

IMAGING PERFORMED BY

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**SonoPath**

Clinical Sonography & Telecytology

EDUCATIONAL TELECONSULTATION SERVICES™

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**DATE PRESENTING CLINICAL SIGNS**

4/5/22 Continued vomiting despite Cerenia.

**PATIENT**

Current Medications: Cerenia injection and SQ fluids 4/2/22. Oral Cerenia started 4/3/22- 24mg 2 SID for 4 days (still on). Mrx gastrointestinal HE. 4/4/22- started Provable and Pre-pectalin.

Violet Lewis

Lab Results: Fecal negative 4/2/22.

**SPECIES**

Canine

Radiographs: Radiology consult 4/2/22, attached. Unremarkable appearance of the GI.

Gastroenteritis/pancreatitis could be possible for the vomiting. A non-identified pyloric outflow disorder cannot be completely ruled out.

Date of Previous IntraPet Ultrasound: No previous.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

**BREED**

Pit Bull

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**SEX**

Spayed Female

**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.

**AGE**

5/29/21

The left kidney has a normal shape and size (5.4 cm). Overall echogenicity is normal with adequate 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, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

**WEIGHT**

40 Pounds

The right kidney has a normal shape and size (5.42 cm). Overall echogenicity is normal with adequate 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, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

**INTERPRETED BY**

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

**Adrenal Glands**

The left adrenal gland is normal in size measuring 0.53 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.

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Andi Parkinson RDMS

The right adrenal gland is normal in size measuring 0.59 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.

**HOSPITAL NAME**

Banfield Towson

**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.

**REFERRING VET**

Dr. Mike

**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.

**INVOICE**

36717

The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are primarily anechoic. 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 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. Jejunum wall measured 0.23 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 pancreas is large and hypoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is evidence of regional mesenteric inflammation. Consistent with mild pancreatitis.

### ***Free Abdomen***

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There are occasional prominent mesenteric lymph nodes. Two measured 0.66 and 0.82 cm. The omentum is of normal echogenicity.

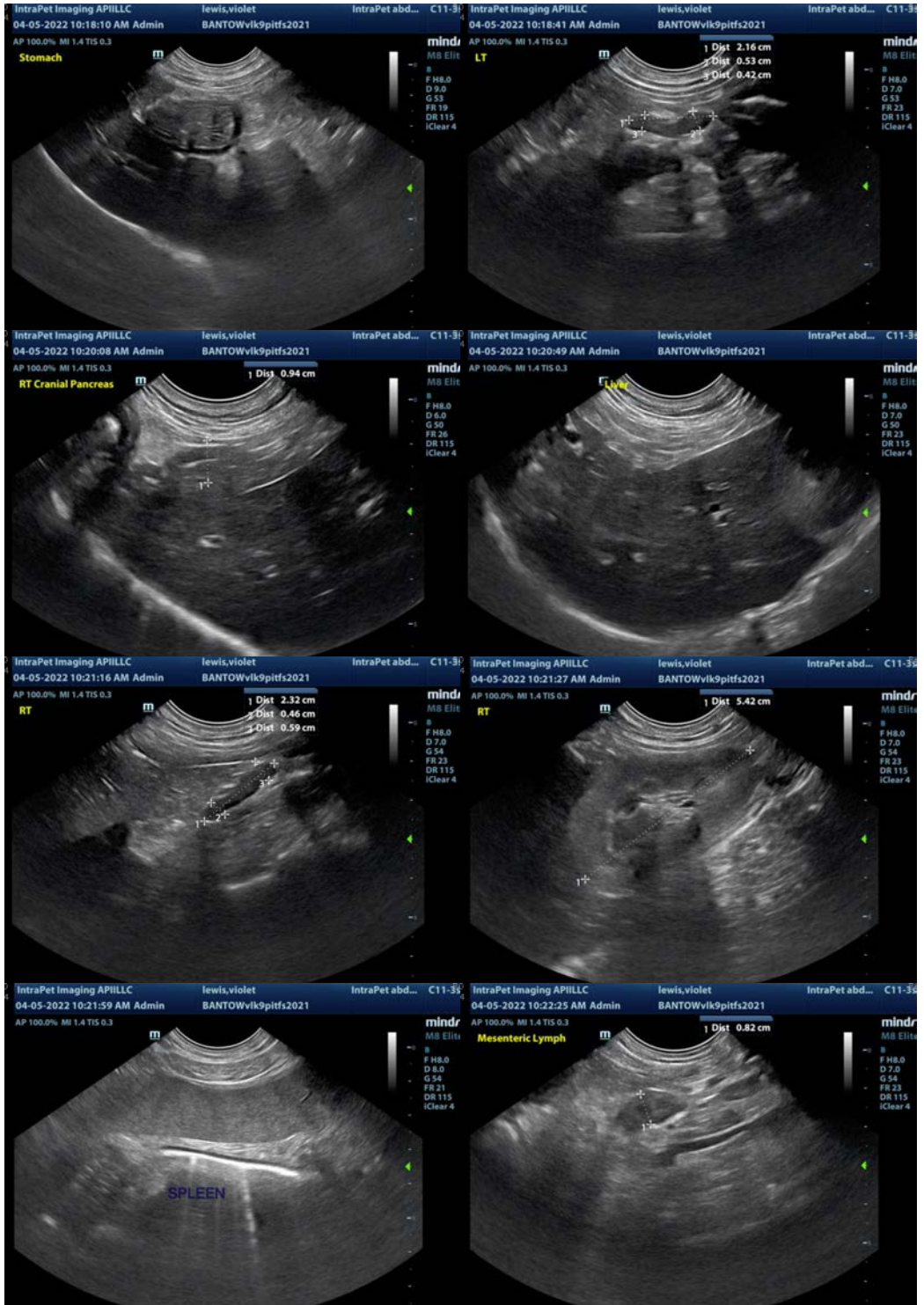
## **ULTRASONOGRAPHIC FINDINGS**

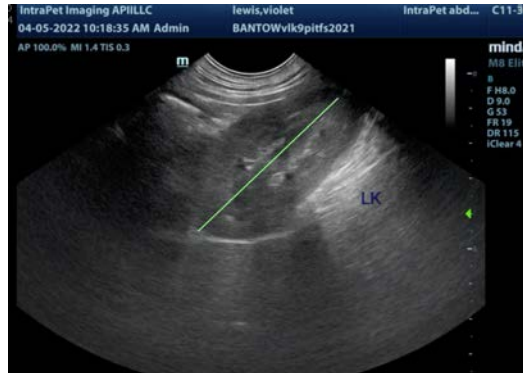
- Hypoechoic pancreas with prominent pancreatic duct and mild hyperechoic surrounding mesentery – The pancreatic changes are most consistent with mild pancreatitis/pancreatic inflammation. Recommend fPLI testing and continued monitoring for improvement or possible development of a pancreatic abscess. Consider fine needle aspirate if not improving.
- Prominent mesenteric lymph nodes – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

## **INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The pancreas appears prominent and mildly inflamed. The appearance of the pancreas does not always correlate with the symptoms associated, so consider this as a possible source of the vomiting reported. Recommend obtaining a qualitative PLI level and treatment for pancreatitis. Keep in mind the possibility for concurrent small intestinal disease, which is not evident on today's exam.

You could consider a GI panel to Texas A&M with a qualitative PLI, TLI, cobalamin and folate to obtain more information regarding the small intestine. If vomiting persists, correlate with serial radiographs, as ultrasound can be insensitive in picking up some types of foreign material. In a dog this age, consider food allergy/dietary indiscretion, GI parasitism, viral enteritis, and less likely intestinal neoplasia.





**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