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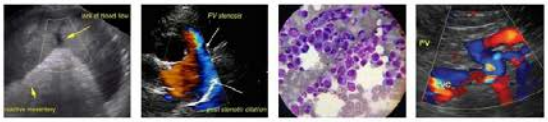

IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Bea House

SPECIES

Canine

BREED

JRT

SEX

Spayed Female

AGE

11 Years

WEIGHT

15.2 Pounds

INTERPRETED BY

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

IMAGING BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

MountainView AH

REFERRING VET

Dr. Sarah Kalivoda

INVOICE

42553

DATE

11/3/22

PRESENTING CLINICAL SIGNS

~Rule out pancreatitis vs other pancreatic disease vs other causing GI symptoms~ : ~Patient presented on 10/18 for annual evaluation and discussion about recurrent vomiting and increased borborygmus. blood work evaluation showed elevated Amylase and Lipase. Rec antacid therapy and rec abd ultrasound to evaluate pancreas and remaining gi tract

Abnormal PE/Chem/CBC/UA Results: LABs attached-~ Amylase 1,796 (337 - 1,469 U/L) Lipase 965 (0 - 250 U/)

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 (3.96 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 (4.01 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 0.41 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 region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. 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, slightly cystic/motheaten appearing lesion within the splenic parenchyma measuring 0.75 cm x 1.67 cm. Additionally, there is a hypoechoic nodule visualized measuring 0.50 cm x 0.48 cm.

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 on the left side of the liver measuring 0.45 cm in diameter.

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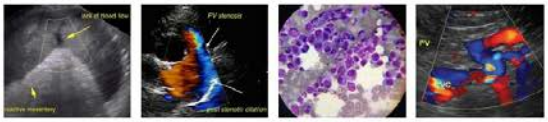

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The gall bladder lumen is significantly distended. Some areas of the wall appear mildly thickened with adherent debris. There is a large amount of primarily non-organized echogenic debris. There is no evidence of bile duct dilation.

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 uniform diameter with minimal fluid distension. Wall appears subjectively, mildly increased. Bowel loops follow a typical curvilinear path with distinct wall layering. Duodenum wall measures 0.50 cm. Jejunum 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 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

There is a scant amount of free abdominal fluid and a prominent mesenteric lymph node measuring 0.22 cm. The omentum is generally of normal echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Motheaten, mildly cystic, hyperechoic lesion in the spleen as well as a hypoechoic nodule – Differentials include lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis.

- Prominent, mottled pancreas – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.

- Mildly heterogeneous liver with hyperechoic nodule – 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. Without significant liver enzyme elevations, changes could be consistent with age related remodeling. The hyperechoic nodule visualized has the appearance most consistent with a benign lesion, although an underlying neoplastic lesion cannot be entirely ruled out.

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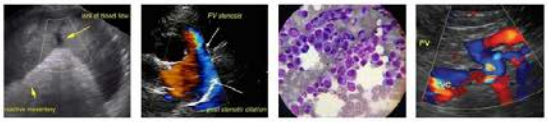

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- Large gallbladder debris – A large amount of debris is evident in the gall bladder with no evidence of a mucocele or associated inflammation at this time. This could represent an early mucocele or cholestasis, with minimal evidence of associated inflammation at this time. Continued monitoring of labwork and ultrasound are warranted for progression of this lesion. Ursodiol therapy could be considered.
- Subjectively thickened small intestine – 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).
- Scant free abdominal fluid

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a hyperechoic cystic lesion visualized within the spleen as well as a hypoechoic nodule. Options moving forward include a fine needle aspirate of these lesions and/or continued monitoring with ultrasound.

The pancreas is somewhat prominent and mottled. This could be consistent with previous episodes of pancreatitis, or mild current pancreatitis. Correlate with a quantitative cPLI level.

There is a large amount of debris visualized within the gallbladder, but the gallbladder wall does not appear thickened and there is no surrounding inflammation. Consider starting chronic Ursodiol therapy and continuing to monitor the gallbladder and liver enzymes for progression of this lesion.

The small intestine appears relatively normal but is subjectively mildly thickened.

Consider such differentials as food allergy/dietary intolerance, GI parasitism, chronic pancreatitis, IBD and less likely neoplasia, etc.. .

- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks)
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc.. to further evaluate for pancreatic/small intestinal disease.
- Consider chronic probiotic therapy.
- If test results are suggestive of primary GI disease and there is no response to a diet change, etc., then consider obtaining GI biopsies.

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

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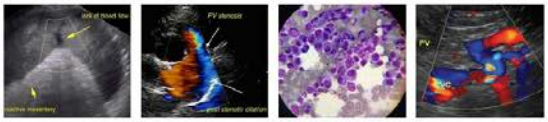

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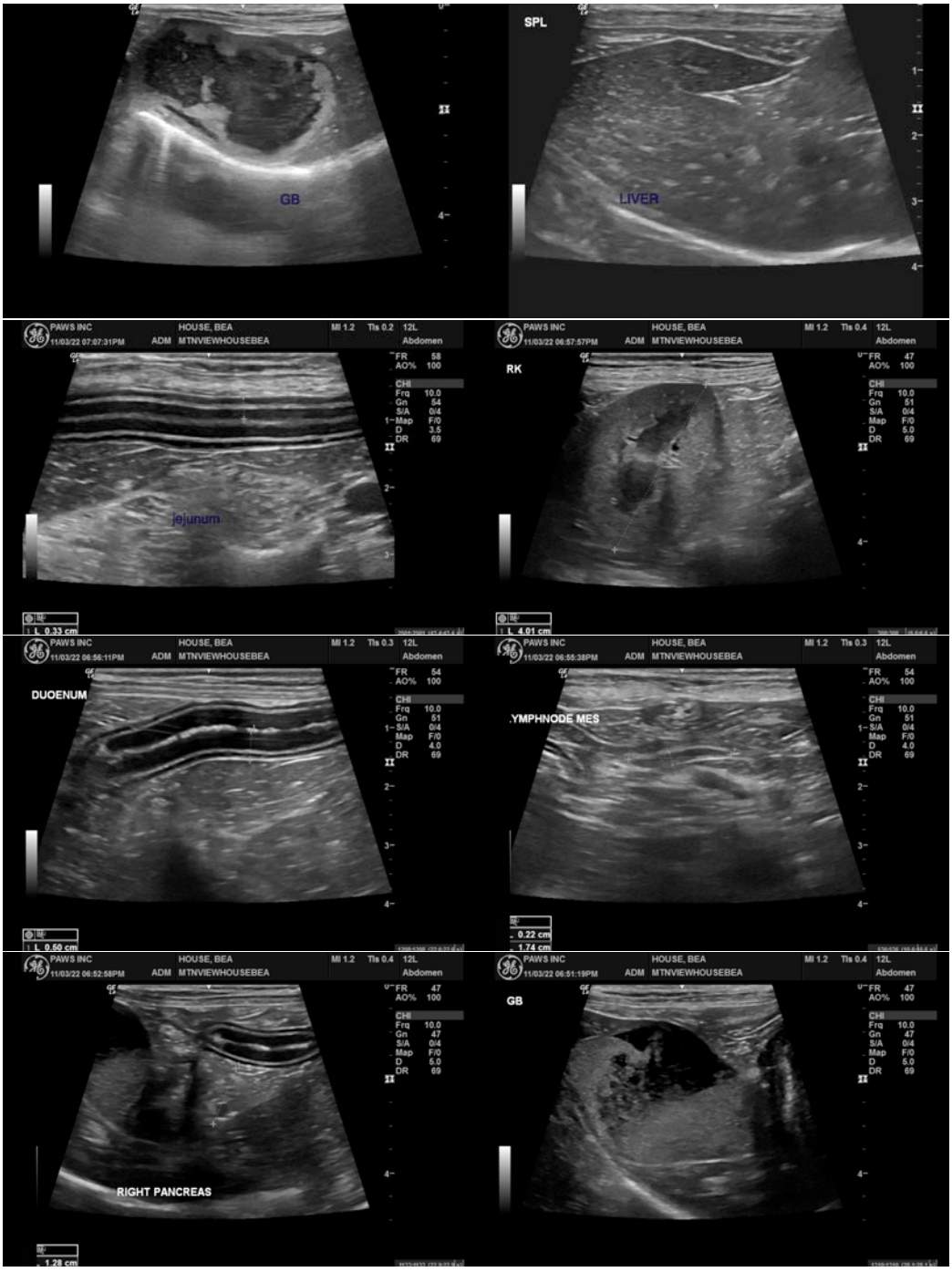

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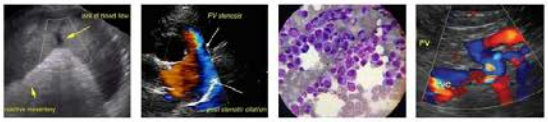

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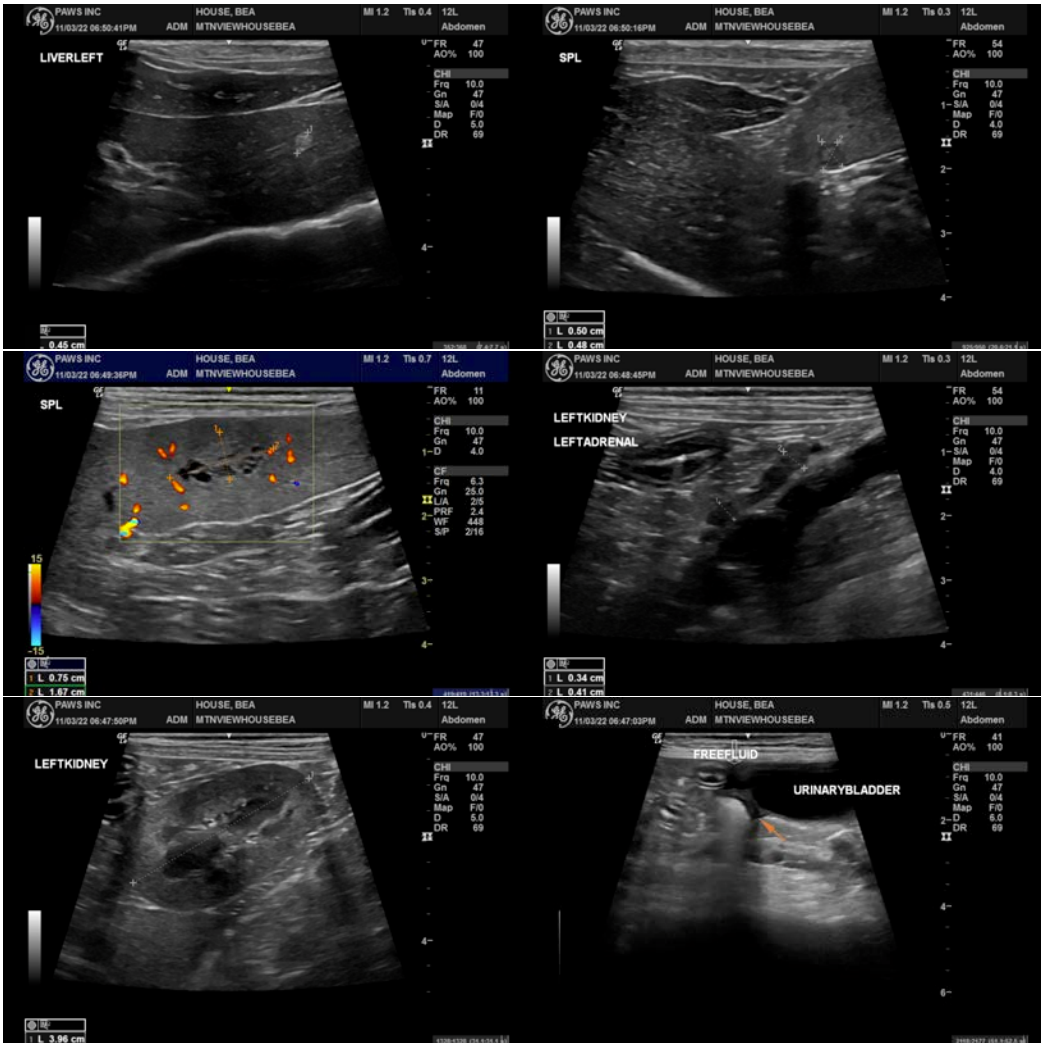

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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