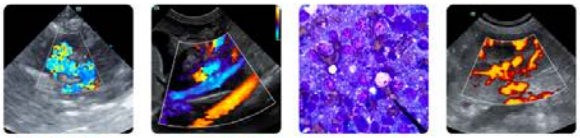

SonoPath www.thefocalzone.com info@thefocalzone.com 289.808.2608

PATIENT

Sadie Davis

SPECIES

Canine

BREED

CKCS

SEX

Spayed Female

AGE

8.5 Years

WEIGHT

17 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Hillview Veterinary Clinic

REFERRING VET

Dr. Stevenson

INVOICE

74127

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PRESENTING CLINICAL SIGNS

Not on any meds, no known allergies. Owner reports not jumping as much, pants more, increased cough and shedding more, snoring more, HR 120, maybe grade 1/6 heart murmur, RR 24, BCS5/9, stage 2 dental disease rest NSF. Diagnosed with heart disease elsewhere. Ongoing GI upset, owner would like sulcrate to have on hand in future.

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 (4.13 cm) with pinpoint cortical 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 hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.73 cm) with pinpoint cortical 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 hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.28 cm at the cranial pole and 0.32 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 1.24 cm at the cranial pole and 0.40 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.

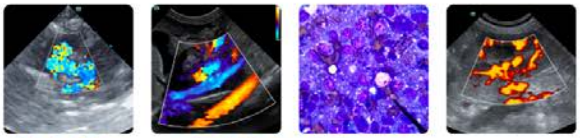
Spleen

The spleen is normal in size but irregular in shape. The blood flow through the hilus and splenic parenchyma appears normal. There is a mixed echogenicity hypoechoic nodule towards the cranial aspect of the spleen measuring 1.58 cm x 2.14 cm, which deviates the splenic margins. There is a similar lesion visualized towards the caudal aspect of the spleen measuring 1.51 cm x 2.08 cm.

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. Luminal contents are mild and likely incidental at this time. The cystic and common bile ducts are normal/not visible.



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Gastrointestinal

The stomach contains mild fluid and shadowing ingesta. The gastric wall is slightly prominent, measuring at 0.48 cm. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. There is focal shadowing material visualized measuring 1.33 cm in diameter. No evidence of an obstruction is visualized at this time.

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 0.44 cm. Jejunum wall measures 0.26 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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

- Two separate mixed echogenicity hypoechoic, large nodules/mass lesions visualized associated with the spleen - There are two non-cavitated hypoechoic splenic nodules visualized. Differentials include lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation other. Cytology or histopathology would be necessary to get a definitive diagnosis.

- Prominent gastric wall with a small amount of fluid and focal shadowing ingesta visualized within the gastric lumen – Correlate with feeding/medication history. Findings could be consistent with ingesta, a small amount of medication, etc. Ingested foreign material cannot be ruled out. No evidence of an obstruction is evident at this time.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal lesions are visualized associated with the small intestine to explain the chronic GI signs reported. There is some focal shadowing material visualized within the stomach. This could represent medication, food, etc., although irritating ingested foreign material cannot be ruled out. No evidence of an obstruction is visualized at this time. Consider a more prolonged/strict fast and reevaluation to determine if ingesta is persistent.

There are two hypoechoic, mixed echogenicity nodules/small mass lesions visualized associated with the spleen. Options moving forward could include a fine needle aspirate for cytologic evaluation, splenectomy for both diagnostic and potentially therapeutic purposes, or continued monitoring with ultrasound.

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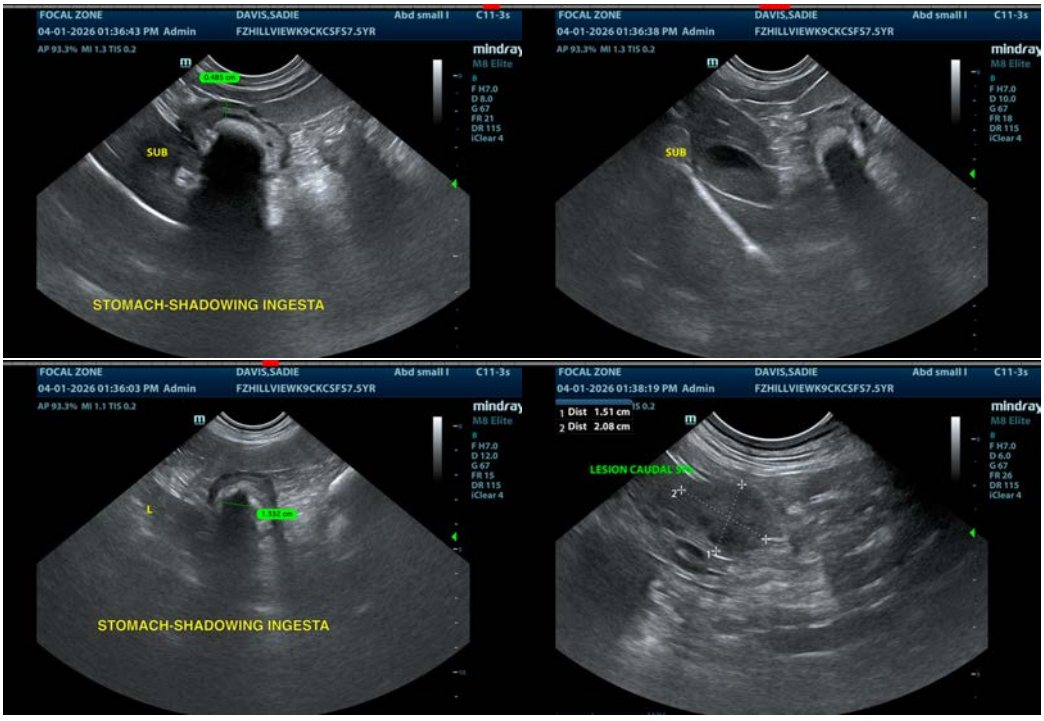
Additional initial diagnostics and therapeutics for the chronic vomiting could include:

- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks)
- If not already done, recommend parasite screening and empirical deworming.
- Consider a baseline cortisol and full bloodwork.
- Consider radiographs, looking for any radiodense material in the stomach.
- A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.
- Recommend chronic probiotic therapy.

If symptoms are persistent, further evaluation and biopsies of the GI tract may ultimately be warranted (surgical with splenectomy or endoscopic?).

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement (disregard if this has already been done).



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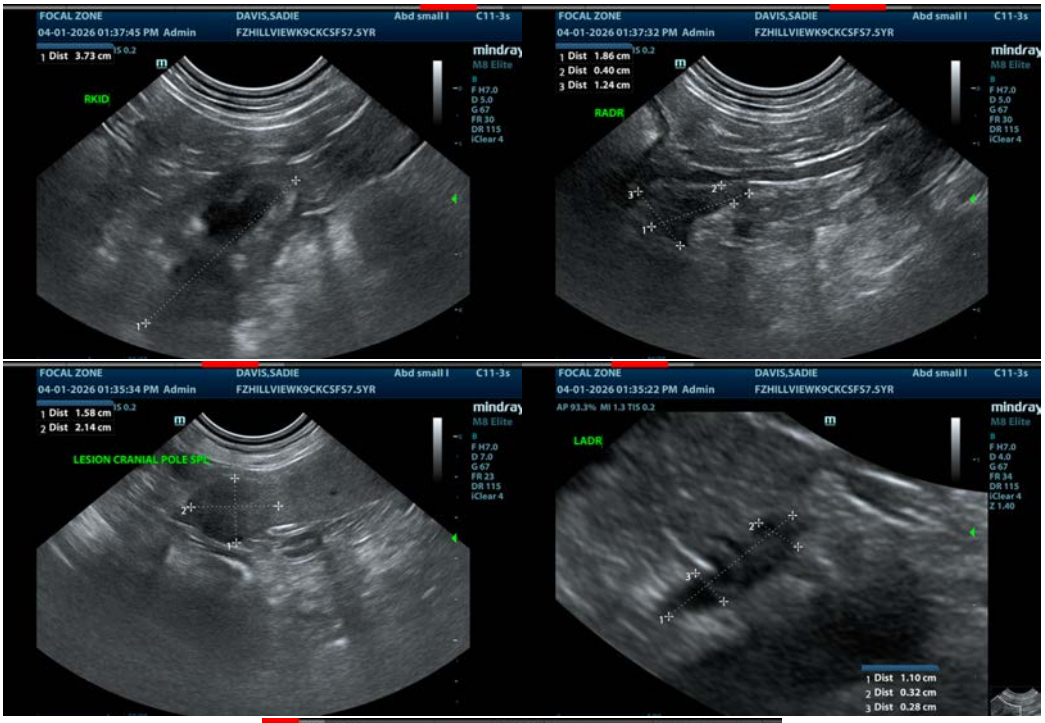

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@sonopath.com