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Clinical Sonography & Telecytology
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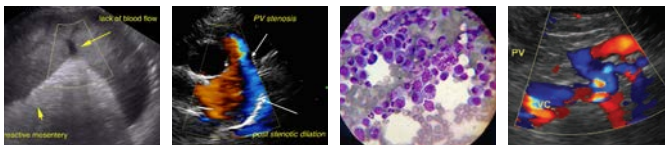


SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Tucker Henzey

SPECIES

Canine

BREED

Cavalier King Charles Spaniel

SEX

Neutered Male

AGE

12.5 Years

WEIGHT

19.2 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Emily Kirk

HOSPITAL NAME

Shiloh Animal Hospital

REFERRING VET

Dr. Shana Silverstein

INVOICE

46675

DATE

4/13/23

PRESENTING CLINICAL SIGNS

Getting slowing thinner despite owner increasing the amount of food (no major changes). - hx of diarrhea that has ultimately been managed with tylosin. had a GI panel in 2019 - nsf. always has had hx of sensitive stomach (diarrhea), also seems to improve with anxiety meds. - he takes chronic fluoxetine + clonidine daily - recent inappropriate urination and urinary incontinence, sporadic. Checked USG and it's not any lower than previous U/A (1.027)

Abnormal PE/Chem/CBC/UA Results: Borderline low end blood proteins (see attached)

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 prostate is normal in size (1.2 cm) and shape for this neutered male dog. The parenchyma is homogenous and the external margins are smooth. The prostatic urethra appears normal with no evidence of irregularity, invasion, mass effect or calculi.

The left kidney has a normal shape and size (5.01 cm). 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, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (5.27 cm). 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, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.46 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.

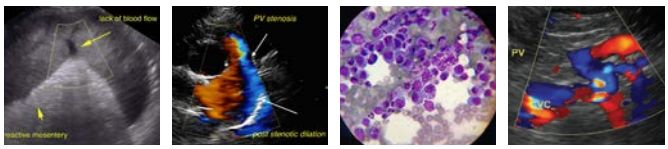
The right adrenal gland is normal in size measuring 0.37 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

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. There is a very subtle hypoechoic nodule visualized near the head of the spleen measuring 0.51 cm in diameter. Additionally, there is a mixed echogenic nodule that slightly deforms the splenic capsule, measuring 0.98 cm x 1.1 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.



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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 minimal luminal contents. 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 uniform diameter with minimal fluid distension. Wall appears subjectively, mildly increased. Bowel loops follow a typical curvilinear path with distinct wall layering. Duodenum wall measures 0.56 cm. Jejunum wall measures 0.40 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. The colon is distended with liquid stool. There is no observed focal or generalized colon wall thickening or loss of layering. Colon wall measures 0.16 cm.

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

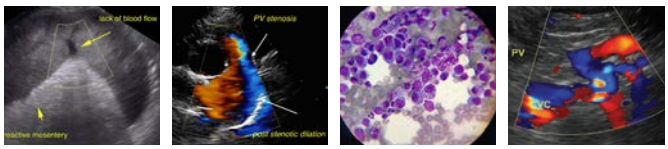
Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Small hypoechoic nodule and small mixed echogenic nodule visualized within the spleen – The significance of these lesions are uncertain. They are both small, although one of these does deform the splenic capsule somewhat. Differentials would include a benign lesion such as hyperplasia, regenerative nodule, etc., or an early neoplastic lesion such as a hemangiosarcoma, carcinoma, lymphoma, 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.
- Mildly thickened small intestine – The mild small intestinal wall changes may be a normal variant in this patient or could be consistent with an inflammatory process (e.g., inflammatory bowel disease).
- Non-formed fecal material visualized within the colon – This is consistent with the reported diarrhea.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal lesions are visualized associated with the GI tract to explain the chronic GI signs reported. Unfortunately, there are many causes for weight loss and diarrhea that cannot be definitively diagnosed by ultrasound alone.



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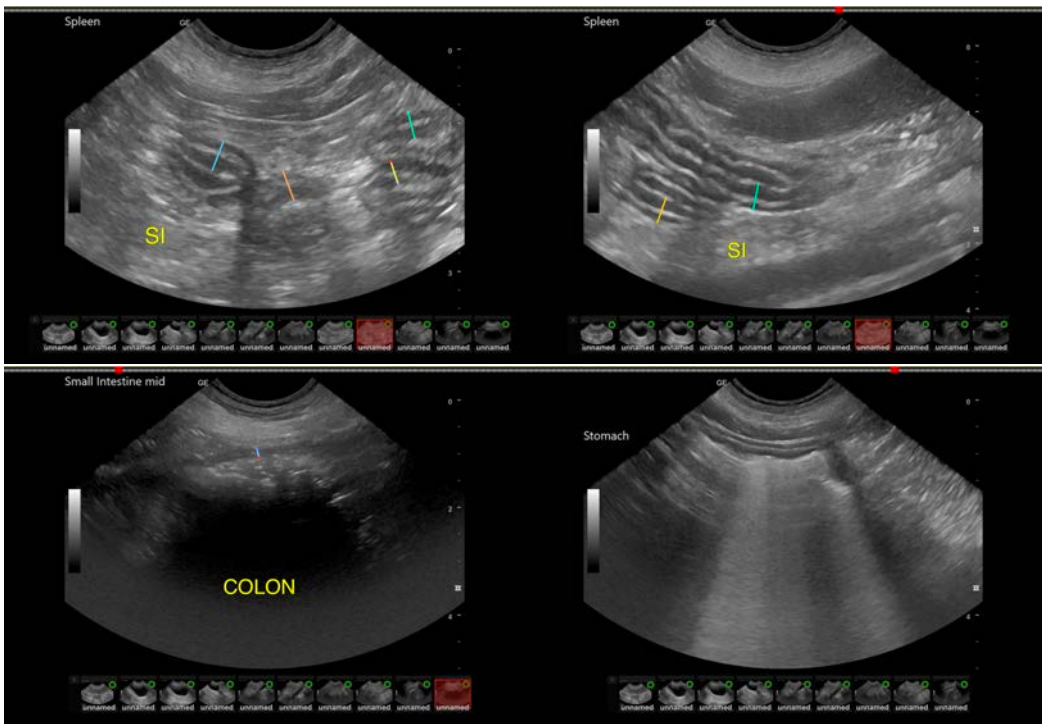
Consider such differentials as food allergy/dietary intolerance, GI parasitism, pancreatitis, dysbiosis, recurrent dietary indiscretion, IBD and less likely neoplasia, etc….

- 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 chronic probiotic therapy.
- Due to the borderline low albumin level, recommend a urine protein to creatinine ratio to look for any evidence of urine protein loss, and a liver function test to look for any lack of production. If these are normal, then this may be progressing towards a protein losing enteropathy.
- If these steps do not improve symptoms, consider obtaining endoscopic GI biopsies.

There is a moderate amount of gallbladder debris visualized. This is likely incidental at this time.

There are two small lesions associated with the spleen. They are likely too small to easily sample (possibly the mixed echogenic nodule). Options include a fine needle aspirate (if there is a window for sampling) or continued monitoring with ultrasound.

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



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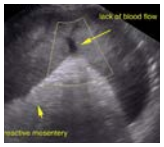
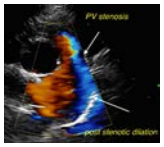
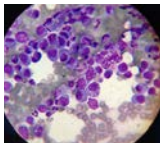
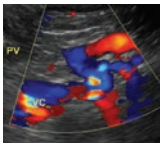

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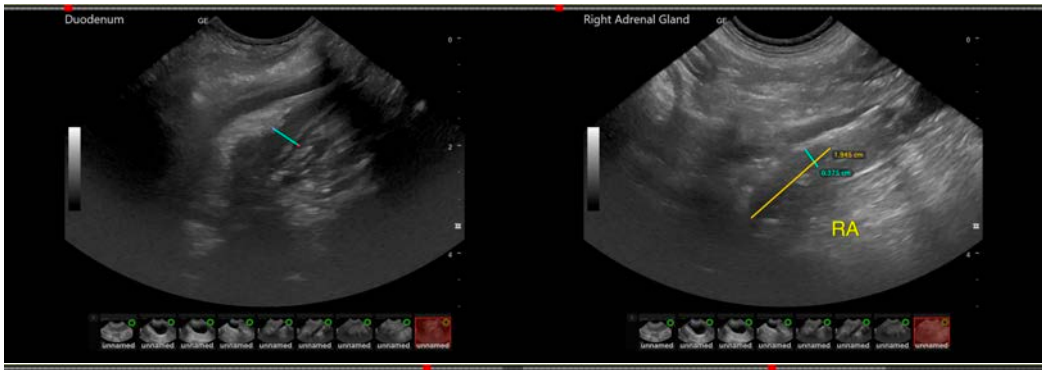

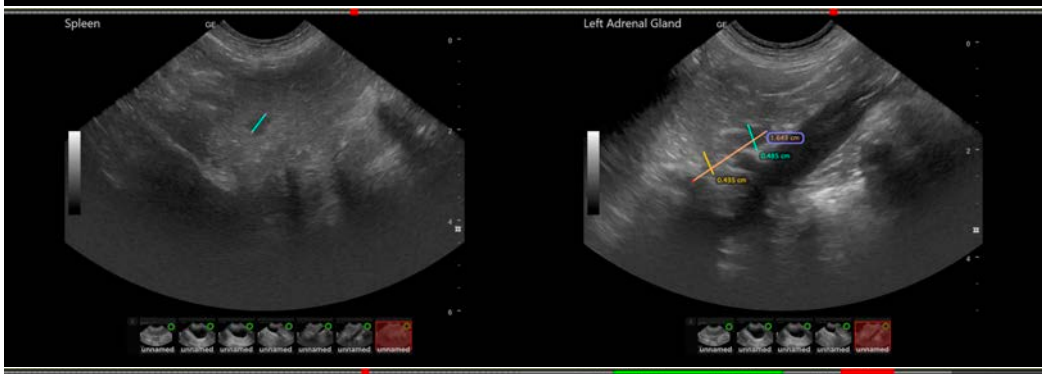

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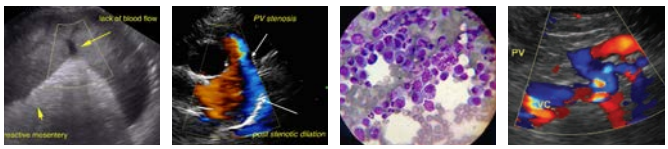

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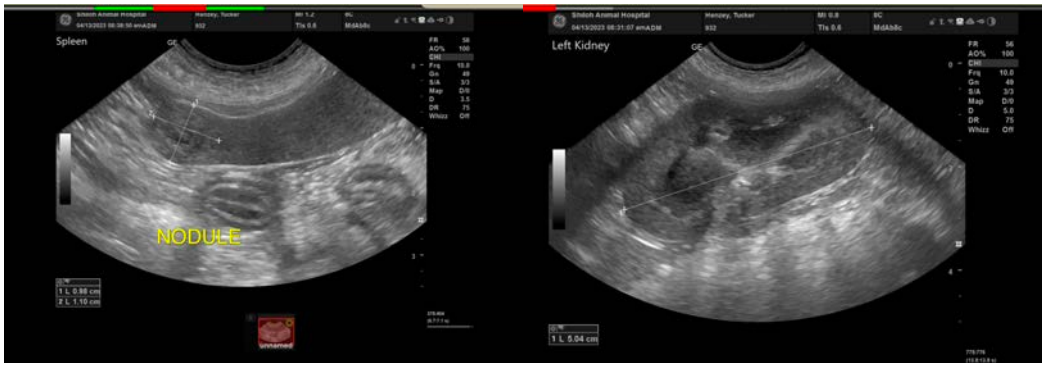

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

kathleen.sennello@sonopath.com