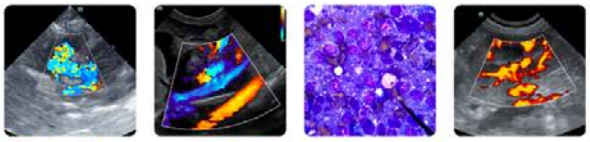

PATIENT

Cookie Monster Lopez

SPECIES

Canine

BREED

Yorkshire Terrier

SEX

Spayed Female

AGE

13 Years 7 Months

WEIGHT

14.8

INTERPRETED BY

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

IMAGING PERFORMED BY

Gabriel Ferrer, DVM

HOSPITAL NAME

Pulse: Pet Ultrasound

REFERRING VET

Dr. Nidia Alvarez Hidalgo

INVOICE

72015

DATE

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PRESENTING CLINICAL SIGNS

Pt presented as a referral for an abdominal u/s to evaluate signs of lethargy, anorexia, vomiting and weight loss. Pt spent 10 days at pet boarding, when pt went back home O noticed pt was not usual self. Stopped eating and disinterested of any food O offered. Vomiting episodes also started (white/foamy). No water intake. 2w of clinical signs, pt lost 2lbs. However, O made observation that weight loss has been occurring since 3m ago but no clinical signs. Initial weight 22lbs, current weight 14.8lbs. Currently taking the following medications: Cerenia 16mg, Famotidine 20mg and Pimobedan 5mg for previous hx of heart conditions.

Abnormal PE/Chem/CBC/UA Results: PE heart murmur. Elevated ALP, ALT. Decreased Cl. Bloodwork is attached as supporting documents. Also attached echocardiogram performed earlier this year in January.

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 (4.9 cm) with occasional small cortical cysts. Overall echogenicity is slightly hyperechoic with poor 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 (5.37 cm). Overall echogenicity is slightly hyperechoic with poor 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.

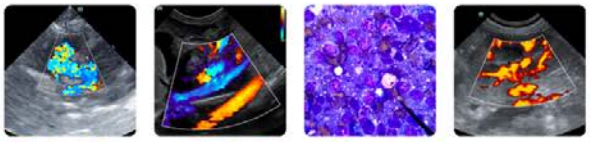
Adrenal Glands

In the region of the left adrenal there is a hypoechoic, irregular structure measuring 0.72 cm x 1.25 cm. This could represent an irregular lesion involving the caudal pole of the left adrenal, or be a nodular, lymph node, etc. A normal adrenal gland is not clearly visualized.

The right adrenal gland is normal in size measuring 0.53 cm at the cranial pole and 0.48 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 (1.05 cm at the hilus), 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 mixed echogenicity, hyperechoic, slightly cystic/cavitated nodule visualized within the parenchyma measuring 1.04 cm x 1.27 cm.



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Liver

The liver is large in size, and normal in 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 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 minimal luminal contents. The gastric wall appears prominent with a prominent muscularis layer, measuring at 0.60 cm. 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 0.35 cm. Jejunum wall measures 0.28 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 visible/mildly mottled in the right 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. There is no evidence of a significant diffuse lymphadenopathy, but the iliac lymph nodes are large. The right measures 0.99 cm x 2.04 cm. The left measures 0.64 cm x 1.49 cm. An occasional ill-defined mesenteric lymph node is prominent measuring 0.91 cm x 1.95 cm.

ULTRASONOGRAPHIC FINDINGS

- Irregular tissue visualized in the region of the left adrenal – Findings could be consistent with an atypical adrenal mass lesion, a lymph node, nodule, etc.
- Age related changes visualized associated with both kidneys.
- Hyperechoic, mixed echogenicity, cystic/cavitated nodule in the spleen – Findings could be consistent with a benign or neoplastic lesion. Consider a fine needle aspirate.
- Pancreatic changes consistent with pancreatic remodeling in the right limb.
- Large, heterogeneous liver – 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

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neoplasia (less likely) or other hepatopathy.

- Prominent/thickened gastric wall with intact wall layering – The stomach wall thickening could be consistent with inflammation, edema, infiltrative neoplasia, imaging artifact due to rugal folds, other.

- Large iliac lymph nodes – Findings could be consistent with reactive or neoplastic lymph nodes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

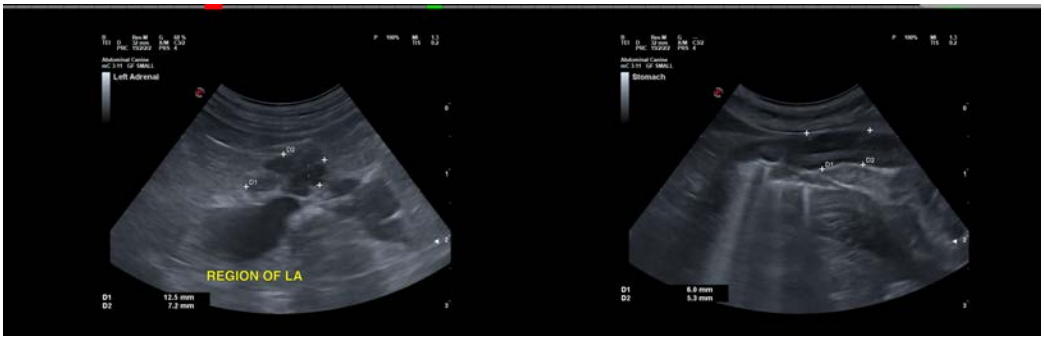
There is irregular hypoechoic tissue visualized in the region of the left adrenal. This could represent an adrenal mass lesion, a lymph node, etc., options for further evaluation would include serial monitoring and/or a contrast CT scan of the region.

There is a mixed echogenicity hyperechoic nodule visualized associated with the spleen. This could represent a benign or neoplastic lesion. Options moving forward would include a fine needle aspirate or continued monitoring with ultrasound.

The appearance of the liver is most consistent with a vacuolar hepatopathy, although other hepatopathies are possible. If further evaluation is desired, consider a liver function test and a fine needle aspirate.

The gastric wall appears somewhat prominent with no loss of layering. This could be consistent with gastritis or other. Consider reevaluation in the future, looking for progression or significant loss of layering, which may require further evaluation.

The iliac lymph nodes are prominent. Recommend a digital rectal exam to evaluate anal glands for any nodules or mass lesions as well as the rectum. Evaluate the pelvic limbs/caudal aspect of the body for any cutaneous mass lesions. A fine needle aspirate could be considered, but there is significant risk with the proximity to the great vessels.



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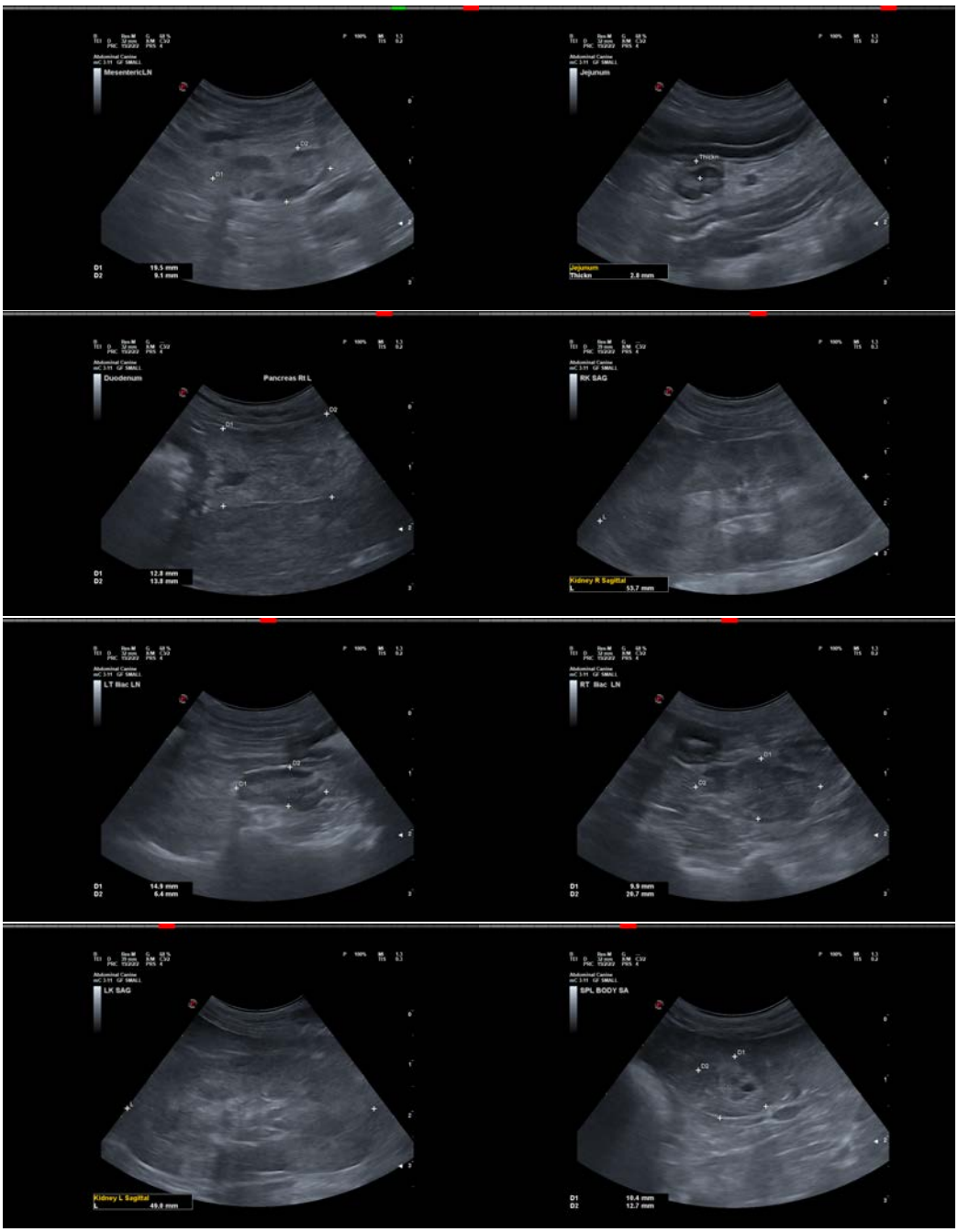

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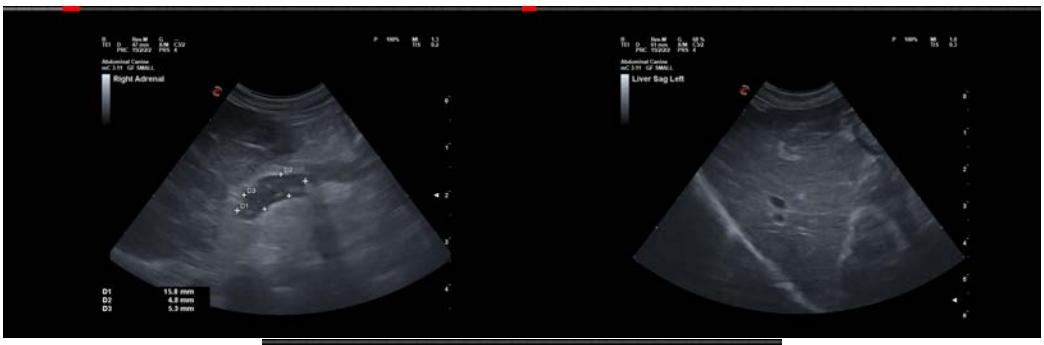

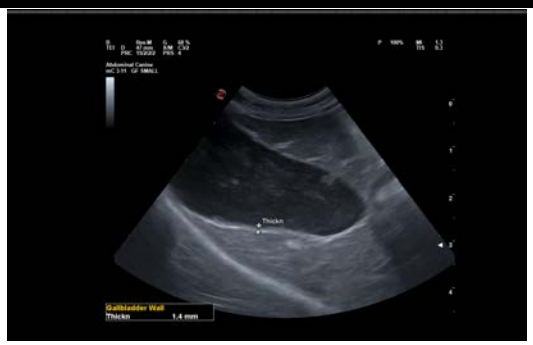

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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