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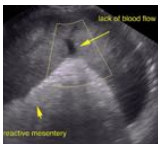
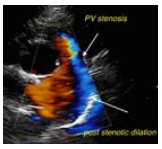
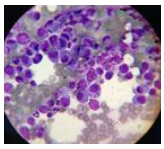
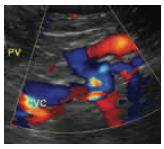

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Henry Sargo

SPECIES
Canine

BREED
Cocker Spaniel

SEX
Neutered male

AGE
5 years

WEIGHT
12.1 kg

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

IMAGING PERFORMED BY
Dr. Callihan/Pacific Crest Mobile

HOSPITAL NAME
Pacific Crest Mobile

REFERRING VET
Dr. Harvey/Skagit

INVOICE
95994

DATE
2/9/22

PRESENTING CLINICAL SIGNS

Chronic pancreatitis/ sensitive stomach/intermittent loose stools; eats Hills I/d low fat with variable interest in food. Also reported to have intermittent fever. -history IMHA late 2020 -history of new seizures Jan of 2021, controlled with Levetiracetam and Zonisamide -history hypertension (unknown inciting cause; though of note, he has been an extremely fearful/apprehensive patient in general) Meds: -mycophenolate, omeprazole, Levetiracetam, amlodipine, Zonisamide
Abnormal PE/Chem/CBC/UA Results: Labs: Tick panel in October 2021 negative Had ultrasound in Jan 2021 indicating chronic pancreatitis, mild/moderate gallbladder sediment; CBC today is normal USG today is 1.040 with trace protein (full UA pending)

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 (1.12 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 (5.31 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 (5.29 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 0.62 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 0.59 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.

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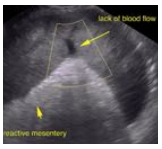
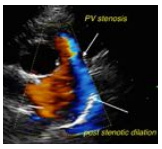
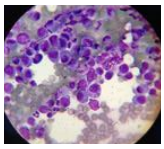
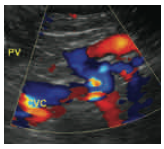

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Liver

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. The gallbladder lumen is moderately distended. The wall of the gallbladder is not thickened and has a smooth mucosal surface. Luminal contents are primarily anechoic. 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 (0.6 cm) and the jejunum measured as normal (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.

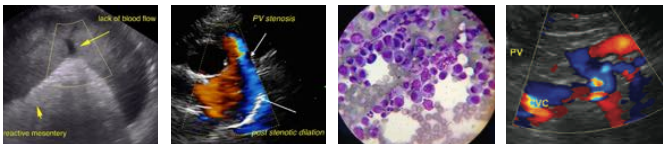
Free Abdomen

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.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS:

- Prominent mottled pancreas. The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- 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 could be normal for this individual.



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- 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.
- 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).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal lesions are visualized to explain the inappetence, vomiting and diarrhea reported. This patient is on a lot of medications so it is possible that you are dealing with drug interactions and medications that could be making him not feel well (this is a common challenge in patients like this). Try to track any patterns as far as any new medications that coincide with the GI signs, etc.

Alternately there could be a concurrent primary GI issue going on. The possibilities would include dietary sensitivity, GI parasites, dysbiosis and pancreatitis sometimes this can be more clinically significant than what it appears like on ultrasound. Less likely IBD or neoplasia.

- Consider a novel protein or hydrolyzed protein prescription diet. If the patient is very picky you can consult with a nutritionist to formulate a homemade novel protein diet which is also low in fat.
- Consider chronic probiotic therapy. If this patient has been on antibiotics during hospital stays it is possible that dysbiosis is playing a role.
- Consider GI panel to Texas A&M for a qualitative PLI, TLI, cobalamin and folate to further evaluate the pancreas and small intestine.

Additionally, try to correlate the fevers with the GI signs. This patient should not be having a fever when immunosuppressed so there could be concern for additional issues going on.

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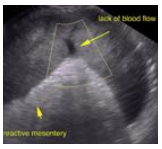
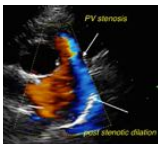
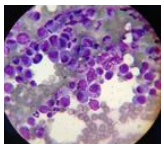
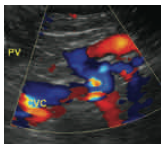

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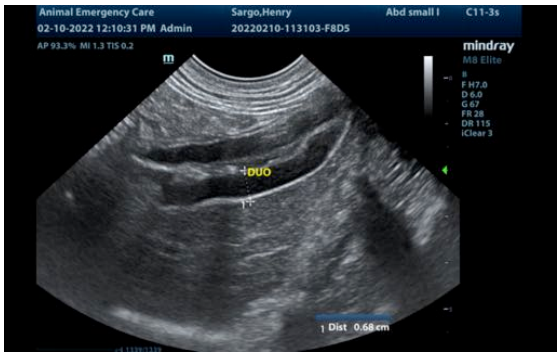

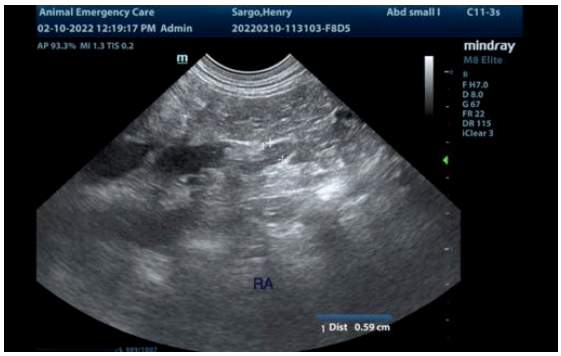

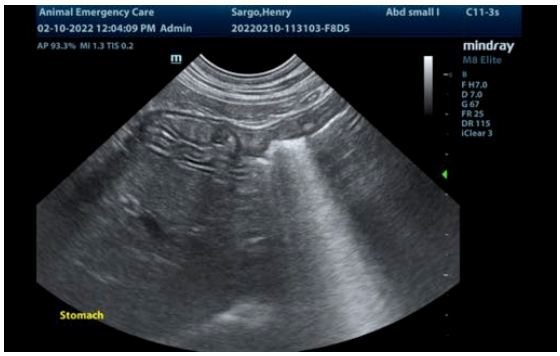

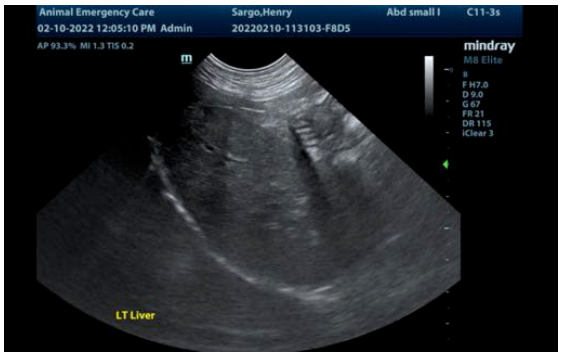

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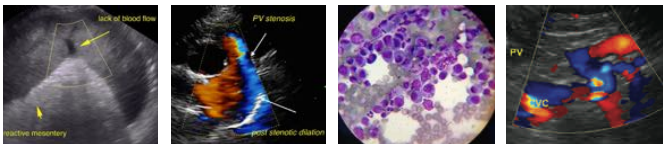

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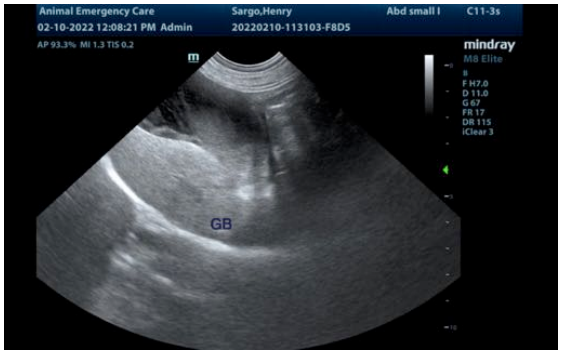

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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kathleen.sennello@sonopath.com