SonoPath
Clinical Sonography & Telecytology
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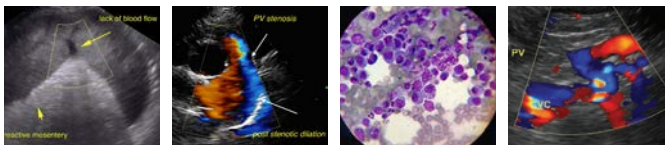

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1-800-838-4268 info@sonopath.com

PATIENT
Twinkie Adams

SPECIES
Canine

BREED
Yorkshire Terrier

SEX
Spayed Female

AGE
13 Years

WEIGHT
2.6 Pounds

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

IMAGING PERFORMED BY
Diane McFadden, RVT

HOSPITAL NAME
Newton Vet Hospital

REFERRING VET
Dr. Barron

INVOICE
46559

DATE
4/12/23

PRESENTING CLINICAL SIGNS

Vomiting, ADR. Inconclusive abdominal rads. On famotidine and Entyce
Abnormal PE/Chem/CBC/UA Results: BUN 54, trig 504, PSL 151

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly to moderately distended with anechoic urine. The Bladder wall largely appears normal with no significant mucosal irregularities or thickening. There is one focal area where there is a slight irregularity in the urinary bladder wall, measuring 0.56 cm x 0.35 cm. A prominent ureteral papilla cannot be ruled out as a differential. The area of proximal urethra appears free of any mass lesions or calculi. Lack of urine distention impairs evaluation of the urinary bladder.

The left kidney has a normal shape and size (2.69 cm) with numerous cortical cysts. 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.

The right kidney has a normal shape and size (2.51 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 0.42 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 0.48 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, but irregular in shape. The blood flow through the hilus and splenic parenchyma appears normal. There is a 1.47 cm x 1.3 cm iso- to mixed echogenic solid mass effect visualized within the caudal body of the spleen.

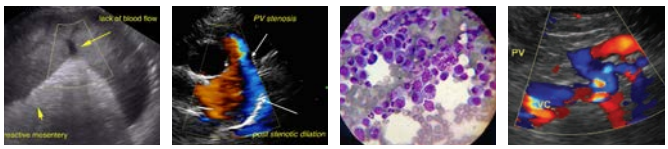
Liver

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 common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains mild to moderate gas and shadowing ingesta. 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



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is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

Most of the visualized areas of small bowel have a relatively uniform diameter with mild to moderate 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 0.37 cm. Jejunum wall measures 0.24 cm. Visualized peristalsis appears appropriate. Some areas of the duodenum appear mildly thickened with fluid dilation and some small focal non-obstructive shadowing material. In these areas, the duodenum appears somewhat corrugated, and mild mucosal speckling is evident.

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 prominent and mottled compared to the surrounding isoechoic 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.

Other

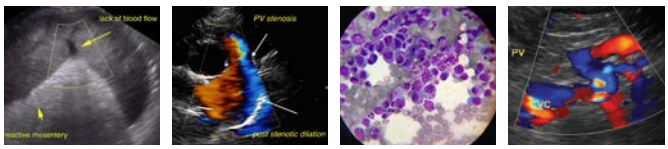
The right auricle and pericardium were visualized and were unremarkable. No obvious pathology is visualized. If cardiac function evaluation is desired a full echocardiogram is warranted.

PRIMARY FINDINGS

- Decreased corticomedullary distinction in both kidneys – The bilateral renal findings are consistent with age-related change.
- Mixed echogenic/isoechoic, solid splenic mass – This mass distorts the splenic capsule. Differentials include : benign lesions (lymphoid hyperplasia, hemangioma etc..) or cancerous lesions (hemangiosarcoma, lymphoma, histocytic sarcoma etc..)
- Gas and soft shadowing ingesta visualized within the gastric lumen – Correlate with the feeding history and abdominal radiographs. This could represent ingesta, medication, etc., or less likely ingested foreign material.
- Mild focal corrugation and therapy distention of the duodenum with mild mucosal speckling – Findings are most consistent with focal enteritis. Ingested foreign material cannot be ruled out, and primary gastrointestinal disease is possible due to the mucosal speckling observed.

SECONDARY FINDINGS

- Small irregularity of the urinary bladder wall – The significance of this is uncertain. Recommend evaluation of the urinary bladder with more urine distention.
- 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



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but seems unlikely to be causing a current issue. Recommend continued monitoring.

- Prominent, mottled pancreas – The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A solid splenic mass is observed on today's exam. I suspect this is unrelated to the vomiting reported, but this could represent a benign or neoplastic process. Options moving forward would include either a fine needle aspirate of the lesion or a splenectomy for both diagnostic and therapeutic purposes.

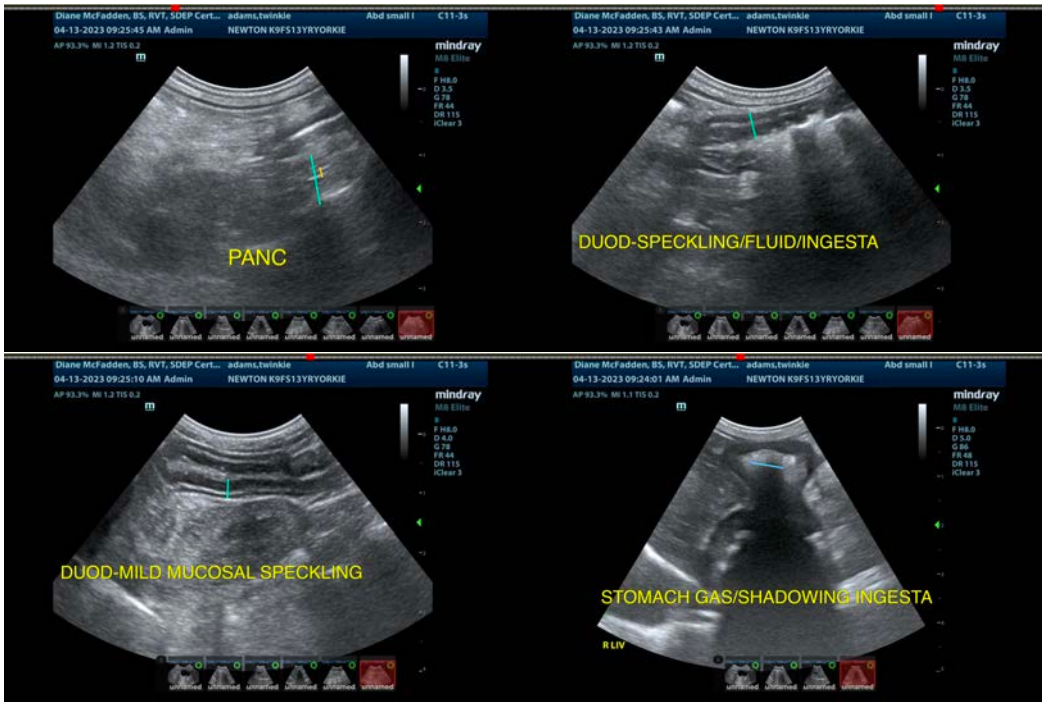
An obvious cause for the vomiting is not visualized, although there is some shadowing material and fluid visualized in both the stomach and duodenum. A focal point of obstruction is not seen. At this time, I would most strongly suspect severe gastroenteritis, but correlate these findings with radiographs, response to therapy, etc., as ingested foreign material cannot be definitively ruled out.

Additionally, there is mucosal speckling visualized associated with the duodenum. If chronic GI signs are present, this could be consistent with underlying inflammatory disease, lymphangiectasia, etc.

If surgery is pursued to evaluate the spleen (or ingested foreign material is suspected), recommend both removing the spleen and biopsy of the small bowel to try to maximize diagnostic results.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.

A small irregularity is visualized associated with the urinary bladder. The urinary bladder is not significantly distended, which can impair evaluation. This could represent a normal anatomic structure (prominent ureteral papilla, etc.), but reevaluation should be considered with more distention.



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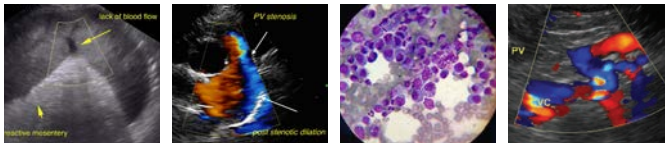

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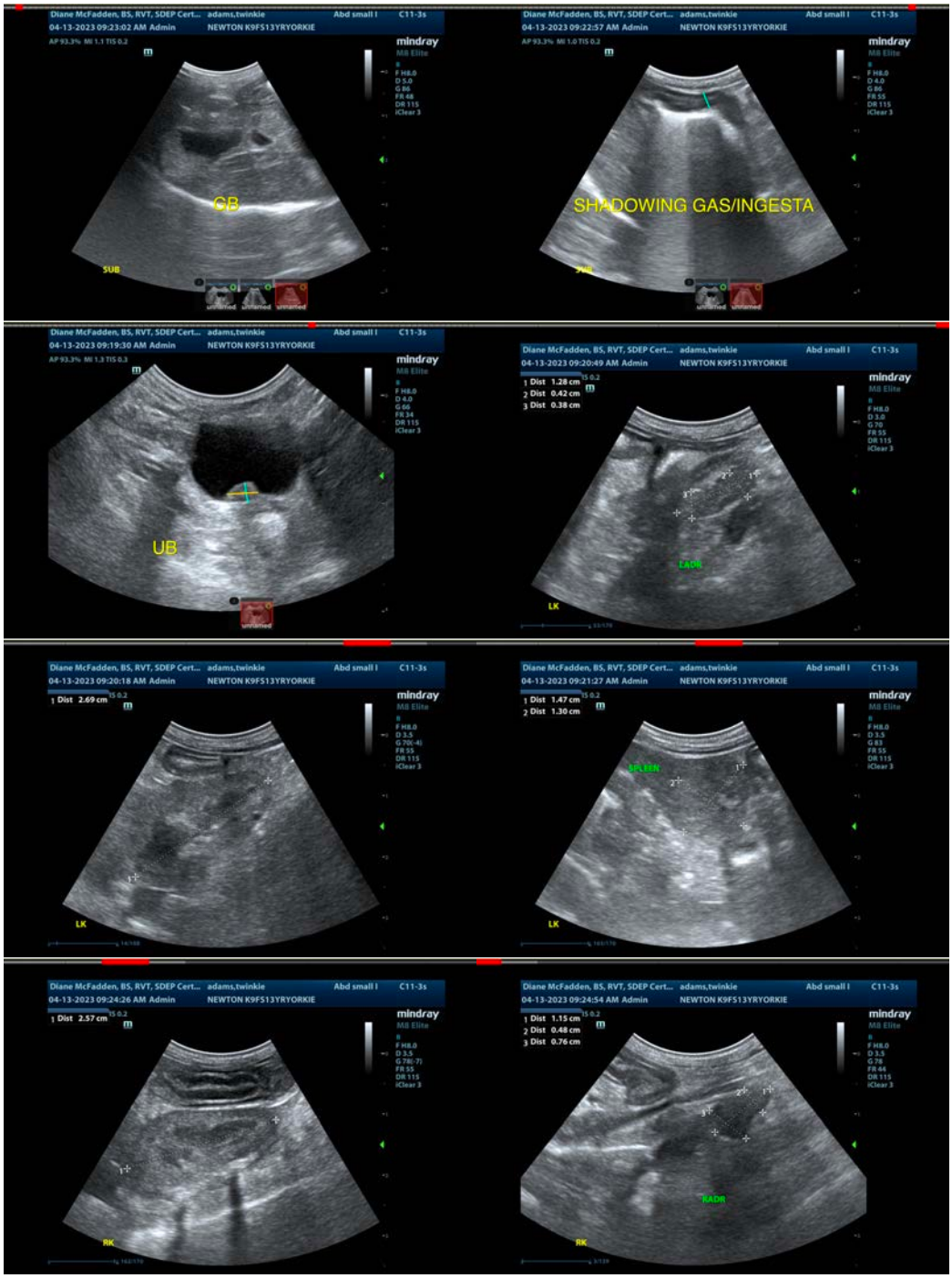

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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