



PATIENT

Corrin Evans

SPECIES

Canine

BREED

Min Poodle

SEX

Spayed Female

AGE

13.8 Years

WEIGHT

13.2 Pounds

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

Dr. Tam Mengine

HOSPITAL NAME

Stoney Creek VH

REFERRING VET

Dr. Tam Mengine

INVOICE

36412

DATE

3/24/22

PRESENTING CLINICAL SIGNS

Patient presented today with 2-day history of anorexia and some seizures. Icteric and subdued on exam, Patient was consistently reactive to probe-pressure over the gallbladder, otherwise comfortable during exam. On CBC / Chem - ALT >2000 (was 345 in 1/22), ALP 1812 (was 145 in 1/22), TBili 8.9. Patient was started on ursodiol in 1/22, on a focal gallbladder U/S at that time, gallbladder contents were similar to today, but wall was clearly delineated and hyperechoic, and patient was not painful

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall largely appears normal and measures at a normal thickness, but towards the apex there is a focal irregularity/mass effect visualized measuring 0.71 cm x 1.3 cm. The area of the trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal and free of any evidence of calculi or mass lesions. Findings are suggestive of a mass lesions, although focal cystitis cannot be excluded as a possibility.

The left kidney has a normal shape and size (3.62 cm) with mild pyelectasia at 0.24 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 nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.65 cm) with a cystic area measuring 0.83 cm and mild pyelectasia at 0.27 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 nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.43 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 0.66 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 large, irregular and hyperechoic. 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 gallbladder lumen is large and distended, measuring 3.0 cm in diameter. The gallbladder wall appears relatively normal in thickness with minimal surrounding inflammation, but an early atypical mucocele is present. There is the suggestion of proximal bile duct dilation, but this is not observed distally. There is minimal surrounding inflammation and no free fluid.



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Gastrointestinal

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The stomach is moderately dilated with fluid. 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 0.43 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. Colon wall measures 0.12 cm.

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Pancreas

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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

WEIGHT

13.2 Pounds

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

INTERPRETED BY

Kathleen Sennello DVM,
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- Large, heterogeneous, hyperechoic, irregular liver with an atypical mucocele present – 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. The gallbladder appears very distended with early organized intraluminal debris, most consistent with mucocele.

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- Decreased corticomedullary distinction in both kidneys with bilateral mild pyelectasia – Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis. Pyelectasia of the left/right kidney could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other.

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- Focal irregularity to the urinary bladder wall – Findings are concerning for a possible urinary bladder mass, but other possibilities exist.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

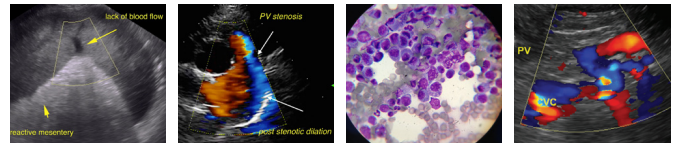
The liver is large and irregular, and the gallbladder appears distended with an atypical mucocele. It is difficult to determine if this is a primary hepatopathy with additional biliary disease, or if this is primarily biliary disease. Recommend fine needle aspirate of the liver as long as coagulation parameters are normal with a STAT evaluation. If there is no evidence of round cell neoplasia, recommend surgical evaluation of the gallbladder with likely removal and liver biopsy (for histopathology, copper levels, and culture). In the meantime, recommend medical treatment for cholecystitis.

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Additionally, there is a focal irregularity to the urinary bladder wall. Recommend urinalysis and culture and urine BRAF testing to further evaluate this lesion. If BRAF testing is positive, this would increase the likelihood that the lesion observed is a transitional cell carcinoma. If BRAF testing is negative, then additional diagnostics will be necessary, if this is an inconclusive result. Alternately, if surgery is pursued for the liver issues, a surgical biopsy of the bladder mass may be possible. The location of this lesion is good in that it is not anywhere near the trigone.

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The changes observed in the kidneys are most consistent with chronic progressive age related kidney disease. Recommend blood pressure evaluation and urinalysis and culture (previously recommended).

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

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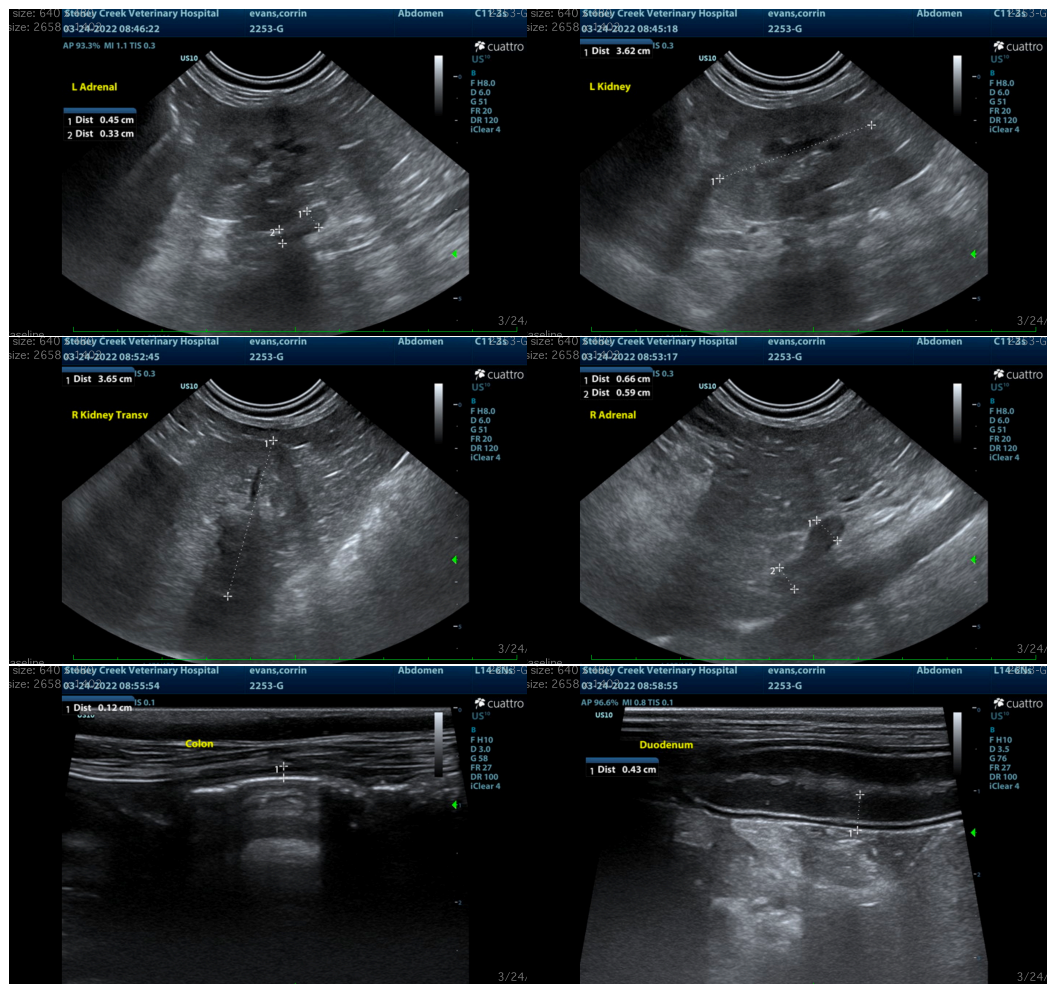
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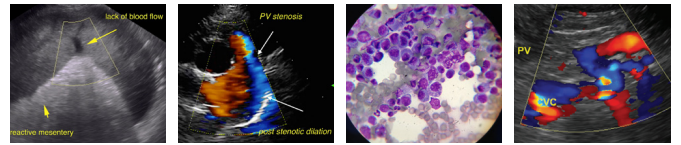
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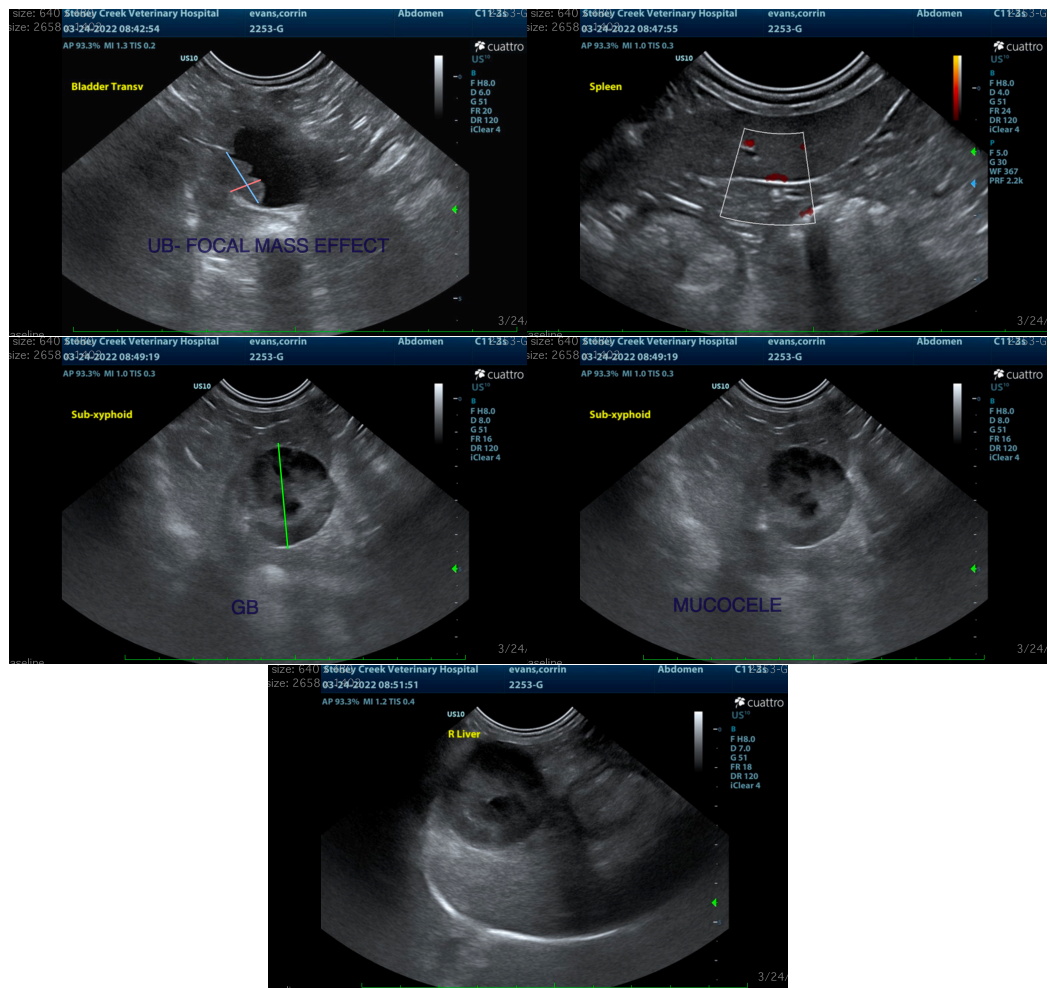
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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