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Clinical Sonography & Telecytology
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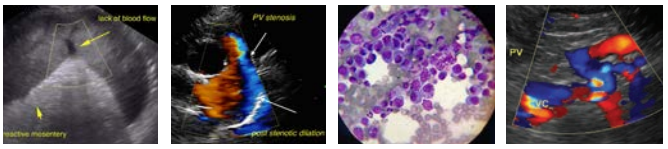

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Bandit Sherman

SPECIES

Canine

BREED

Labradoodle

SEX

Neutered Male

AGE

9.5 Years

WEIGHT

83.5 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Kelly Vazquez

HOSPITAL NAME

Bergen County VC

REFERRING VET

Dr. Megan Moore

INVOICE

30050

DATE

11/24/21

PRESENTING CLINICAL SIGNS

Progressively elevated ALT, newly elevated AST. R/O neoplasia vs. infection/inflammation vs. other. Abnormal PE/Chem/CBC/UA Results: ALT 237, AST 56, cholesterol 495, CK 387. U/A: trace protein, USG 1.053.

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 (0.57 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 (6.94 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 (7.19 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 0.38 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 0.68 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 heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. There is a focal hypoechoic area caudal to the liver, surrounded by hyperechoic mesentery. This is most consistent with a pancreatic lesion, but could also be consistent with a caudal peripheral hepatic lesion.

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.

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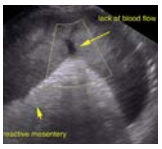
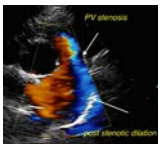
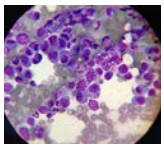
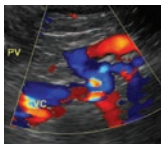

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Gastrointestinal

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. The duodenum measured as normal (between 0.3-0.5cm in wall thickness) and the jejunum measured as normal (between 0.2-0.47cm.) 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 itself is somewhat prominent, but isoechoic to surrounding mesentery. There is a focal hypoechoic area caudal to the liver measuring approximately 3.16 cm x 3.89 cm, which is irregular and surrounded by hyperechoic mesentery. The location and appearance of this lesion is most consistent with a focal peritonitis, and possible pancreatitis or even an early pancreatic abscess.

Free Abdomen

There is no free fluid. No lymphadenopathy is noted. The omentum is hyperechoic in the cranial abdomen surrounding the hypoechoic focal lesion, which most likely represents either a pancreatic/hepatic lesion or possibly an inflamed lymph node.

ULTRASONOGRAPHIC FINDINGS

- Focal hypoechoic inflamed tissue that appears caudal to the liver in the region of the pancreas – most strongly suspect pancreatic lesion, alternately could be hepatic or lymp node. Recommend fine needle aspirate.
- 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 neoplasia (less likely) or other hepatopathy.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No obvious focal parenchymal hepatic lesions are evident, but there is a focal region of inflammation caudal to the liver, which could be originating in caudal liver or pancreas. Other alternative would be stomach/lymph node, etc. Recommend a fine needle aspirate of this region. Consider a GI panel to Texas A&M with a quantitative PLI, TLI, cobalamin and folate to get more information regarding the small intestine and pancreas. If symptoms persist despite supportive care, antibiotics, etc., then consider either exploratory surgery or advanced imaging (contrast CT scan) to further evaluate this area of focal inflammation. Alternately, serial ultrasound could be considered to see if this are becomes more defined over time.

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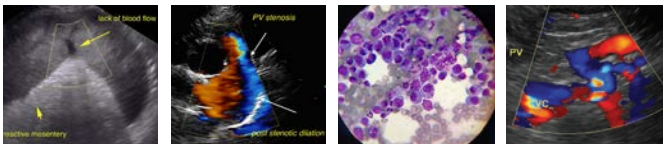

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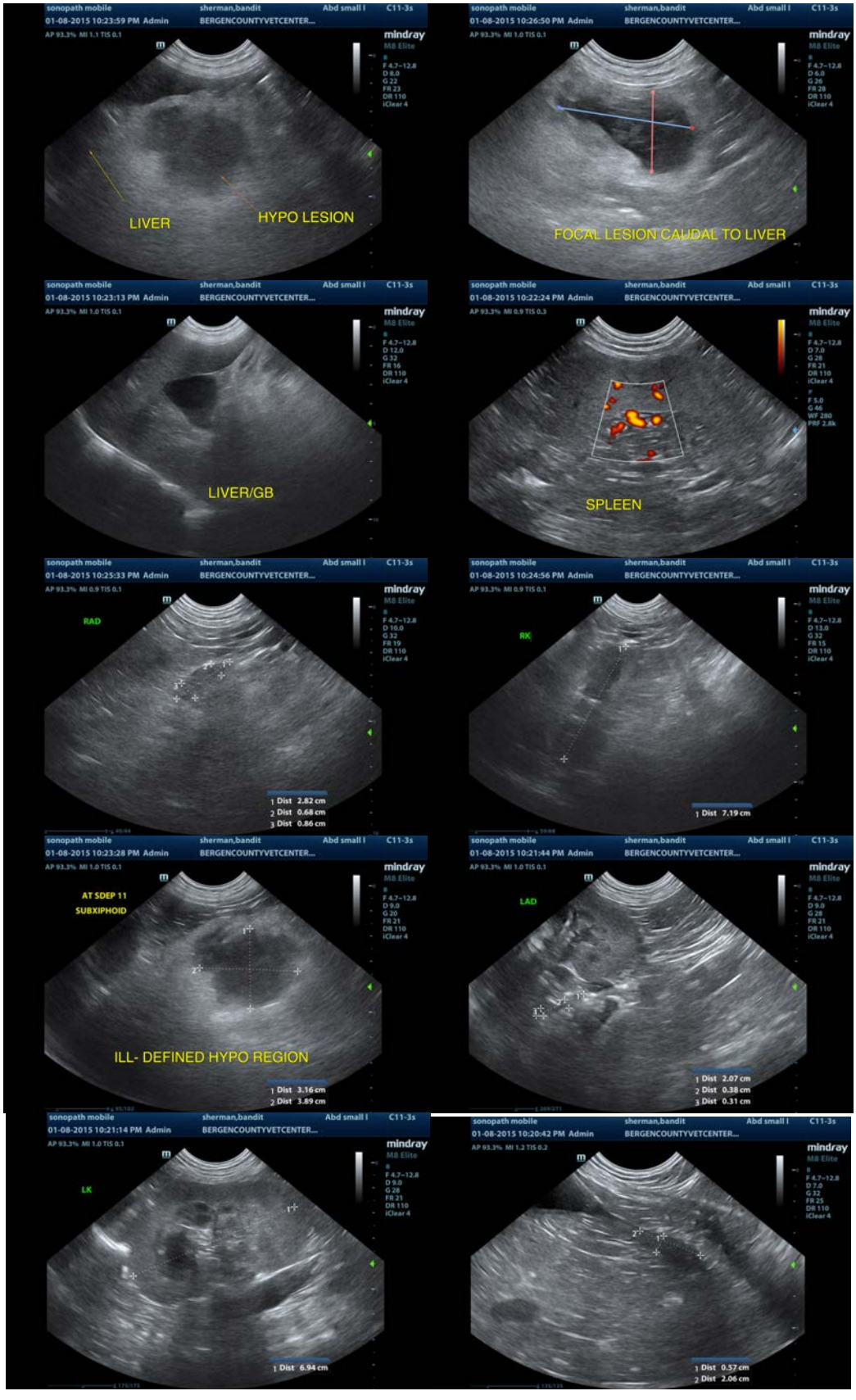

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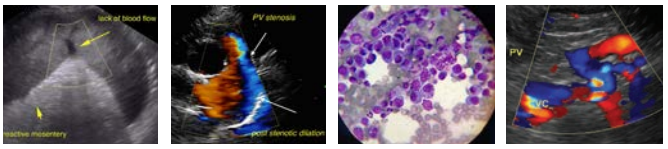

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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