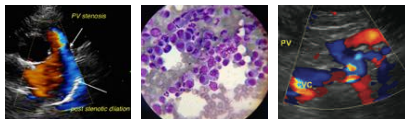
IMAGING PERFORMED BY

IntraPet.com



SonoPath
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DATE
2/25/22

PATIENT
Brynlee Mills

SPECIES
Canine

BREED
Goldendoodle

SEX
Spayed Female

AGE
6/15/13

WEIGHT
59.7 lbs

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

HOSPITAL NAME
Pleasantville AH

REFERRING VET
Dr. Gounaris

INVOICE
96333

PRESENTING CLINICAL SIGNS

2/4 owner reports intermittent vomiting for about 2 weeks. Patient will also seem to have difficulty swallowing and will "belch". Owner is fairly sure she is not getting into things she shouldn't, other than grass. Patient has normal appetite and energy. PE is WNL. Chem/CBC is WNL. Patient responded to Omeprazole and Cerenia but after medication was finished clinical signs returned. 2/15 follow up- performed rads w/ barium swallow- no sign of megaesophagus/barium transits to the stomach as expected. NSF on abdominal Rads.
Current Medications: None current.
Lab Results: WNL.
Radiographs: NSF.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Rachel Brilhart, RDMS.

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 (6.86 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 (6.27 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 0.68 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 0.7 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 heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. There is an intraparenchymal hyperechoic nodule that measured 1.98 x 1.48 cm.

This is associated with the small cystic lesion measuring 0.7 cm. 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 (0.45 cm) and the jejunum measured as normal (0.26 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. A sublumbar lymph node is visualized as prominent and measured 1.63 x 0.73 cm. There is no free fluid and the omentum is of normal 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.

- Heterogenous liver with small, hyperechoic nodule and small cyst. 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.

- Mildly prominent sublumbar lymph node. Differentials include inflammation, infection or less likely underlying neoplasia. I recommend thorough digital rectal exam to look for any changes in the anal gland or perianal area.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

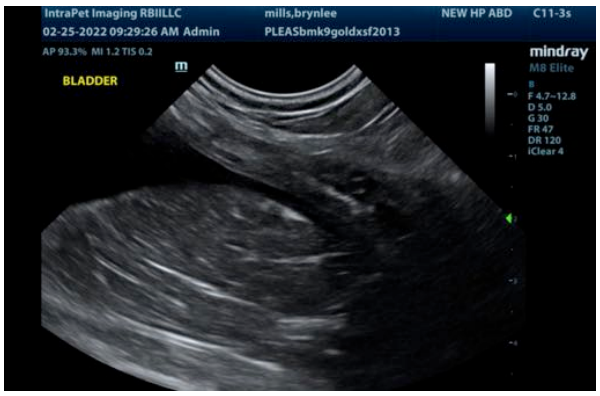
No focal lesions are observed associated with the gastrointestinal tract. There is a small nodule within the liver, which is most characteristic of a benign lesion, but should continue to be monitored with ultrasound. If it progresses consider a FNA.

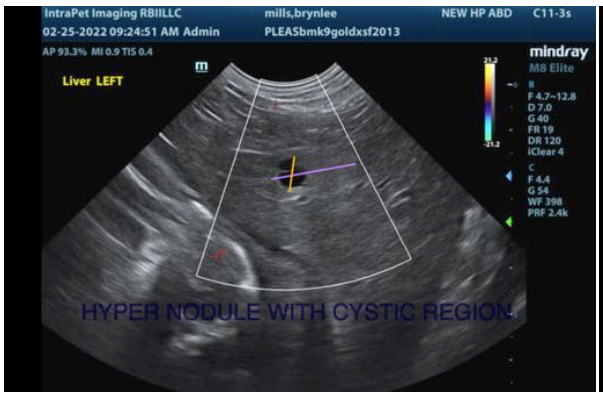
The pancreas is somewhat prominent. You can consider a quantitative PLI, TLI, cobalamin and folate to the University of Texas GI lab to further evaluate the pancreas and for underlying small intestinal disease.

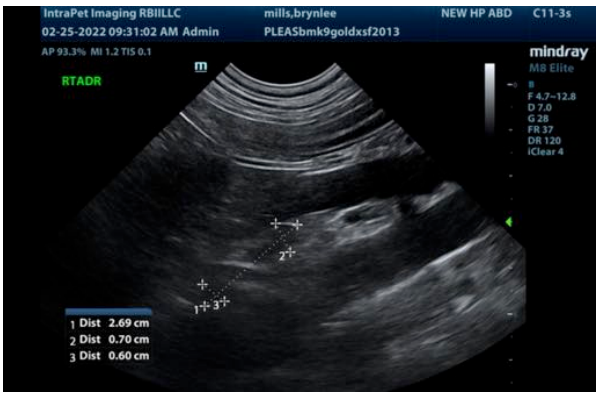
If metabolic disease is thought unlikely (normal full blood work including electrolytes, calcium level, etc.) then consider primary GI causes such as food allergy/dietary intolerance, GI ulceration, parasitic disease, pancreatitis, IBD and less likely gastrointestinal neoplasia. Additionally a dysmotility disorder is possible.

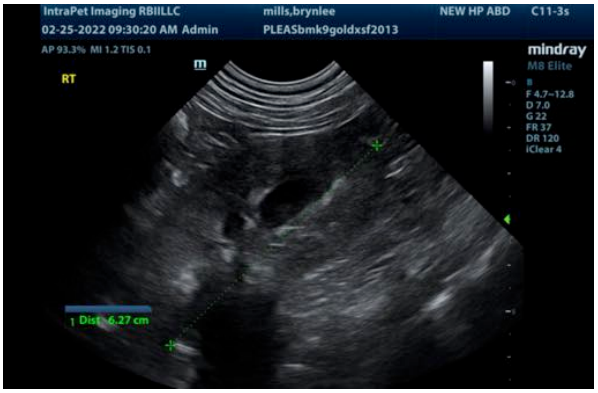
- Consider a novel protein/hydrolyzed protein prescription diet.
- Consider chronic probiotic therapy.
- Consider the aforementioned GI panel.
- If symptoms persist consider upper GI endoscopy to further evaluate the esophagus, stomach and proximal GI tract and obtain biopsies.

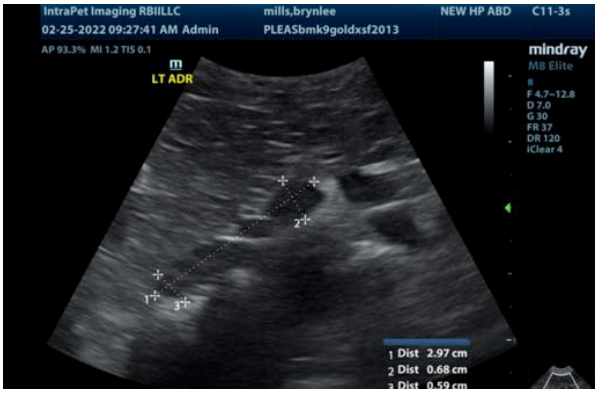
The sublumbar lymph node is mildly prominent. This could be an incidental finding. I recommend careful digital rectal exam to look for any lesions that could be contributing (anal gland, peri-anal area, etc.).

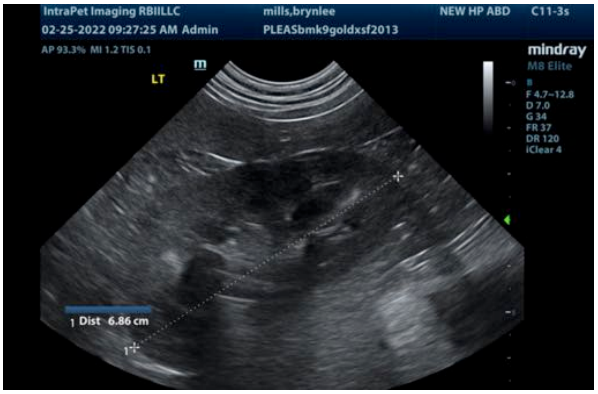


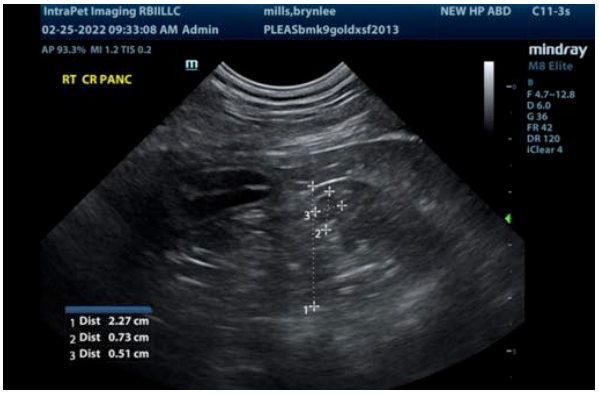


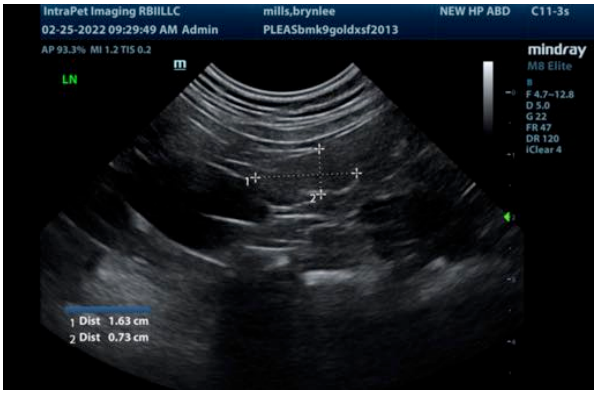


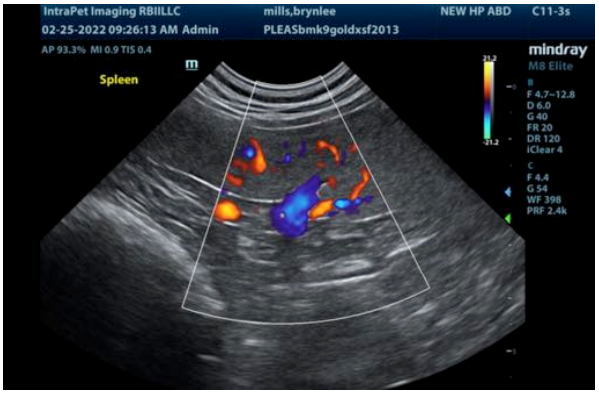












The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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