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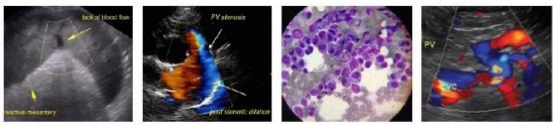


THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

DeeGee Willson

SPECIES

Canine

BREED

Cockapoo

SEX

Neutered Male

AGE

14 Years

WEIGHT

16.3 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Niagra VEC

REFERRING VET

Dr. Toth

INVOICE

13219

DATE

12/29/21

PRESENTING CLINICAL SIGNS

History: Difficult to get full history from DeeGee's owners. DeeGee came in for vomiting and anorexia, heavy breathing. He got into the garbage on Sunday then started vomiting and not eating. Presented with inspiratory wheeze, mouth appeared brown from vomitus and pet was dehydrated. Radiographs showed mixed gas pattern. Bloodwork mild anemia, elevated renal values (mild azotemia - creat 197 mmol/L), hyperphosphatemia, abnormal snap cPL. Admitted to hospital for IVF and supportive care with repeat radiographs in the morning. Cerenia, Pantoprazole, Buprenorphine and Ace.

Abnormal PE/Chem/CBC/UA Results: Bloodwork mild anemia, elevated renal values (suspect pre-renal), hyperphosphatemia, abnormal snap cPL. Radiographs showed mixed gas pattern. After supportive care with IV fluids, cerenia and buprenorphine, repeat abdominal radiographs reveal: - decreased serosal detail in general, areas of significant dilation present within small intestine - large urinary bladder AFAST - negative for free fluid in all quadrants

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 2 cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The visualized areas of prostate and surrounding tissue appear normal. Unfortunately, the prostate is not fully visualized likely due to its intrapelvic location. Correlate with rectal exam findings.

The left kidney has a normal shape and size (5.05 cm). Overall echogenicity is slightly hyperechoic with decreased corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of infarcts or hydroureter. There is numerous small non-obstructive nephroliths Renal vasculature is normal.

The right kidney has a normal shape and size (5.22 cm). Overall echogenicity is slightly hyperechoic with decreased corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of infarcts or hydroureter. There is numerous small non-obstructive nephroliths Renal vasculature is normal.

Adrenal Glands

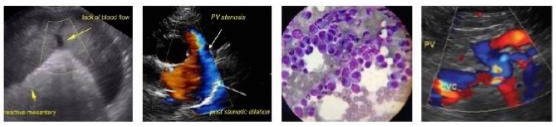
The left adrenal gland is normal in size measuring 0.72 cm at the caudal. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.6 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 The spleen echotexture is heterogenous and mottled, the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. There is a 1.2 cm hypoechoic nodule deviating the splenic capsule in the cranial portion of the spleen.

Liver



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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

The gall bladder lumen is mildly 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. The cystic and common bile ducts are normal/not visible.

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 0.3-0.5 cm in wall thickness) and the jejunum measured as normal (between 0.2-0.47 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. The majority of the visible colon appears fluid dilated and has 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

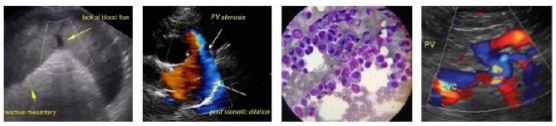
Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum appears of increased echogenicity in the cranial abdomen.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Mottled spleen with hypoechoic nodule which deviated the splenic capsule. There is a non-cavitated, hypoechoic splenic nodule visualized. Differentials include lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis. This lesion is more concerning because of the degree of splenic mottling overall and the fact that it deviates the splenic capsule.

- Hypoechoic prominent pancreas surrounded by hyperechoic mesentery. The pancreatic changes are most consistent with mild pancreatitis/pancreatic inflammation. Recommend a quantitative PLI and continued monitoring for improvement or possible development of a pancreatic abscess Consider an FNA if not improving.



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- Heterogenous 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.

- Decreased corticomedullary distinction in both kidneys with nonobstructive nephroliths. The bilateral renal findings are consistent with age-related change.

Secondary Findings

- Moderate gallbladder debris. The significance of the aggregated gallbladder debris is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting.

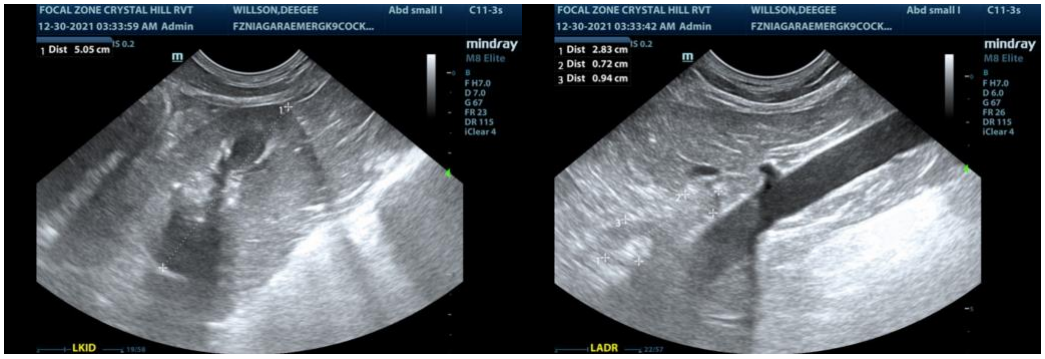
- Fluid dilated colon consistent with current or impending diarrhea

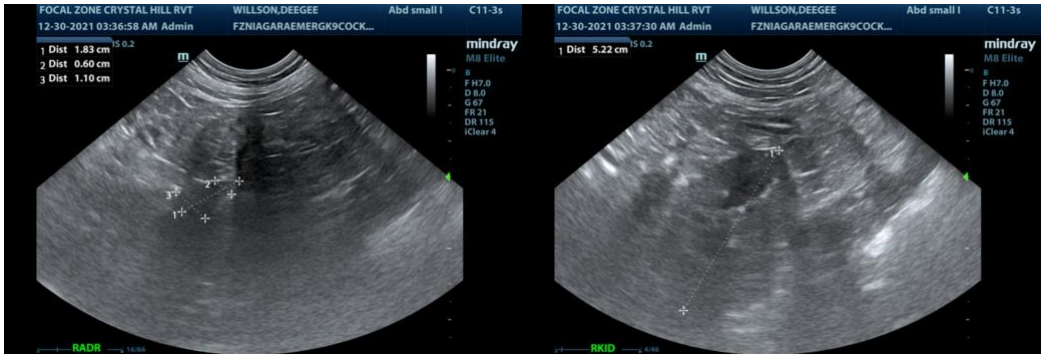
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes observed in the kidneys are consistent with chronic progressive, likely age-related, change. I recommend urinalysis, culture and blood pressure evaluation.

The pancreas is prominent, and the cranial abdomen appears generally somewhat inflamed. I suspect that there is some degree of pancreatitis present. Additionally, there is a nodule on the spleen and the spleen appears diffusely mottled. Options would include either a fine needle aspirate of the spleen or splenectomy with histopathology.

I was unable to visualize any significant foreign material or evidence of an obstruction. I suspect the dilated bowel visualized on radiographs is colon. Although, ultrasound can be insensitive in picking up some types of foreign material. So, continued serial radiographs and close monitoring is warranted. I recommended three-view thoracic radiographs.





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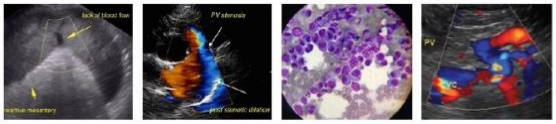

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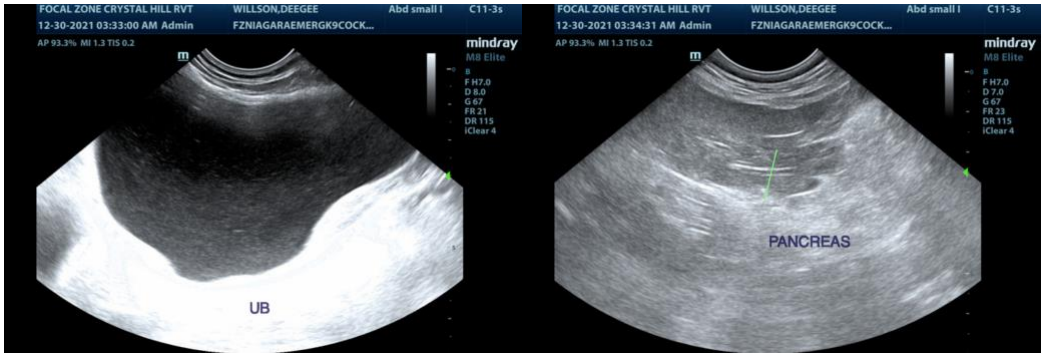

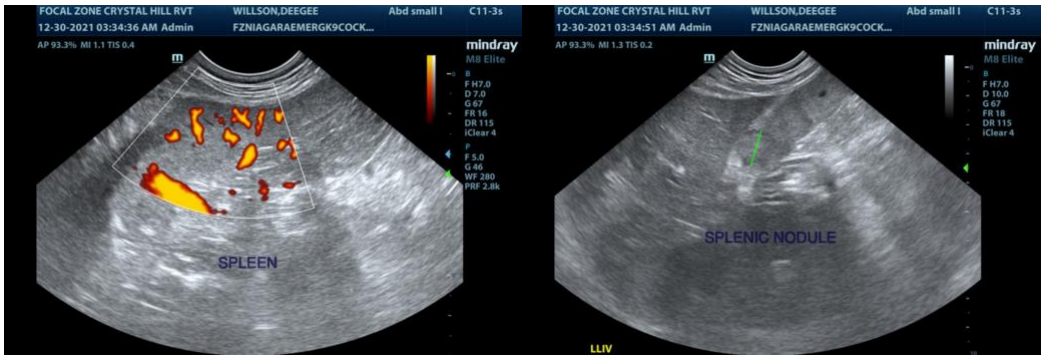

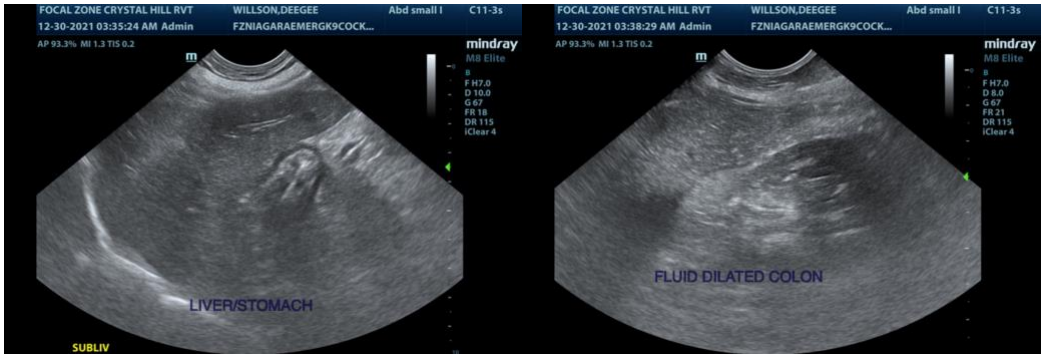

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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