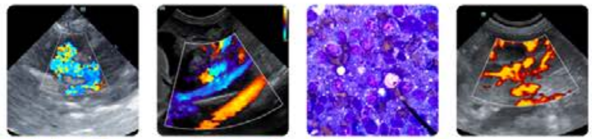


PATIENT
Pie Lezcano

SPECIES
Canine

BREED
Yorkie-Poo

SEX
Spayed Female

AGE
11 Years 8 Months

WEIGHT
7.9 lbs

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

IMAGING PERFORMED BY
Megan Cassels-Conway, DVM

HOSPITAL NAME
Central Broward Animal Hospital

REFERRING VET
Janeen Lezcano, DVM

INVOICE
72950

DATE
2/12/26

PRESENTING CLINICAL SIGNS

This is my personal p. She is hypothyroid and also suffers from extreme anxiety. For many yrs she has had excessive licking /yawning. I have tried different hypoallergenic diets but recently it is much worse. BM's are normal, 1/day, no flatulence or borborygmus. She was a rescue who had a rubber band tied around her muzzle for many days/weeks. The scab had grown over and hidden the rubber band, the lip becomes adhered to buccal gingiva. She has a grove along the center of her muzzle as well as her mandible. Her main symptoms are marked licking/yawning, occasional hyporexia and vomiting. She also has rear limb weakness and presumptive IVDD and atopy.

Current meds: fluoxetine 5mg qd, Soloxine 0.1mg bid (recently increased from 0.1mg in AM and 0.05mg in PM), lorazepam 0.5mg po sid-bid (mostly bid), gabapentin 50mg bid, trial of cerenia 8mg po qd for 2-3 weeks (no improvement). Was on carprofen 12.5mg po qd, helped w rear limb weakness but discontinued in case possible cause of hyporexia. She also had a 2 day bought of diarrhea. Apoquel 1.8mg po 4x weekly. Tried sucralfate many years ago and only able to administer ONE dose :-(. She hides from me big time and she is smart. I have also tried Metoclopramide 1.25-2.5mg po bid for 2-3 weeks (no marked improvement). I'm sure through the years I've tried famotidine also. She has seemed better on hill's d/d venison but recently is has worsened. I recently changed her to wynwood skin and allergy support (pork and sweet potato)

Abnormal PE/Chem/CBC/UA Results: Most current blood work: CBC: WNL Chem: creat: 1.0, choles: 521H HW: NEG UA: SG: 1.047, slight hematuria (cysto sample), UCS: no growth pT4: 2.3 BA: pre: 18.9H, post: 13.3, Cobalamine: 921H, folate: 16.1, TLI: 22.0, PLI: 96.

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.

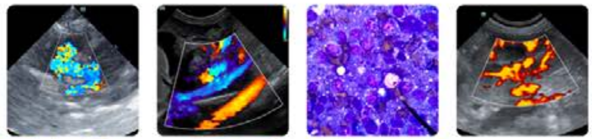
The left kidney has a normal shape and size (3.18 cm) with pinpoint cortical mineralizations. Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.22 cm) with pinpoint non-obstructive cortical mineralizations. 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, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.40 cm at the cranial pole and 0.51 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 0.48 cm at the cranial pole and 0.50 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal



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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 (0.99 cm), 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 gall bladder lumen is significantly distended. Some areas of the wall appear mildly thickened with adherent debris. There is a large amount of primarily non-organized echogenic debris. There is no evidence of bile duct dilation.

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 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 0.49 cm. Jejunum wall measures 0.27 cm. Ileum wall measures 0.39 cm. Visualized peristalsis appears appropriate. The muscularis layer is prominent in some segments of small intestine. There is mild mucosal speckling visualized associated with the ileum.

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

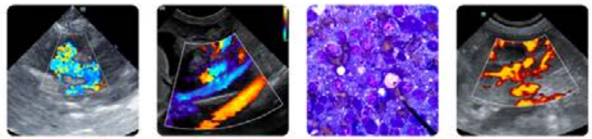
The pancreas is mildly mottled in the right limb. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

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

- Age related changes visualized associated with both kidneys.
- Pancreatic changes most consistent with chronic pancreatic remodeling – Mild chronic pancreatitis cannot be ruled out.
- Large, hyperechoic, non-organized gallbladder debris with some debris adhered to the gallbladder wall – A large amount of debris is evident in the gall bladder with no evidence of a



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mucocele or associated inflammation at this time. This could represent an early mucocele or cholestasis, with minimal evidence of associated inflammation at this time. Continued monitoring of labwork and ultrasound are warranted for progression of this lesion. Ursodiol therapy could be considered.

- Areas of prominent muscularis layer of the small intestine and mild mucosal speckling of the ileum – Bright mucosal speckling has been postulated to represent dilated lacteals or focal accumulations of mucus, cellular debris, etc.. in the mucosal crypts. The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma.

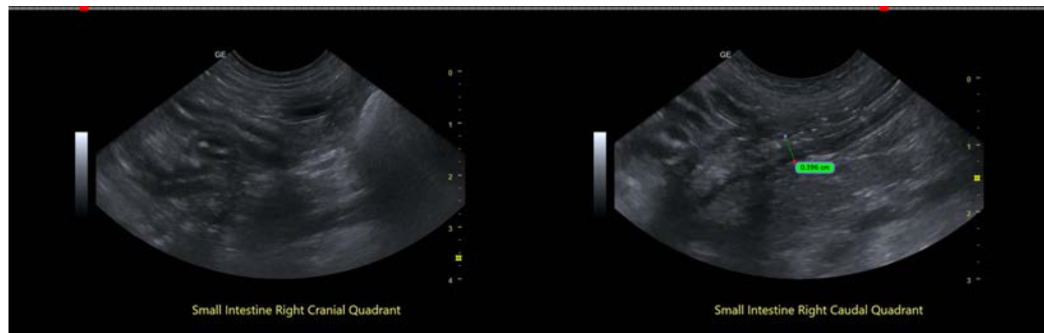
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The gallbladder has a large amount of debris, but there is no evidence of significant organization or inflammation associated with the wall. You could consider chronic Ursodiol therapy with continued monitoring of the gallbladder. If liver enzyme elevations are a concern, you could consider empirical treatment for cholecystitis, although this could be an incidental finding at this time.

The pancreas is visible without significant associated inflammation. Correlate with PLI level. If this is significantly elevated, consider treatment for chronic pancreatitis.

There are some mild changes visualized associated with the small intestine, primarily inflammatory in nature. At this time, you have already pursued a diet change. Additionally, you could consider a combination hydrolyzed/ultra low-fat prescription diet (Royal Canin) in the case that fat content is contributing to the elevated cholesterol levels and lymphangiectasia(?).

A definitive cause for the symptoms described is not visualized. You could consider consultation with a veterinary dentist in the case that there are any significant bony changes, necrosis or similar, which could be causing discomfort(?). An anesthetized oral exam should be considered if not already done. Additionally, you could consider further workup for a potential enteropathy with upper GI endoscopy and GI biopsies.



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Stomach

Splenic Body Sagittal

Cranial Right Liver Sagittal

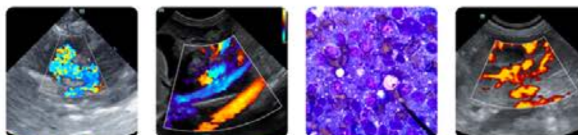
Jejunum Measurement

Duodenum Measurement

Right Adrenal

Right Kidney Sagittal Length

Left Adrenal



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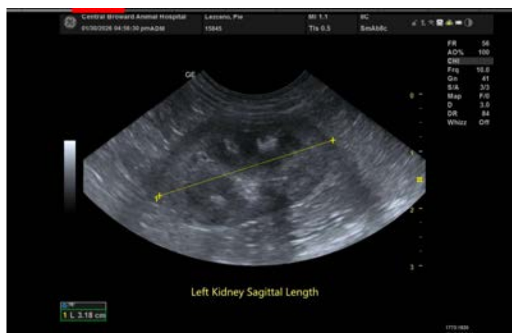

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@sonopath.com