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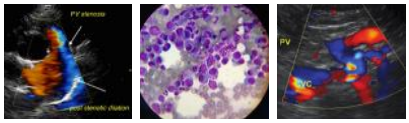

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DATE

4/28/22

PATIENT

Moses Parker

SPECIES

Canine

BREED

Pit Bull

SEX

Neutered Male

AGE

12/28/11

WEIGHT

62 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Andi Parkinson RDMS

HOSPITAL NAME

Fullerton AH

REFERRING VET

Dr. Levine

INVOICE

37264

PRESENTING CLINICAL SIGNS

Had dental fractures and presented to dentistry service for work. Initially had elevated ALT, Alk Phos, GGT. Repeated later and although improving still elevated. On repeat blood work, mild neutrophilia and monocytosis and mildly elevated globulin level, so additional concern for some inflammatory response.

Current Medications: Apoquel 8mg bid and has been on long term.
Lab Results: See attached.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Patient sedated with Dexdomitor.
Stat Report: Not requested.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly distended with anechoic urine. The Bladder wall is diffusely thickened and irregular, measuring at 0.47 cm. The area of the trigone and proximal urethra to a depth of 2.0 cm and ureteral papillae appear normal and free of any mass lesions or calculi. Findings are most consistent with bacterial cystitis or lack of urine distention.

In the area of the prostate, there is a large cystic lesion, most consistent with a cystic prostate. This is large in size, measuring 4.08 cm in width with relatively smooth external margins. There is minimal parenchyma present, but what is visible appears hyperechoic with large cavitations. It is difficult to visualize the prostatic urethra.

The left kidney has a normal shape and size (6.86 cm) with 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 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 (6.59 cm) with 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 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 0.56 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 0.64 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 heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gall bladder lumen is significantly distended. Some areas of the wall appear mildly thickened with adherent debris. There is a large amount of primarily non-organized echogenic debris. The common bile duct is dilated and somewhat tortuous. It is difficult to visualize due to isoechoic intraluminal contents. It is visibly dilated at the level of the duodenal papilla, measuring 1.12 cm in diameter. In this area there is intraluminal material, most consistent with biliary debris, but a soft tissue mass effect cannot be 100% excluded. These changes can be consistent with an early gall bladder mucocele.

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 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. The duodenum measured as normal (between 0.3-0.5cm in wall thickness) and the jejunum measured as normal (between 0.2-0.47cm.) 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 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.

PRIMARY FINDINGS

- Large volume gallbladder debris with a dilated bile duct and large volume of suspected intraluminal material causing a partial obstruction – findings are most consistent with cholecystitis and biliary sludging, causing a partial obstruction.

- Heterogeneous liver – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy.

- Hyperechoic cystic structure in the region of the prostate – findings are suggestive of a severely cystic prostate. This can be seen with an involuted prostate post neutering if it was highly cystic prior to neutering.

- Mildly irregular urinary bladder wall – The bladder mucosal changes could be consistent with cystitis or artifactual due to lack of adequate luminal distension. Bladder neoplasia cannot be ruled out but is considered unlikely in this patient.

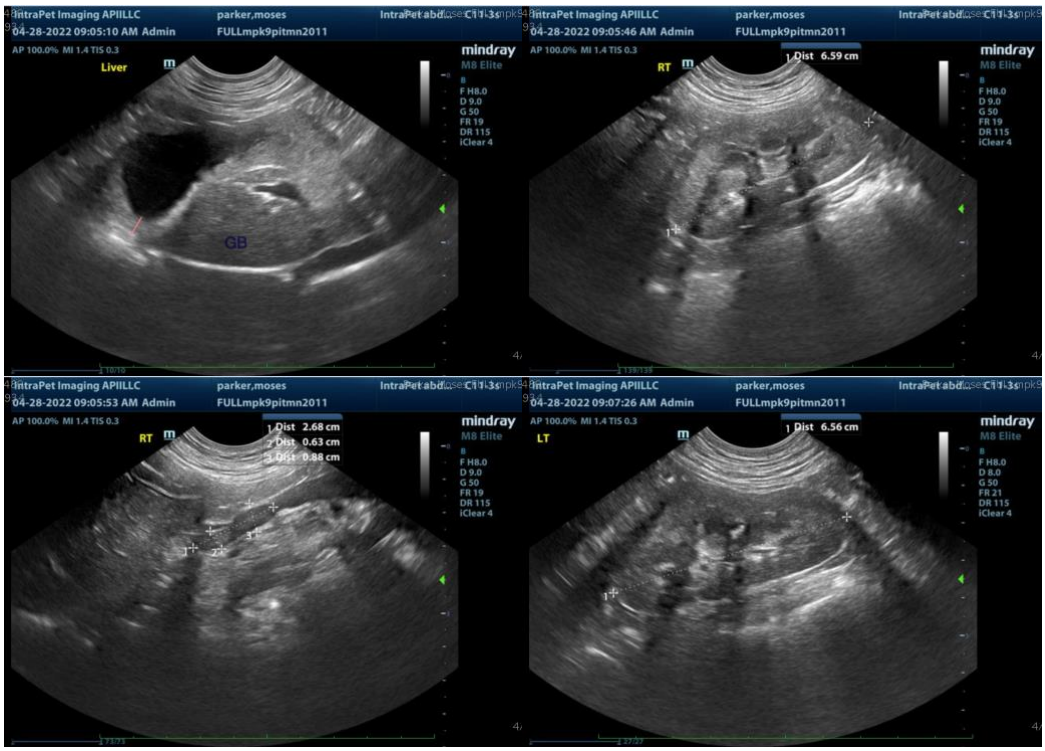
SECONDARY FINDINGS

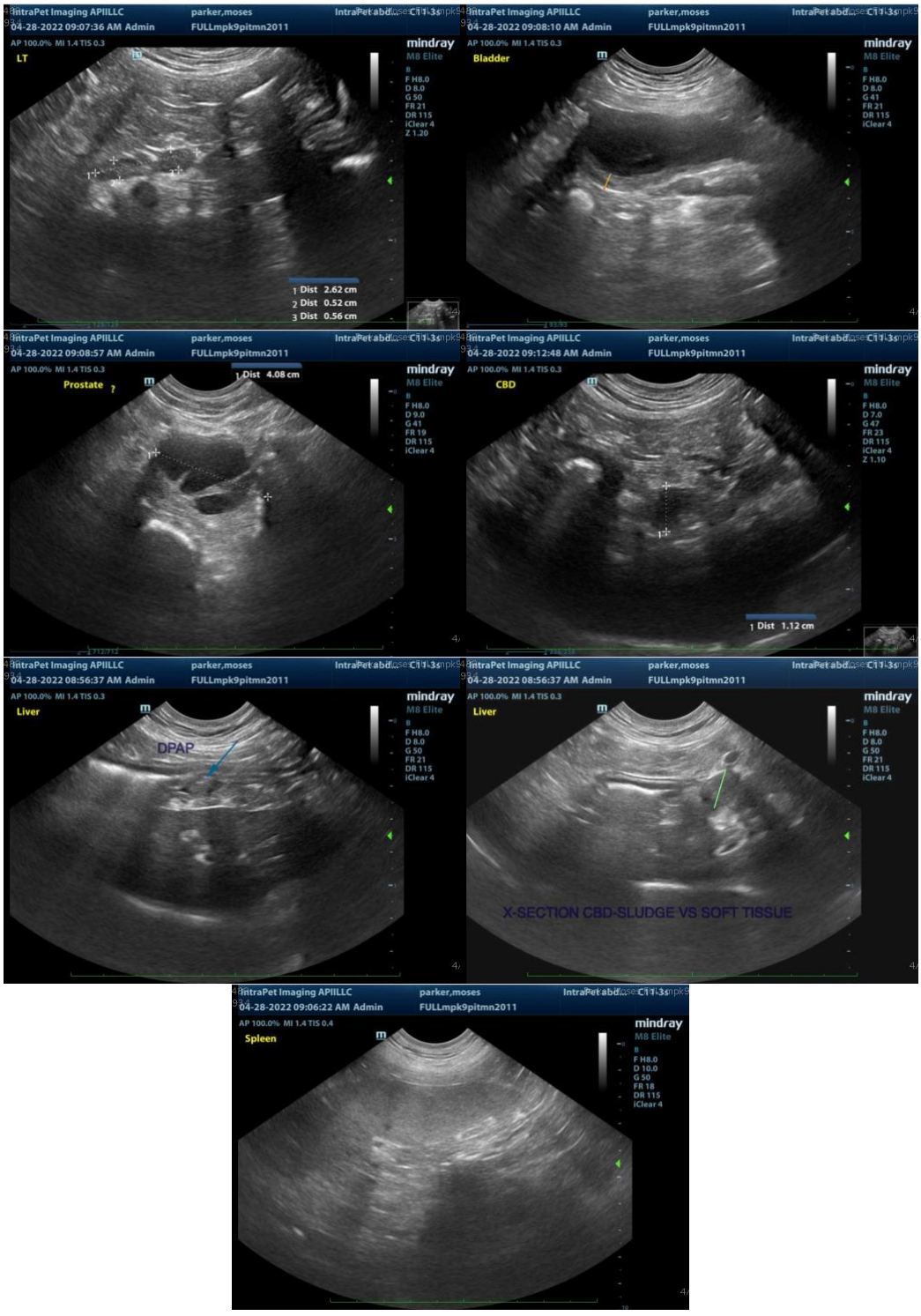
- Decreased corticomedullary distinction in both kidneys – The bilateral renal findings are consistent with age-related change.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The liver is somewhat heterogeneous, but there are no focal lesions visualized within the parenchyma. The gallbladder is not significantly distended, but it has a large amount of biliary debris within the lumen, and this debris extends into a dilated bile duct. This dilation appears to extend to the level of the duodenal papilla, where additional intraluminal debris is visualized. A mass effect cannot be excluded as a possibility, but my suspicion is this is cholecystitis with severe biliary sludging. Recommend antibiotic therapy, Denamarin and Ursodiol, and continued monitoring of liver enzymes and the bile duct. If liver enzymes continue to rise, then consider a fine needle aspirate of the liver and advanced imaging of the liver and biliary tract to look for any evidence of a focal mass effect.

There is a hyperechoic cystic structure in the region of the prostate. I suspect this represents a prostate with previous cystic lesions that was neutered late in life. If this is not the case, then you could consider a fine needle aspirate and sampling of the cystic structure. Recommend urinalysis and culture.





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