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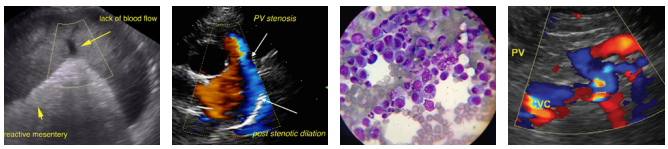

PATIENT

Thor Wortman

SPECIES

Canine

BREED

Shepherd

SEX

Neutered Male

AGE

1 Year

WEIGHT

80 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Megan Cassels Conway

HOSPITAL NAME

Central Broward AH

REFERRING VET

Dr. Janeez Lezcano

INVOICE

35597

DATE

2/10/22

PRESENTING CLINICAL SIGNS

P has hx of intermittent anorexia, vomiting and diarrhea. P also has delayed weight gain. All else WNL. P has been properly dewormed w Fenbendazole. P is alos current on vac and preventatives
Abnormal PE/Chem/CBC/UA Results: 8/2021: CBC: WNL, Chem: Phos: 7.7H, creat: 1.0, CA; 11.5, choles: 384H, US: SG: 1.055, trace prot, quiet sediment O+P; NPS, Giardia: NEG 2/22: radio consult: hip dysplasia w sec OA. mild hepatomegaly, mild generalized cardiomegaly,

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is minimally 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. Lack of urine distention prevents full evaluation of the urinary bladder.

No significant lesions were observed in the prostate, but the prostate was difficult to visualize due to an intrapelvic location and lack of urinary bladder distention for contrast.

The left kidney has a normal shape and size (7.33 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 (7.95 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 0.70 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 0.60 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 subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. 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 primarily anechoic. The cystic and common bile ducts are normal/not visible.

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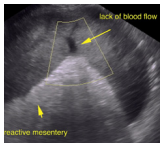

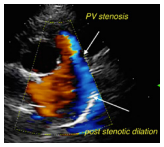

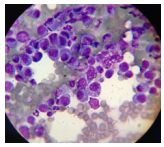
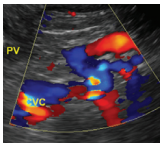

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Gastrointestinal

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. 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. Duodenum wall measured 0.39 cm. Jejunum wall measured 0.37 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 normal and isoechoic to surrounding 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

- 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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Today's scan was relatively normal. The pancreas was somewhat prominent, but this is likely an incidental finding. Unfortunately, there are many causes for vomiting and diarrhea, which cannot be diagnosed by ultrasound alone.

- Consider metabolic causes. Recommend an ACTH stimulation test to rule out Addison's disease. Recommend a GI panel to Texas A&M for a qualitative PLI, TLI, cobalamin and folate to look for evidence of exocrine pancreatic insufficiency, B12 deficiency, dysbiosis, etc.

- If metabolic disease is thought unlikely, then consider primary GI causes. In a young dog like this, consider dietary indiscretion, dietary intolerance, GI parasites (seems unlikely with deworming history), dysbiosis, etc.

- Consider a novel protein/hydrolyzed protein prescription diet, recommend chronic probiotic therapy, recommend the aforementioned GI panel, and if symptoms persist despite these changes, consider obtaining GI biopsies +/- fecal transplant if dysbiosis is likely.

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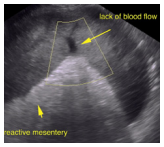

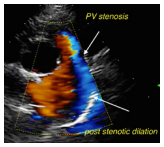

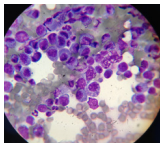
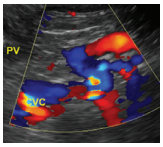

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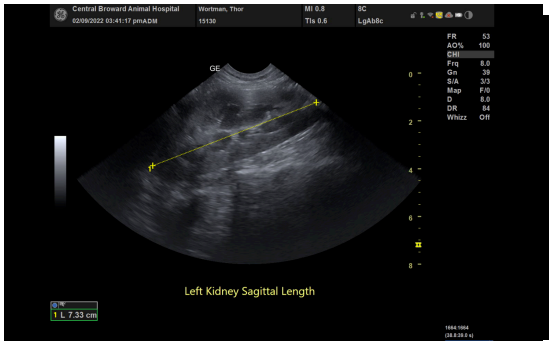

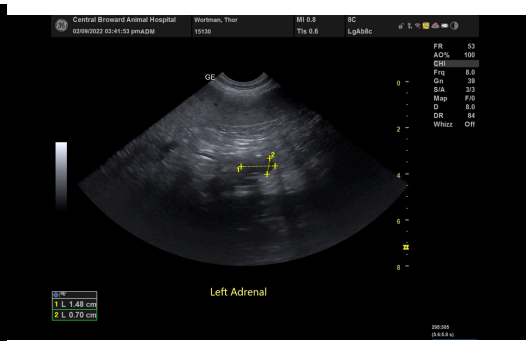

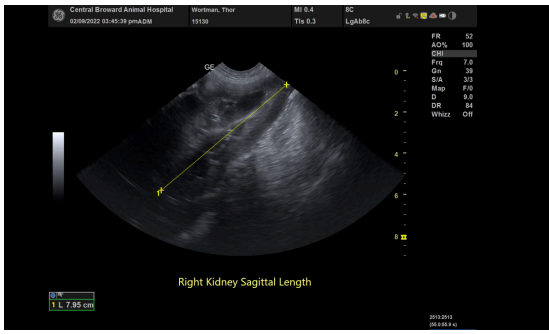

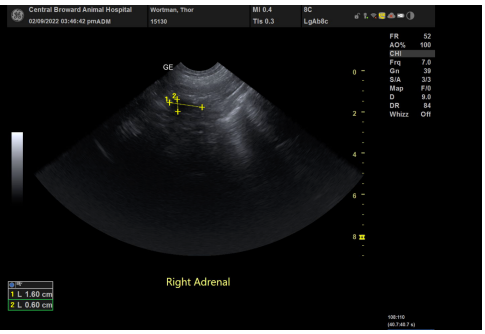

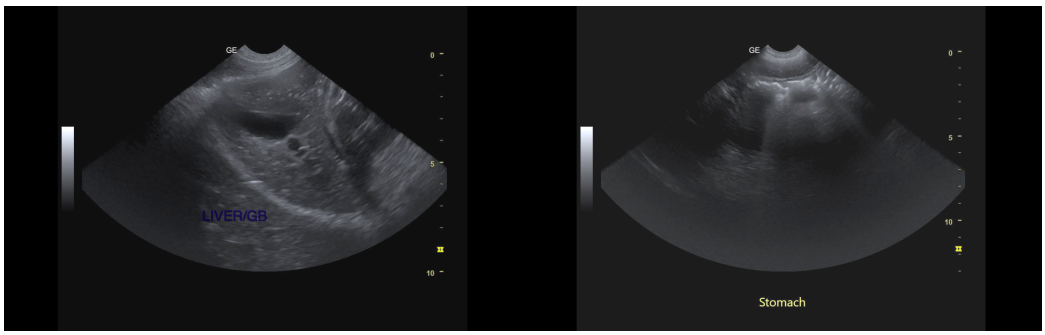

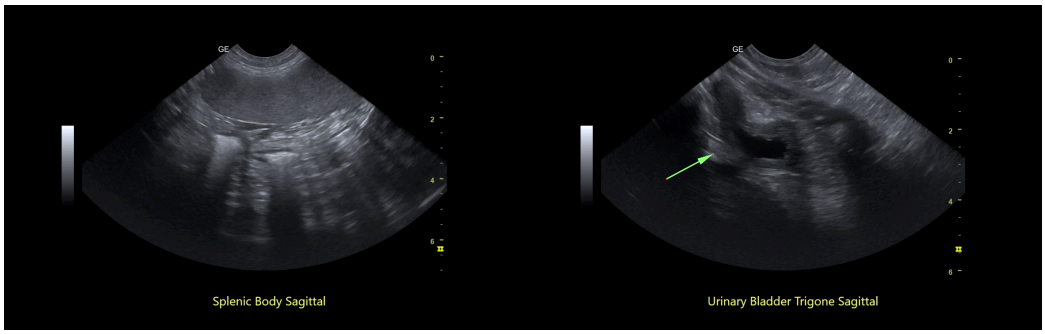

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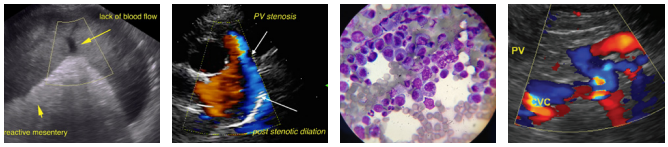

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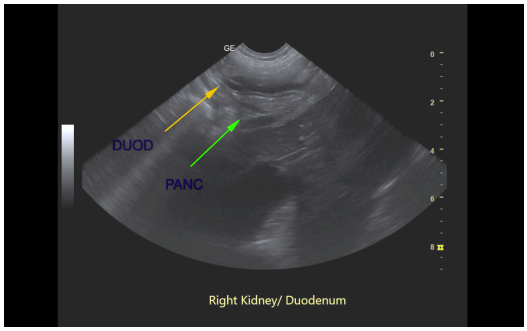

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

kathleen.sennello@sonopath.com