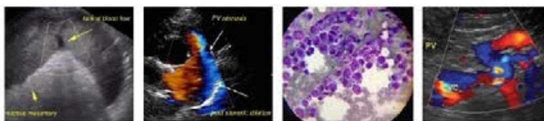


PATIENT

Freddie Elderdog
Canada

SPECIES

Canine

BREED

Westie

SEX

Neutered Male

AGE

10 Years

WEIGHT

7.5 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

Parkside AH

REFERRING VET

Dr. Zak

INVOICE

46248

DATE

3/29/23

PRESENTING CLINICAL SIGNS

Vomiting, diarrhea, eating less Per O Hx of IBD Current Medications Cerenia, Galliprant, Gabapentin, Cartrophen

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly to moderately distended with anechoic urine. The Bladder wall appears normal with no significant mucosal irregularities or mass lesions observed. In the dependent portion of the urinary bladder, there is hyperechoic, lightly shadowing debris, most consistent with mineralized debris (sand/small stones). The region of the trigone, ureteral papillae and proximal urethra appear free of any mass lesions or calculi. Visualization of the bladder is somewhat impaired by shadowing gas and fecal material in the region.

The visualized areas of prostate and surrounding tissue appear normal. Unfortunately, the prostate is not fully visualized likely due to its intrapelvic location. Correlate with rectal exam findings.

The left kidney is normal in size but slightly irregular, measuring 3.78 cm with mild pyelectasia at 0.22 cm and pinpoint non-obstructive nephroliths. 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 infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size but slightly irregular, measuring 3.55 cm with mild pyelectasia at 0.22 cm and pinpoint non-obstructive nephroliths. 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 infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.42 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 0.45 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.

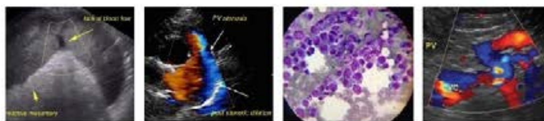
Spleen

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.

Gallbladder is moderately distended with anechoic bile as well as moderate suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.



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Gastrointestinal

The stomach contains moderate 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.

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 0.42 cm. Jejunum wall measures 0.37 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

- Dependent hyperechoic shadowing debris in the urinary bladder – Findings are most consistent with sandy mineralized debris/small stones. Correlate with abdominal radiographs.
- Decreased corticomedullary distinction in both kidneys with bilateral 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 – 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.
- Moderate fluid in the stomach – Correlate with feeding history. If the patient was adequately fasted, consider such differentials as delayed gastric emptying, partial outflow tract obstruction, etc.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal lesions were visualized associated with the gastrointestinal tract to explain the vomiting and diarrhea reported. There is a moderate amount of fluid/ingesta visualized in the gastric lumen. Correlate this with the feeding history, abdominal radiographs, etc. If the patient was adequately fasted, this could represent delayed gastric emptying, partial outflow tract obstruction, etc. The material visualized within the stomach interferes with full evaluation of the pyloric region. Unfortunately, there are many causes for vomiting and diarrhea that cannot be diagnosed by ultrasound alone.

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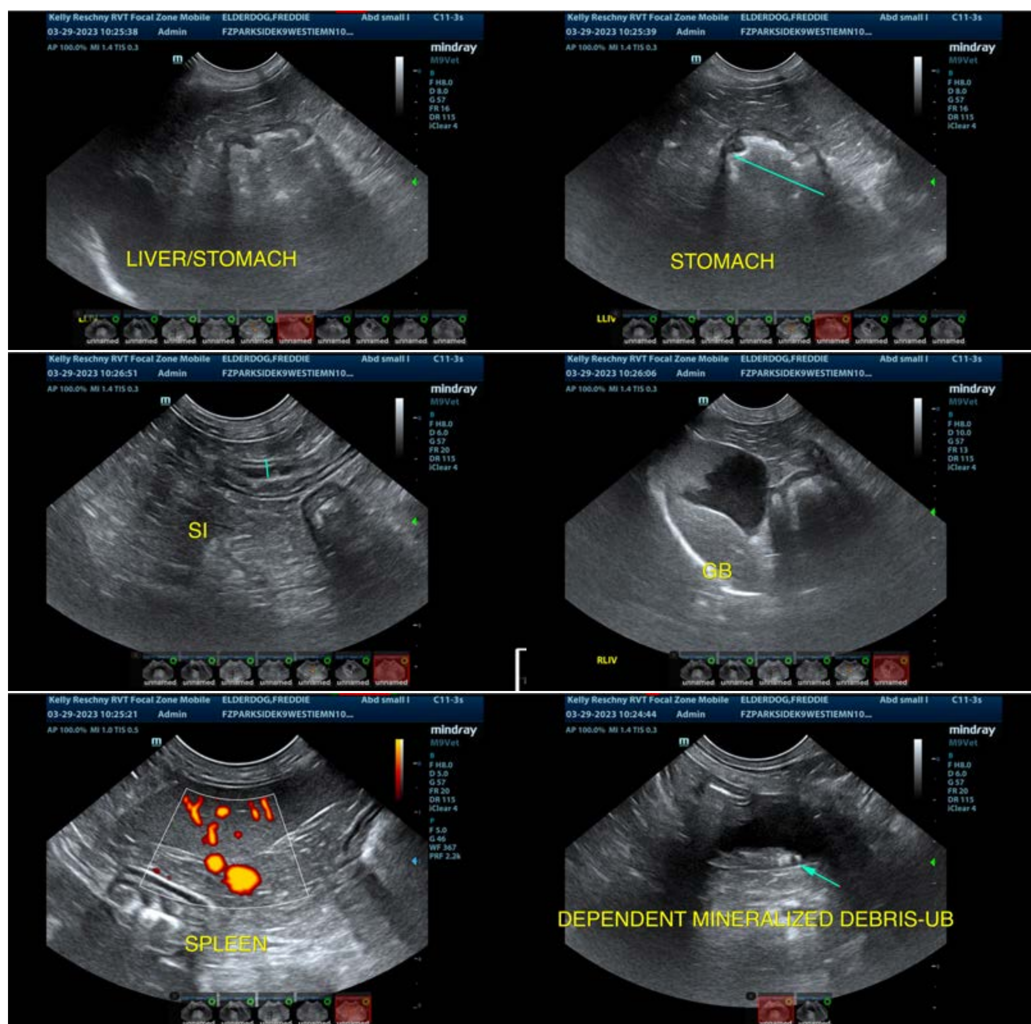
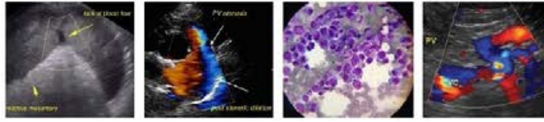
Consider such differentials as food allergy/dietary intolerance, GI parasitism, pancreatitis, dysbiosis, recurrent dietary indiscretion, IBD and less likely neoplasia, etc….

- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks)
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc.. to further evaluate for pancreatic/small intestinal disease.
- Recommend pre- and probiotic therapy.
- If symptoms persist and underlying metabolic disease is ruled out as a cause, consider obtaining GI biopsies.

There is some dependent lightly shadowing material visualized in the urinary bladder, most consistent with sandy debris and small stones. Correlate these findings with abdominal radiographs, urinalysis and culture.





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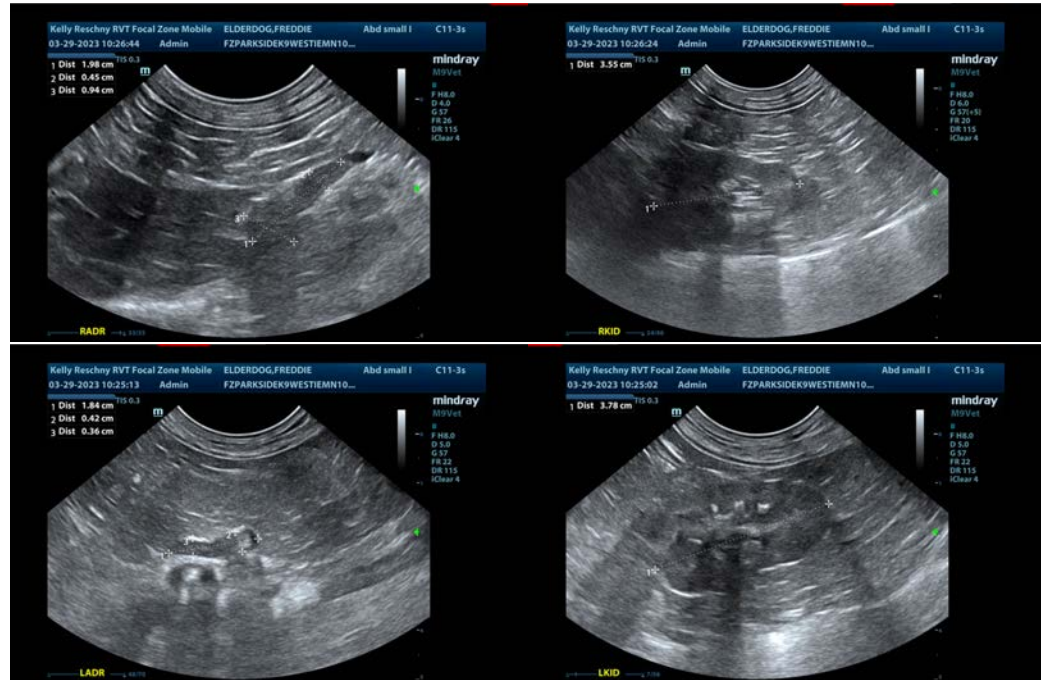

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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