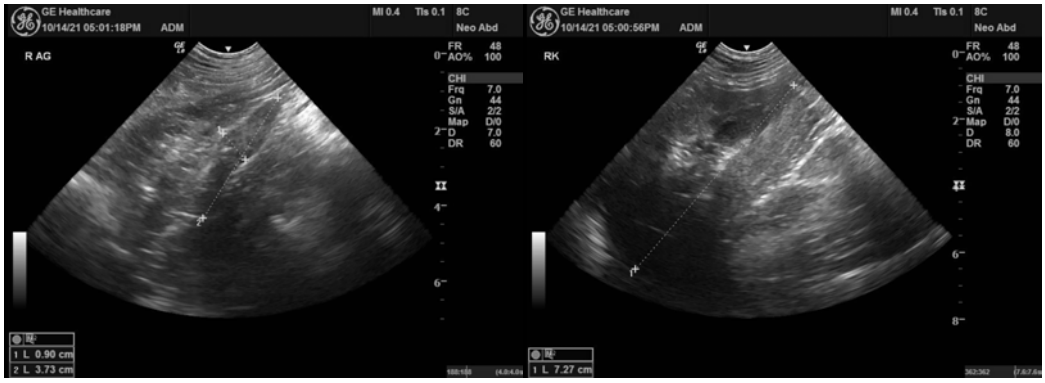

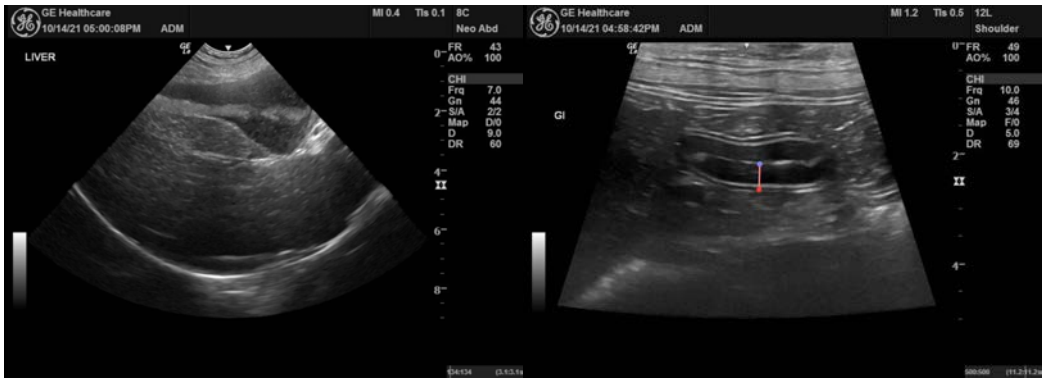

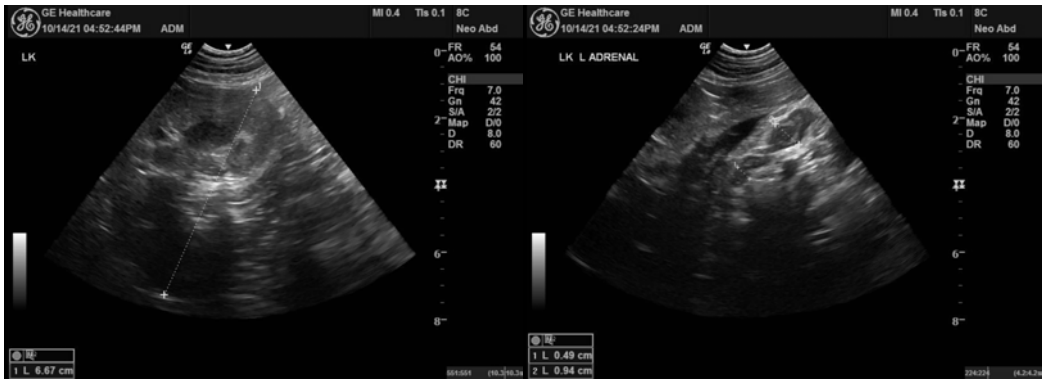

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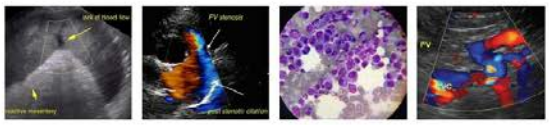

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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