



PATIENT

Mushi Rodriguez
Rexach

SPECIES

Canine

BREED

Pomeranian

SEX

Spayed Female

AGE

13 Years

WEIGHT

10.5 Pounds

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

Dr. Ferrer

HOSPITAL NAME

Paseos Vet Center

REFERRING VET

Dr. Franco Ortiz

INVOICE

35886

DATE

2/24/22

PRESENTING CLINICAL SIGNS

Presented for abdominal ultrasound as pt is having decreased appetite. On Feb 22 presented for vomiting and decrease appetite. The patient came in today on Feb 24 because continue with anorexia -- hx of owner going on vacation and patient is staying with daughter
Abnormal PE/Chem/CBC/UA Results: PE: no major abnormalities cbc - wnl chem - elevated liver enzymes on Feb 22, but normal on Feb 24. T4 wnl sdma high fecal - none seen

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 (3.95 cm). Overall echogenicity is slightly hyperechoic with mildly reduced 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. Several small cortical cysts are present, the largest visualized measuring 0.7 cm x 0.49 cm.

The right kidney has a normal shape and size (3.84 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. 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 0.63 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 0.47 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. There is a very ill-defined, hypoechoic nodule visualized within the parenchyma measuring 0.30 cm. Additionally, there is an anechoic cystic lesion measuring 0.43 cm x 0.39 cm.

Liver

The liver is large in size, and normal in echogenicity with rounded 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 hepatic lesions are observed, but there are very indistinct hyperechoic nodules visualized within the parenchyma measuring 0.40 cm, 0.37cm, etc.

The gall bladder lumen is moderately 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.



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Gastrointestinal

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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.

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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 0.37 cm. Jejunum wall measured 0.31 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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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.

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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.

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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.

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ULTRASONOGRAPHIC FINDINGS

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- Decreased corticomedullary distinction in both kidneys with left-sided cortical cysts – The bilateral renal findings are consistent with age-related change.
- Subtle hypoechoic nodule within the splenic parenchyma as well as a small cystic lesion – 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. The cystic lesion likely represents a benign lesion, but recommend continued monitoring with ultrasound.
- 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.
- Heterogeneous liver with very subtle hyperechoic nodules – 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.
- Moderate gallbladder sludge – The significance of the aggregated gallbladder sludge is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal lesions are observed in the gastrointestinal tract to explain the vomiting and inappetence reported. Many of the lesions described are likely age related, and could be incidental findings. Recommend continued monitoring of the renal cysts and the two lesions observed in the spleen. If the



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patient continues to not feel well, fine needle aspirate of the spleen could be considered.

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The pancreas is somewhat prominent but does not appear overtly inflamed. The changes are most likely consistent with previous episodes of pancreatic inflammation, but you could consider a GI panel to Texas A&M with a qualitative PLI, TLI, cobalamin and folate to further evaluate the pancreas and small intestine.

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The changes observed in the liver likely represent age related remodeling if the liver enzyme elevations are not persistent. If liver enzyme elevations are present, consider a liver function test and a fine needle aspirate of the liver.

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There is a moderate amount of debris within the gallbladder lumen, but no surrounding inflammation or significant wall thickening. If there is no evidence of liver enzyme elevation, recommend continued monitoring of the gallbladder with ultrasound.

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As previously stated, none of these lesions seem likely to be directly related to the anorexia reported. Correlate these findings with routine blood work and radiographs, as ultrasound is not good at picking up all types of ingested foreign material, etc.

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- Recommend symptomatic therapy for gastroenteritis.
- Consider probiotic therapy.
- If these are frequent episodes, consider a hydrolyzed protein or novel protein diet in case of dietary sensitivity/IBD.
- Consider behavioral issues with separation anxiety, etc.
- If symptoms persist, consider re-imaging and the possible need for GI biopsies in the future.
- Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.

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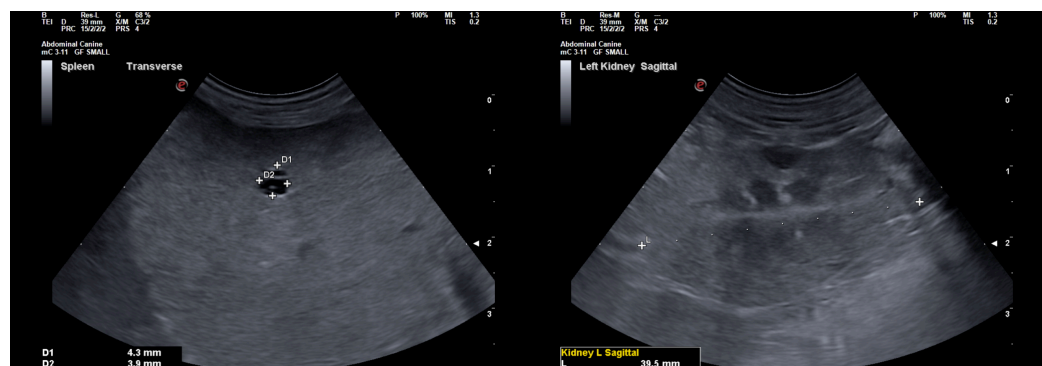
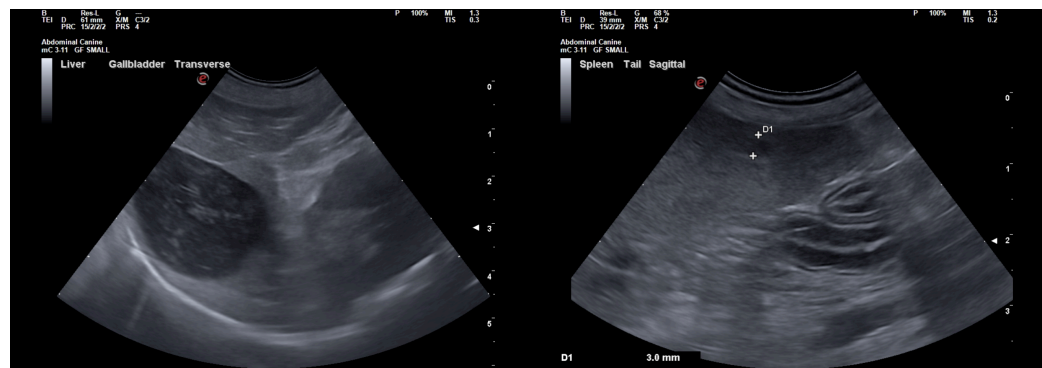
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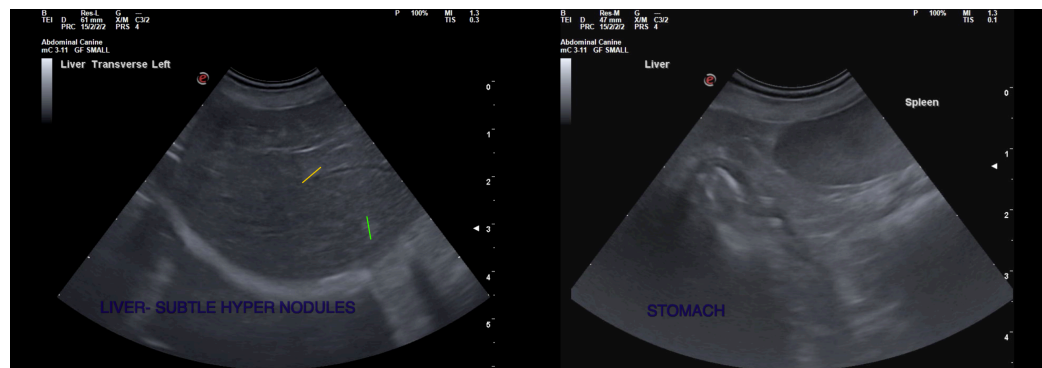
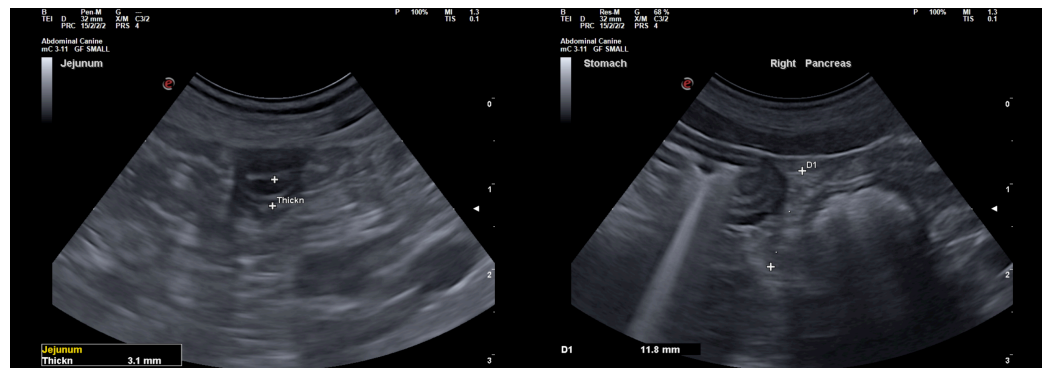
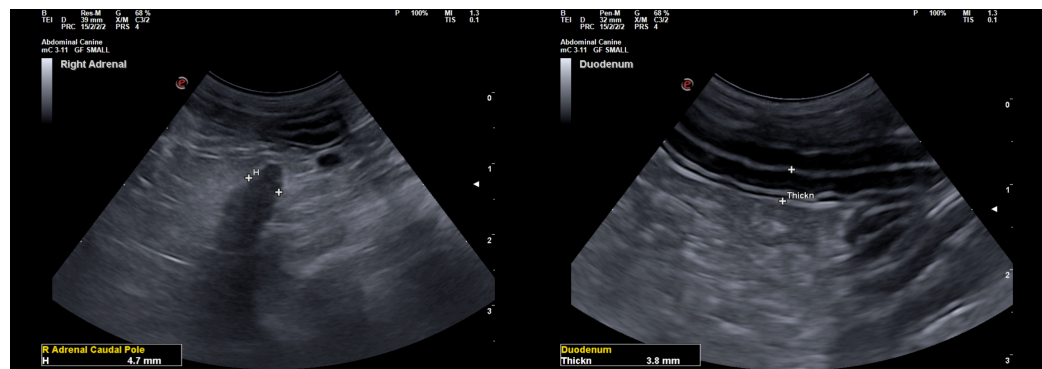
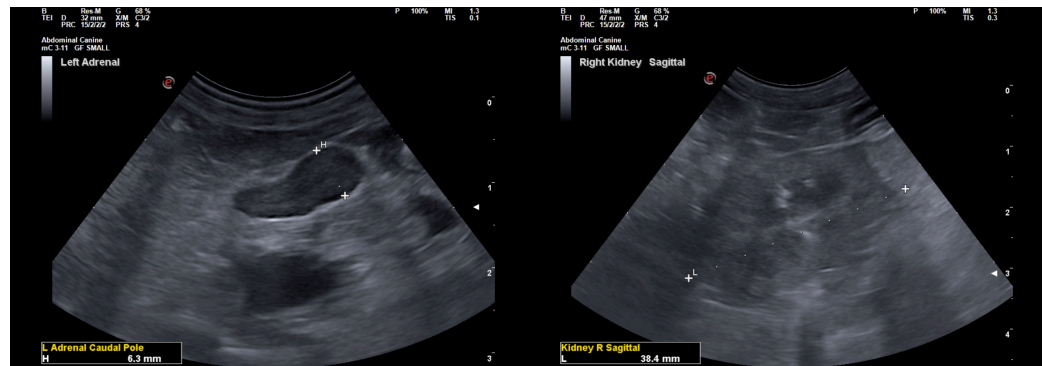
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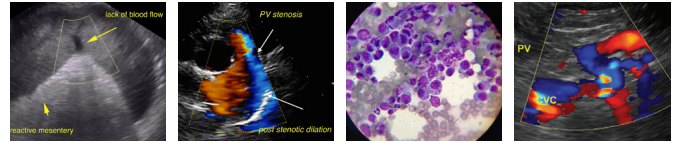
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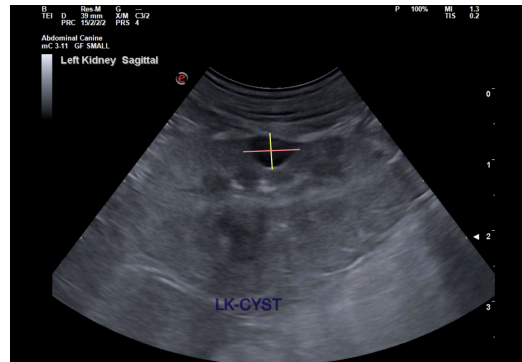
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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