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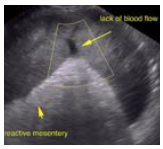
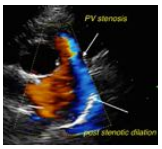
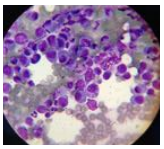
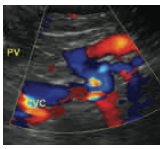




SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Penelope Venezia

SPECIES

Canine

BREED

Morkie

SEX

Spayed Female

AGE

15 years

WEIGHT

9 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Kelly Vazquez , CVT

HOSPITAL NAME

Westwood Regionl AVH

REFERRING VET

Dr. Gabriel

INVOICE

96085

DATE

2/15/22

PRESENTING CLINICAL SIGNS

Patient with history of lung tumor removal 3 months ago presents today for vomiting and lethargy. Abnormal PE/Chem/CBC/UA Results: Mild BUN elevation 31, low albumin 2.1, T. bili 1.0, mild neutrophilia 15.1, CPL abnormal.

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 (3.53 cm). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. Pinpoint, non-obstructive nephroliths and small cortical cysts were noted. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.99 cm). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. Pinpoint, non-obstructive nephroliths and small cortical cysts were noted. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal

Adrenal Glands

The left adrenal gland is normal in size measuring 0.45 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.

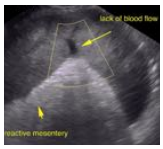
The right adrenal gland is normal in size measuring 0.5 cm at the caudal pole It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

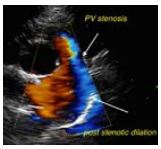
Spleen

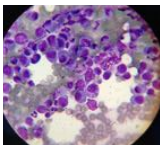
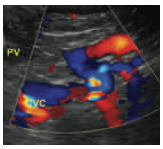
The spleen is subjectively normal in size, echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

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 gallbladder 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.





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Gastrointestinal

The stomach is moderately dilated with fluid and irregular shadowing material most consistent with normal ingesta and gas. 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 layering 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. The duodenum measured 0.51 cm and the jejunum measured 0.38 cm with mucosal speckling. Bowel loops follow a typical curvilinear path with distinct wall layering. 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 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.

Free Abdomen

There is a small volume of free abdominal fluid. No lymphadenomegaly was visualized and the omentum appears mildly increased.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS:

- Hypoechoic, prominent pancreas. The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.
- Mild gastric dilation. The findings are most consistent with ingesta. Consider such differentials as a recent meal or delayed gastric emptying.
- Diffusely thickened small intestine with diffuse mucosal speckling. The bowel wall thickening could be consistent with inflammation, edema, or infiltrative neoplasia. Bright mucosal speckling has been proposed to represent dilated lacteals or focal accumulation of mucus, cellular debris etc.. in the mucosal crypts of the small intestine.
- Small volume of free abdominal fluid.

SECONDARY FINDINGS:

Decreased corticomedullary distinction in both kidneys with pinpoint, non-obstructive nephroliths and cortical cysts. The bilateral renal findings are consistent with age-related change.

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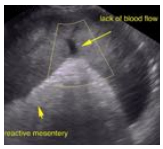
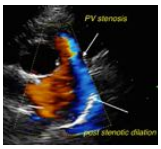
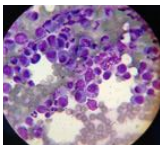
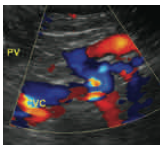

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Mild gallbladder debris. The significance of the aggregated gallbladder debris is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

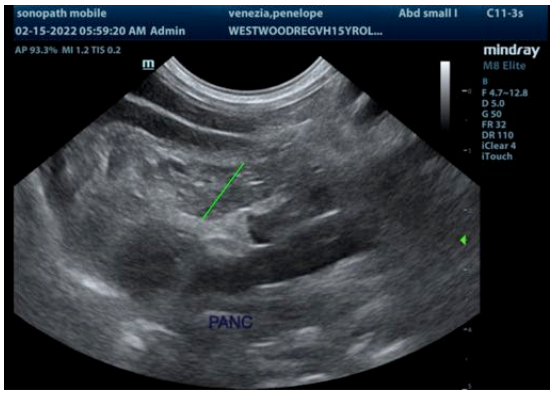
The most prominent lesion visualized on today's scan is the diffusely thickened small intestine with mucosal speckling. This is concerning for a primary enteropathy such as IBD, lymphangectasia, or less likely intestinal neoplasia. This increase is concerning for a possible protein losing enteropathy.

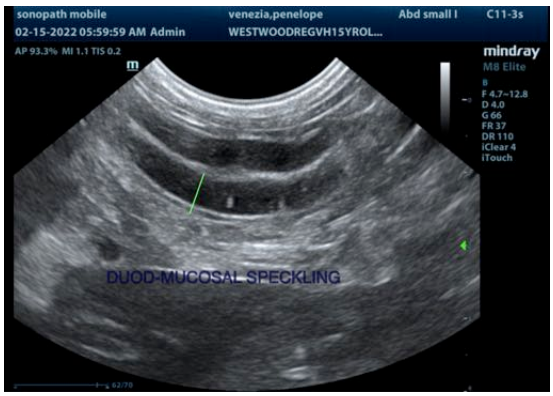
- Consider a GI panel to Texas A&M with a qualitative PLI, TLI, cobalamin and folate to further evaluate the pancreas and small intestine.
- Consider an ultra low-fat prescription diet or a novel protein/hydrolyzed prescription diet.
- Optimal treatment would ideally entail a definitive diagnosis based on GI biopsies. Consider upper GI endoscopy. If the patient is not stable enough for this empirical therapy for one of these disease processes would need to be considered.

The pancreas is prominent. This could be due to current pancreatic inflammation, previous/resolving pancreatic inflammation or pancreatic edema secondary to the hypoalbuminemia present.

The changes observed in the kidneys are most consistent with chronic, progressive renal disease. Consider blood pressure evaluation, urinalysis and culture.

Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.





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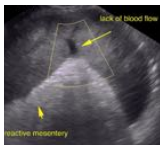
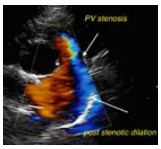
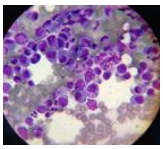
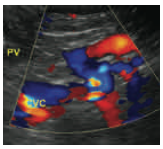

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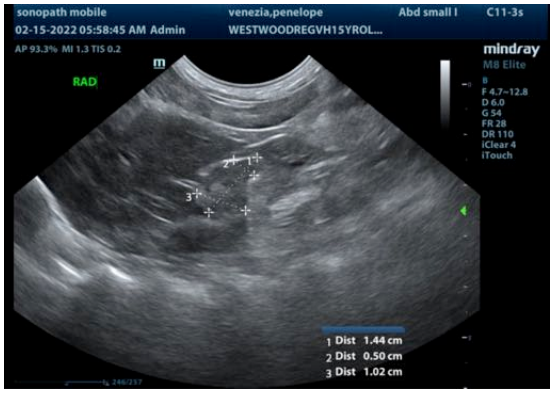

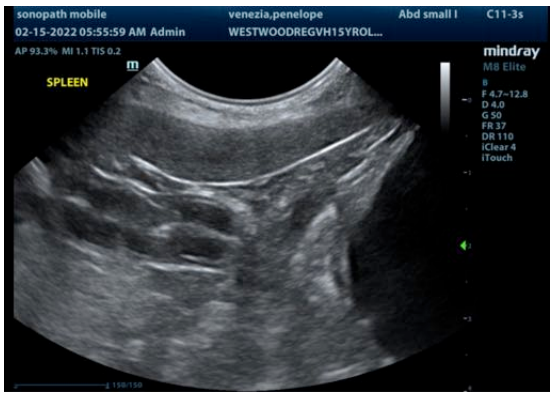

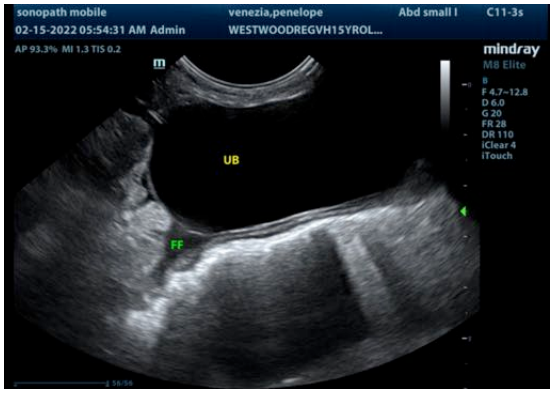

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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