



PATIENT PRESENTING CLINICAL SIGNS

Penny Finn

P presents for acute vomiting. Started vomiting last night and through this morning. P ate a little but generally hyporexic during this time. P had chronic/intermittent regurgitation and lick smacking that was worked up in February 2022. An ultrasound was performed and sent to Sonopath with minimal findings. CBC/Chem27/T4/UA was WNL at that time. P was started on omeprazole and the lip smacking improved significantly. P continued to regurgitate intermittently. Labs are being repeated with basal cortisol add on. cPL included in panel. Chest rads WNL in house, sending off for interpretation.

SPECIES

Canine

BREED

Papillon

Abnormal PE/Chem/CBC/UA Results: Chem 27/CBC/T4/cPL/UA/cortisol/chest rads pending.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

SEX

Spayed Female

Urinary System

The urinary bladder is mildly distended with mildly echogenic 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.

AGE

13 Years

The left kidney has a normal shape and size (3.96 cm). Overall echogenicity is slightly hyperechoic with mildly reduced 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.

WEIGHT

11.5 Pounds

The right kidney has a normal shape and size (3.66 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.

INTERPRETED BY

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

Adrenal Glands

The left adrenal gland is normal in size measuring 0.49 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.

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Dr. Saum Hadi

The right adrenal gland is normal in size measuring 0.51 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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Spleen

The spleen is subjectively normal in size. The spleen echotexture is heterogenous and mildly mottled, 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.

REFERRING VET

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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.

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The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a moderate amount of non-organized echogenic debris, including a 0.57 cm cholelith. The cystic and common bile ducts are normal/not visible.

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11/8/22



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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.

SPECIES

Canine

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. Jejunum wall measures 0.22 cm.

BREED

Papillon

Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

SEX

Spayed Female

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.

AGE

13 Years

Pancreas

The pancreas is prominent and hypoechoic as 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.

WEIGHT

11.5 Pounds

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 of normal uniform echogenicity.

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- Hypoechoic, prominent pancreas – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.
- 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. This also could be consistent with age related remodeling. Correlate with bloodwork.
- Moderate to mild gallbladder debris with a hyperechoic shadowing cholelith – This is similar in appearance and size to the previous scan in 2/2022.

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SECONDARY FINDINGS

- Mild echogenic debris visualized in the urinary bladder – The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus.
- Decreased corticomedullary distinction in both kidneys – The bilateral renal findings are consistent with age-related change.

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- Mildly mottled spleen – The diffuse splenic changes are non-specific and could be consistent with lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis. This description is similar to the previous description in 2/2022 and does not appear to have progressed.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is no evidence of an obvious obstructive pattern or mass effect associated with the GI tract. The pancreas is somewhat hypoechoic and prominent. This was described on the previous ultrasound and could be consistent with a recurrence of pancreatic inflammation or previous episodes of pancreatic inflammation. Correlate with a quantitative cPLI level.

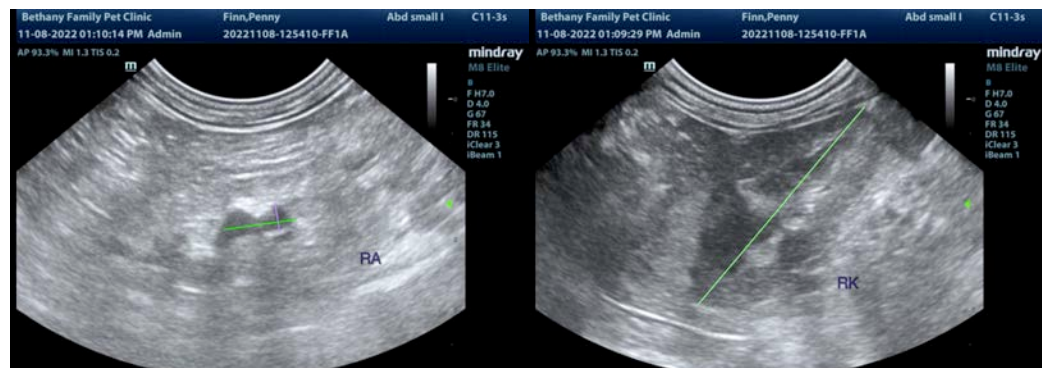
Unfortunately, there are many causes for vomiting that cannot be definitively diagnosed by ultrasound alone. Consider such differentials as food allergy/dietary intolerance, GI parasitism, acute pancreatitis, dietary indiscretion, non-specific gastroenteritis, ingested foreign material, IBD and less likely neoplasia, etc.

Consider treatment for acute gastroenteritis/pancreatitis. If symptoms are not improving, consider serial radiographs looking for evidence of foreign material or an obstructive pattern +/- reimaging with ultrasound. Additionally, you could consider the following:

- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks)/
- Recommend chronic probiotic therapy.
- 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.
- If these symptoms are occurring routinely, you could consider obtaining GI biopsies.

The liver is somewhat heterogeneous. This could be consistent with age related remodeling. Correlate with current bloodwork. If liver enzyme elevations are present, consider a liver function test and a fine needle aspirate.

If the chronic regurgitation is an issue, you could consider a fluoroscopic barium esophagram. Additionally, consider treatment for esophagitis with sucralfate and Omeprazole. Additionally, chronic Metoclopramide will help some pets that have frequent regurgitation, provided a foreign body has been ruled out.





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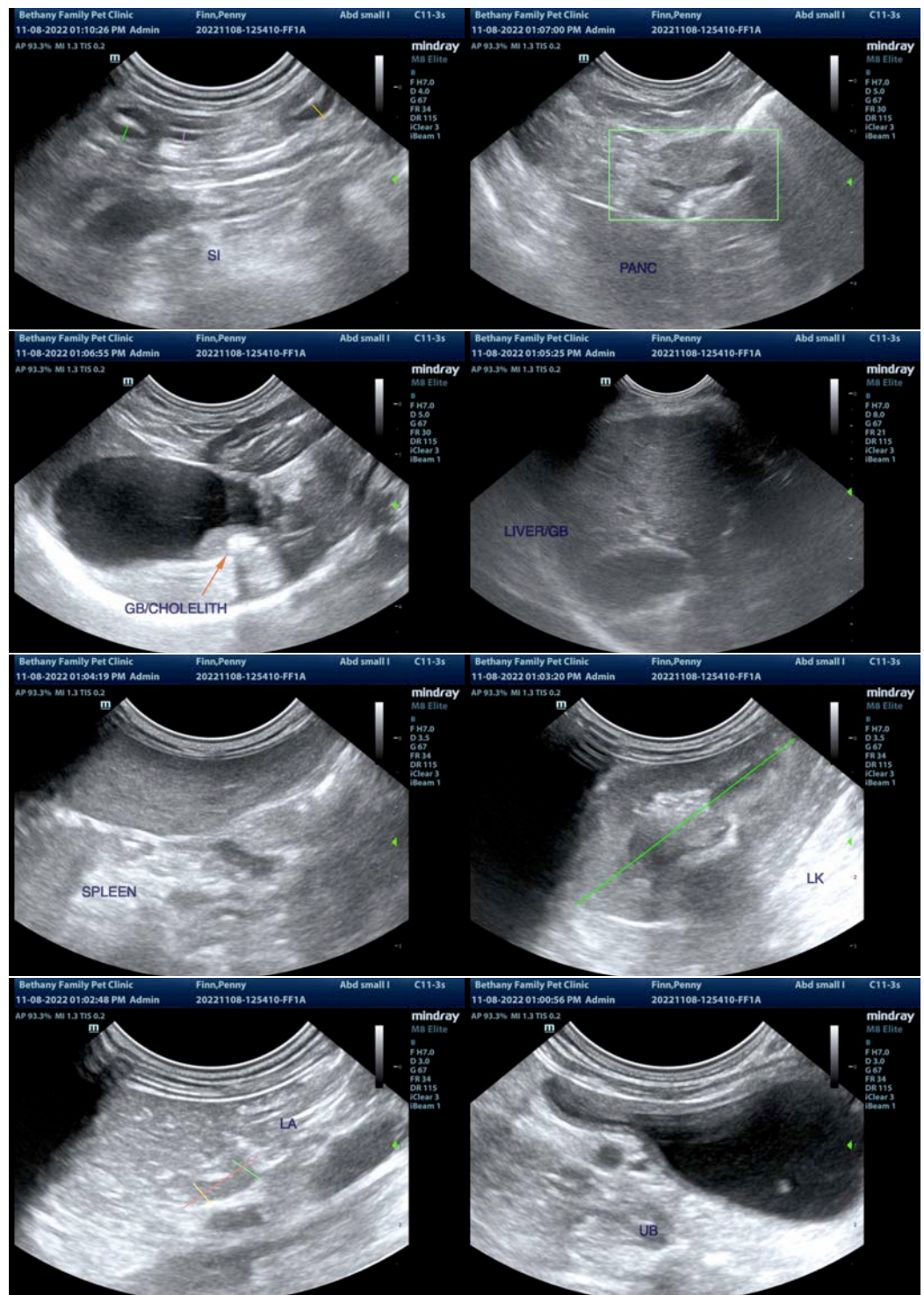
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

SPECIES

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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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