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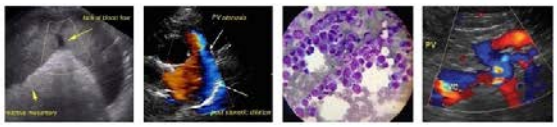

THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Lizzie Van Berkel

SPECIES

Canine

BREED

Yorkie X

SEX

Spayed Female

AGE

13 Years

WEIGHT

7.68 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Snelgrove VS

REFERRING VET

Dr. Gusninger

INVOICE

42628

DATE

11/8/22

PRESENTING CLINICAL SIGNS

Recent history of GI upset. Ongoing for about 3 weeks. Nausea, vomiting, not eating. Gabapentin 50 mg q8h, omeprazole 5 mg q24h, thyro-tab 0.1 mg q12h, cerenia 24 mg q24h prn, propalin 0.13 ml q24h.

Abnormal PE/Chem/CBC/UA Results: ALT 224 (10-125) ALP 629 (23-212) Otherwise bloodwork NSF Radiographs show mild hepatomegaly. Significant stool present at time of study however is passing stool. No obvious obstructive pattern or foreign material. Mild gas in stomach. No obvious masses noted.

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 (4.02 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.

The right kidney has a normal shape and size (4.54 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

The left adrenal gland is normal in size measuring 0.75 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 0.64 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 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 gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and primarily anechoic. The cystic and common bile ducts are normal/not visible.

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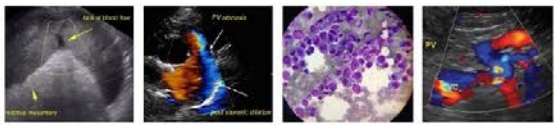

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Gastrointestinal

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. On one image there is a small 1.0 cm shadowing object visualized within the gastric lumen. This is likely incidental but correlate with abdominal radiographs. There is no evidence of an obstructive process.

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 0.55 cm. Jejunum wall measures 0.36 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 large and hypoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is evidence of regional mesenteric inflammation. Consistent with mild pancreatitis.

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 slightly hyperechoic in the cranial abdomen.

PRIMARY FINDINGS

- Mildly hypoechoic right limb of the pancreas with mottling and mildly hyperechoic mesentery – The pancreatic changes are most consistent with mild pancreatitis/pancreatic inflammation. Recommend fPLI testing and continued monitoring for improvement or possible development of a pancreatic abscess. Consider fine needle aspirate if not improving.
- 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 neoplasia (less likely) or other hepatopathy.
- 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).

SECONDARY FINDINGS

- Decreased corticomedullary distinction in both kidneys – The bilateral renal findings are consistent with age-related change.
- Small shadowing structure within the gastric lumen – This could be consistent with ingesta, a small amount of foreign material, etc. Correlate with abdominal radiographs. This is likely incidental.

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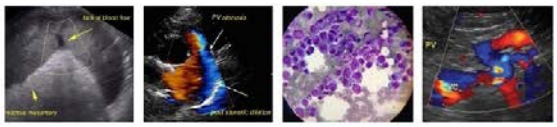

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

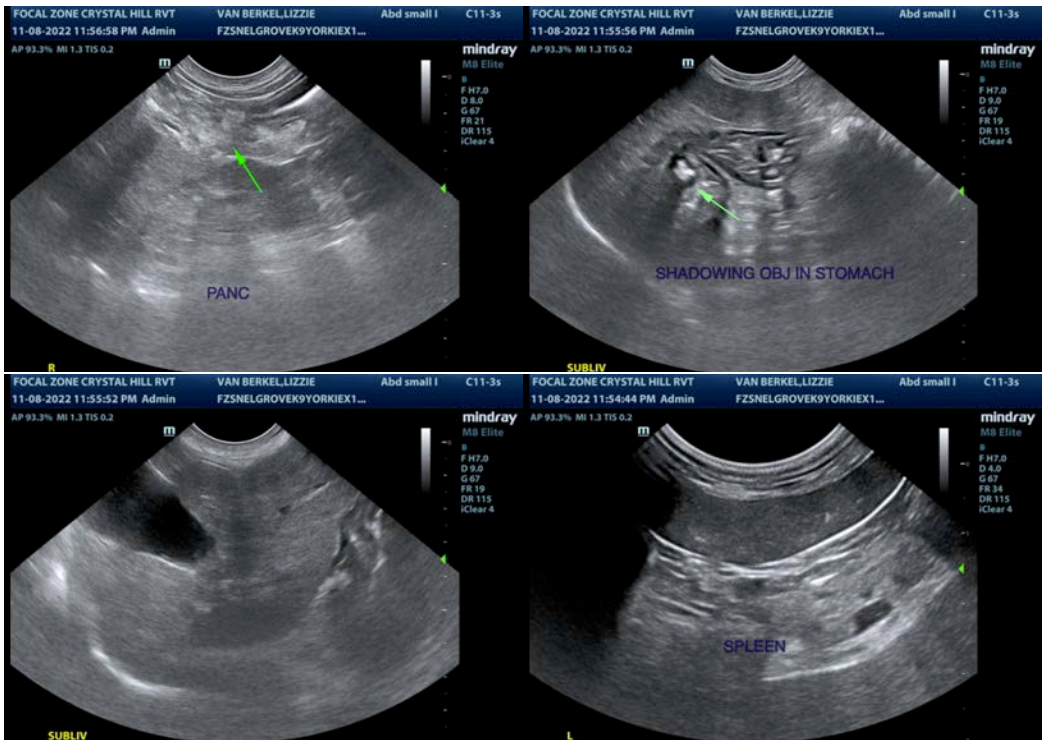
The pancreas appears slightly prominent on today's exam. This could be consistent with previous episodes of pancreatitis or could be consistent with an episode of mild current inflammation. Correlate with a quantitative cPLI level to further evaluate.

Additionally, the liver is large and heterogeneous. This seems less likely to be causing acute vomiting, but you could consider a liver function test and a fine needle aspirate of the liver if symptoms are not improving.

The small intestine appears subjectively very mildly thickened. This could be incidental or be associated with the mild enteropathy.

Consider such differentials as food allergy/dietary intolerance, GI parasitism, acute pancreatitis, dietary indiscretion, non-specific gastroenteritis, ingested foreign material, IBD and less likely neoplasia, etc….

- 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.
- Recommend chronic probiotic therapy.
- For now, consider an ultra low-fat diet such as chicken and rice, etc. In the future, either consider an ultra low-fat diet or a hydrolyzed protein diet.
- If symptoms are not improving with general treatment for acute gastroenteritis/pancreatitis, recommend repeat imaging to reassess.
- Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.



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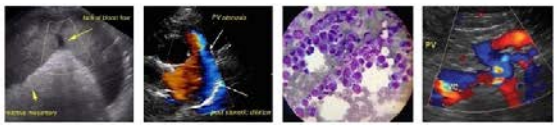

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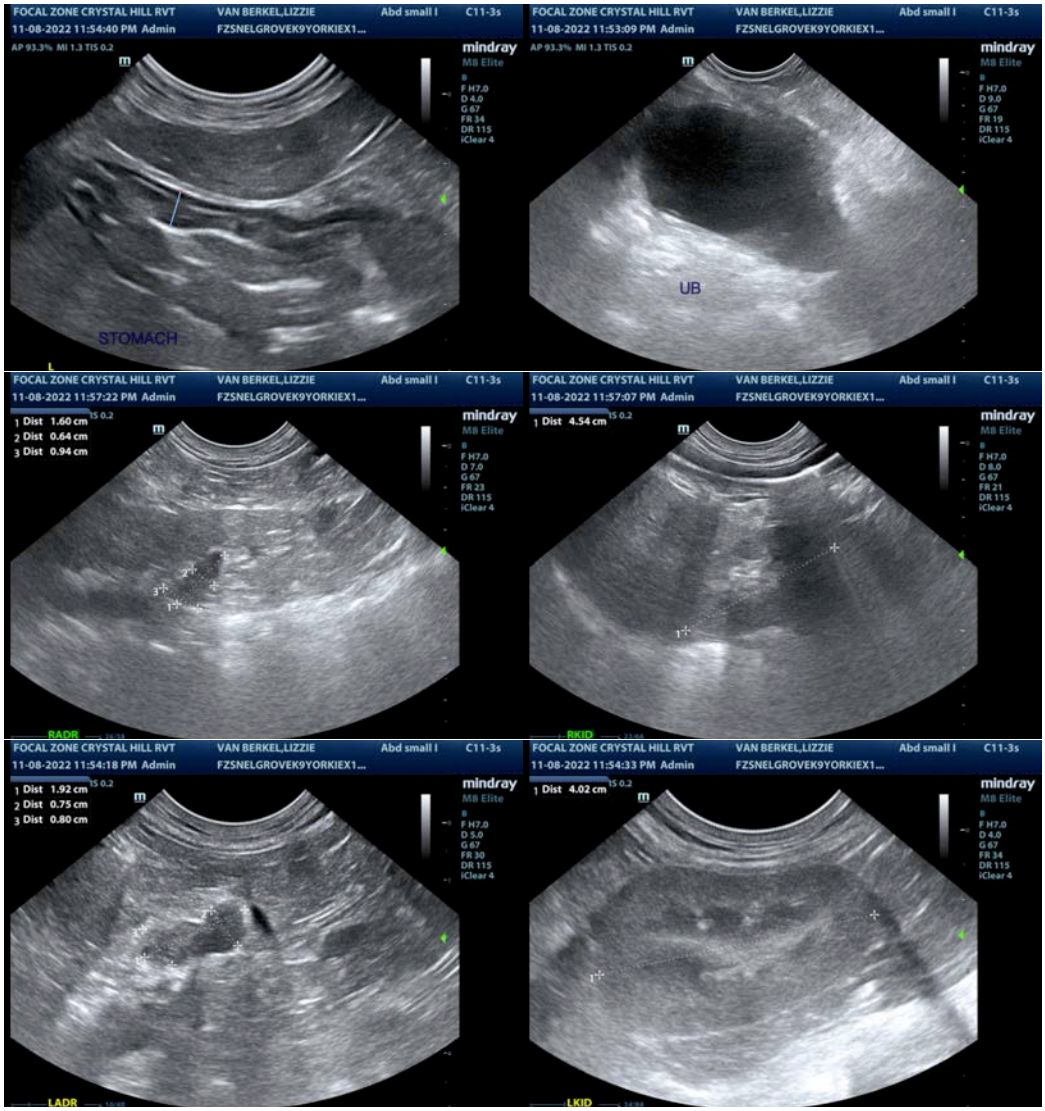

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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