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Clinical Sonography & Telecytology
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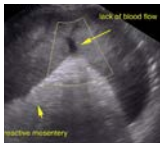
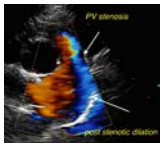
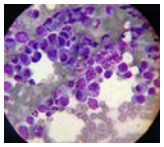
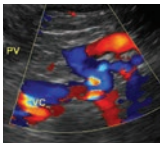

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Kahlua Frosted Faces

SPECIES

Canine

BREED

Chihuahua X

SEX

Spayed Female

AGE

13

WEIGHT

2.2 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Neil Russell

HOSPITAL NAME

Frosted Faces Foundation

REFERRING VET

Dr. Neil Russell

INVOICE

46234

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3/28/23

PRESENTING CLINICAL SIGNS

1. Anorexic since Sunday, following period of hyporexia 2-3 wks, V+ bile in kennel, D+ (no bld or mucus), 2lb weight loss since Feb!! r/o neoplasia vs metabolic vs endo vs pancreatitis vs infxn vs ++++ PLUS 1. Prev reported PU/PD vs Pollakiuria r/o PU/PD causes vs urinary: UTI vs urolith vs neo VS behavioral vs USMI 2. Pacing, at night, doesn't sleep well, vocalizes r/o cognitive decline (vs vestibular vs urinary vs ortho vs neuro) 3. Bi lateral cherry eye 4. Ulcer OD 5. NS OU 6. MPLs 2/4 bi lateral 7. Mild Head tilt L side r/o vestibular vs otitis media vs neoplasia vs ++ 8. Murmur reported albeit not ausc today

Abnormal PE/Chem/CBC/UA Results: - HCT 30.6% non-regen - Neutrophilia 24K with left shift - Monocytosis 2.7K - ALT 270 - AMYL 440 - UA: 1.025 suspect cocci, needs bact confirmation: none - Urine C&S pending

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly 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, or masses. There are occasional pinpoint mineralizations in the dependent portion of the urinary bladder consistent with small sand or calculi.

The left kidney has a normal shape and size (2.56 cm) with pyelectasia at 0.31 cm. Overall echogenicity is slightly hyperechoic with poor 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 nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.4 cm). Overall echogenicity is slightly hyperechoic with poor 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, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.39 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 0.52 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.

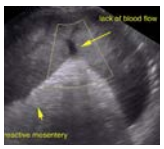
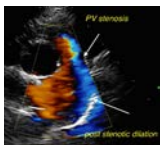
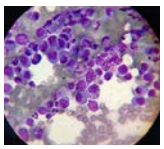
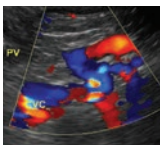
Spleen

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 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

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common bile ducts are normal/not visible. There is a slightly heterogeneous mass effect visualized associated with the wall of the gallbladder. This lesion appears to deviate in towards the lumen of the gallbladder and measures 0.74 cm x 0.51 cm. It is most consistent with a focal gallbladder mass, or less likely a clump of debris.

Gastrointestinal

The stomach contains a large amount of ingesta/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. The pylorus appears somewhat prominent with the wall measuring 0.45 cm.

The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal fluid distension. Wall thickness is increased. Bowel loops follow a typical curvilinear path. Some areas have reduced detail of wall layering. Duodenum wall measures 0.39 cm. Jejunum wall measures 0.24 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

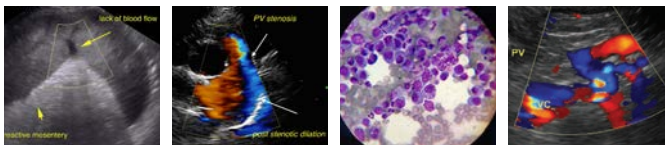
The area of the pancreas is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

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

- Occasional pinpoint mineralizations visualized in the urinary bladder – Findings are consistent with very small stones (approximately 1.0 mm).
- Decreased corticomedullary distinction in both kidneys with left-sided pyelectasia – Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis. Pyelectasia of the kidney(s)could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other.
- Moderate gallbladder debris with a suspected gallbladder mass – The significance of the aggregated gallbladder debris is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting but seems unlikely to be causing a current issue. Recommend continued monitoring. The mass effect visualized does not appear to be causing an obstruction. Recommend continued monitoring.
- Large shadowing ingesta and fluid within the gastric lumen – Correlate with the feeding history and abdominal radiographs. If the patient was adequately fasted consider such differentials as delayed gastric emptying, a partial outflow tract obstruction (none seen) or ingested foreign material.
- Subjective small intestinal thickening – The mild small intestinal wall changes may be a normal



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variant in this patient or could be consistent with an inflammatory process (e.g., inflammatory bowel disease).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

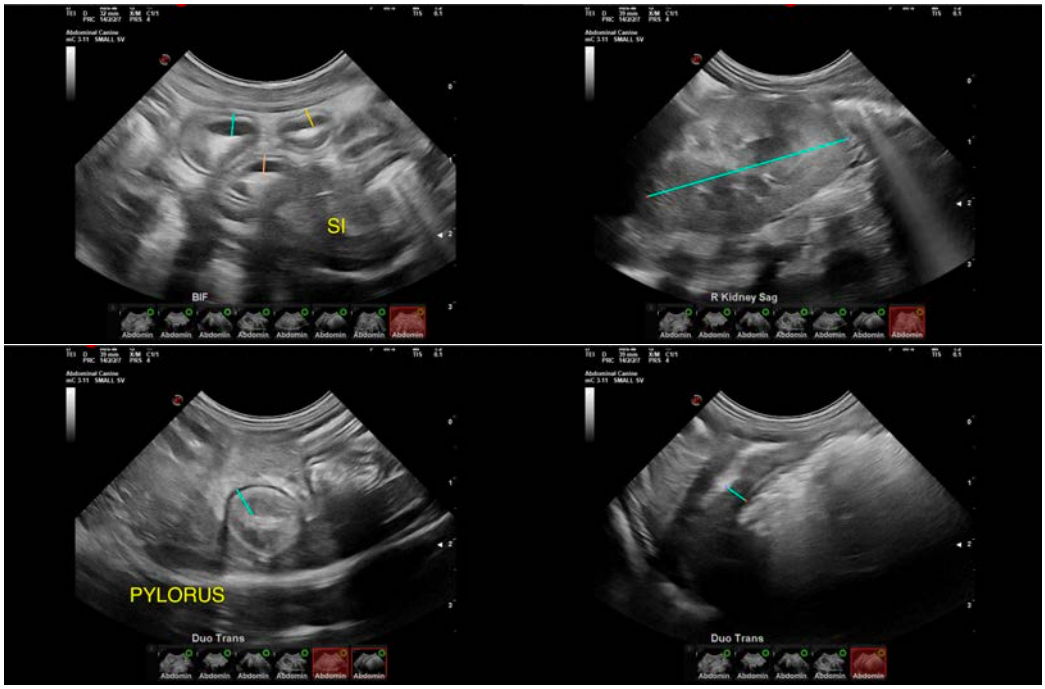
Both kidneys have decreased corticomedullary distinction and there is significant pyelectasia in the left kidney. Recommend urinalysis, culture, and blood pressure evaluation. Consider possible pyelonephritis.

There is a small nodule/mass effect visualized within the gallbladder. The significance of this lesion is unclear. It does not appear to be causing any obstruction, and there is no surrounding inflammation. Recommend continued monitoring.

The stomach is significantly dilated with fluid and ingesta. Additionally, some of the small bowel appears somewhat thickened with some intraluminal fluid. Findings could be consistent with delayed gastric emptying/generalized ileus, although I cannot rule out the possibility of a partial obstruction not observed on today's scan. Recommend continued monitoring of the stomach and repeat imaging (radiographs +/- ultrasound) to ensure that the stomach empties. If it remains fluid distended, consider the possibility of a pyloric outflow tract obstruction (none clearly visualized).

If this patient continues to not eat, you may need to consider a feeding tube or similar while performing diagnostics and waiting for therapies to work.

No focal lesions were visualized associated with the GI tract, but there is the general impression of somewhat thickened small bowel. This could be normal anatomic variation, inflammation, less likely a neoplastic change. It is likely that GI biopsies would be necessary to further evaluate for these changes.



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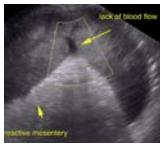
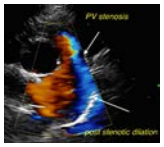
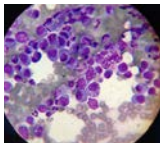
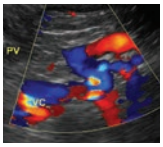

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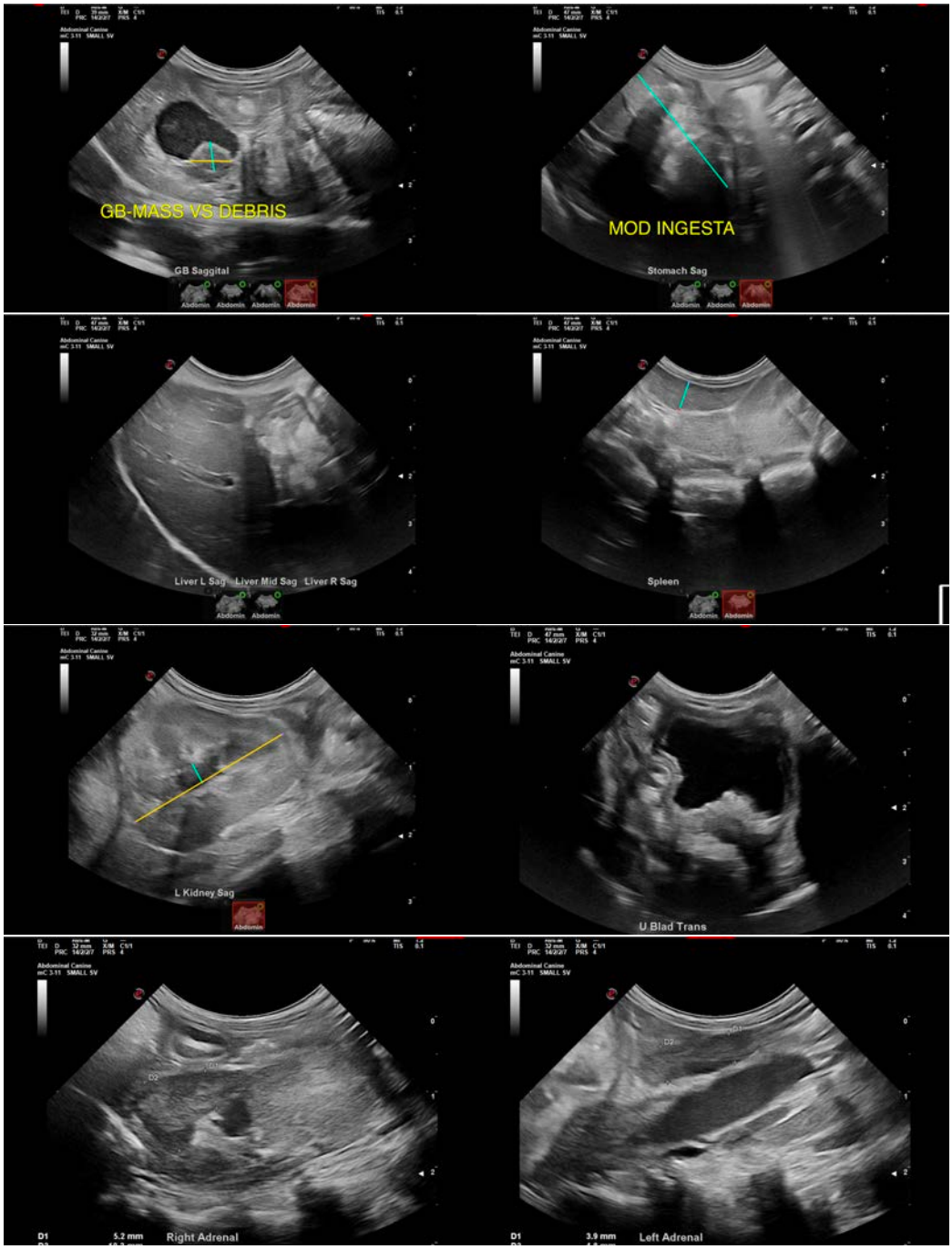

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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