

**DATE PRESENTING CLINICAL SIGNS**

2/7/23

Presented to me 1/10 for cough, lethargy, and recent pneumonia diagnosis. Likely has pre-existing lower airway disease (bronchitis suspected vs interstitial disease, combination, other). During workup for pneumonia at Pet ER had AUS that revealed splenomegaly. Spleen remains large and somewhat firm on palpation. Pneumonia has resolved, moderate cough persists. Additional history of mild urinary incontinence.

PATIENT

Prism Wells

SPECIES

Canine

BREED

Border Collie X

SEX

Spayed Female

AGE

12/29/11

WEIGHT

26.2 kg

INTERPRETED BY

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

HOSPITAL NAME

Nexus Vet Specialists

REFERRING VET

Dr. Steele

INVOICE

44794

Current Medications: Theophylline 200mg BID, Diphenoxylate 5mg BID-TID.

Lab Results: No significant changes.

Date of Previous IntraPet Ultrasound: No previous.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

Imaging Performed By: Andi Parkinson, BS, 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 (6.37 cm) with occasional pinpoint mineralizations. Overall echogenicity is normal with adequate 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 hydronephrosis. Renal vasculature is normal.

The right kidney has a normal shape and size (6.64 cm) with small pinpoint mineralizations. Overall echogenicity is normal with adequate 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 hydronephrosis. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.78 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 0.75 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 normal to borderline large in size and appears somewhat "plump" in shape. Echotexture is homogenous. The blood flow through the hilus and splenic parenchyma appears normal. The parenchyma is normal. There is a slight bulge in the parenchyma in the region of the hilus that is isoechoic and likely within normal limits.

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. No focal nodules or cystic lesions are observed.

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 and additionally some focal hyperechoic shadowing debris most consistent with a mineralization or pile of mineralized debris. 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. Duodenum wall measures 0.55 cm. Jejunum wall measures 0.42 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

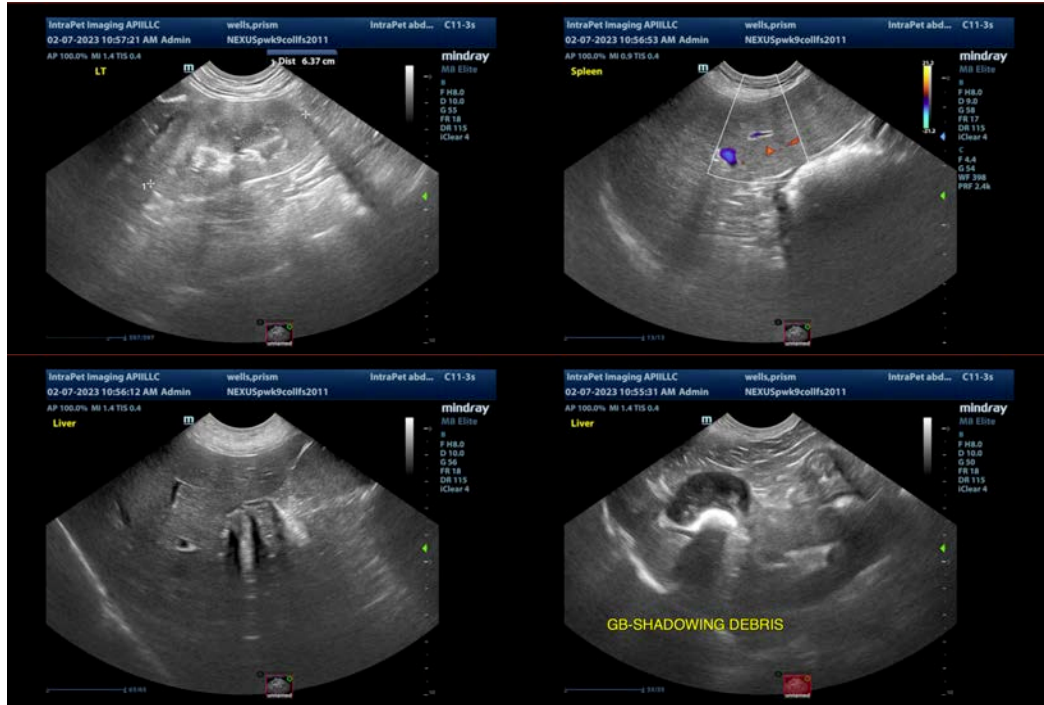
- Borderline large/plump spleen with an isoechoic bulge – This is likely within normal limits for this individual. If there is concern for splenomegaly, consider a fine needle aspirate.
- Heterogeneous liver – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy.
- Moderate gallbladder debris with isoechoic shadowing focus – Findings are concerning for a possible cholelith.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Ultrasonographic findings include a somewhat “plump” appearing, large spleen with an isoechoic bulge and normal parenchyma, a heterogeneous liver, and a likely cholelith or mineralized gallbladder debris.

Further diagnostic and therapeutic recommendations regarding this exam to be made by Dr. Cara Steele.





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.

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