



PATIENT

Finley Pike

SPECIES

Canine

BREED

Pointer

SEX

Neutered Male

AGE

11 Years

WEIGHT

55.6 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Emily Kirk

HOSPITAL NAME

Shiloh AH

REFERRING VET

Dr. Shayne Zimmerman

INVOICE

46449

DATE

4/6/23

PRESENTING CLINICAL SIGNS

Nausea (licking floor after eating) started beginning of this year, intermittent vomiting that got worse w/ omeprazole. Recently treated for anal sacculitis w/ clavamox/rimadyl- vomiting got worse and responded to cerenia. Doesn't have diarrhea. No previous imaging. Currently taking fluoxetine. Pre-med with gabapentin prior to scan.

Abnormal PE/Chem/CBC/UA Results: labs consistent w/ pancreatitis (Texas A&M GI panel 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 (0.95 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 (6.47 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 (6.12 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 region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. No evidence of a mass effect is visualized.

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 small hypoechoic nodule towards the tail of the spleen measuring 1.07 cm x 0.73 cm. This lesion mildly deforms the splenic capsule.

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 gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and primarily anechoic. The cystic and common bile ducts are normal/not visible.



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Gastrointestinal

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The stomach contains mild fluid/gas. 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.

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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 0.43 cm. Jejunum wall measures 0.35 cm. There is mild mucosal speckling visualized associated with the duodenum. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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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.

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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.

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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.

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ULTRASONOGRAPHIC FINDINGS

- Hypoechoic splenic nodule – There is a non-cavitated, hypoechoic splenic nodule visualized. Differentials include lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis. This lesion is slightly more concerning because it deforms the splenic capsule mildly.
- Mucosal speckling visualized associated with the duodenum – Bright mucosal speckling has been postulated to represent dilated lacteals or focal accumulations of mucus, cellular debris, etc.. in the mucosal crypts.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal lesions are visualized associated with the gastrointestinal tract to explain the chronic vomiting reported. Unfortunately, there are many causes for vomiting that cannot be diagnosed by ultrasound alone.

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

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- 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 (this has already been done)
- Recommend chronic pre-/probiotics.
- Consider a fine needle aspirate of the splenic nodule visualized.



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Based on the mucosal speckling visualized, I'm concerned about a primary enteropathy. It is likely that GI biopsies would be necessary for a diagnosis. If there is no response to dietary therapy, this would likely be the next step.

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

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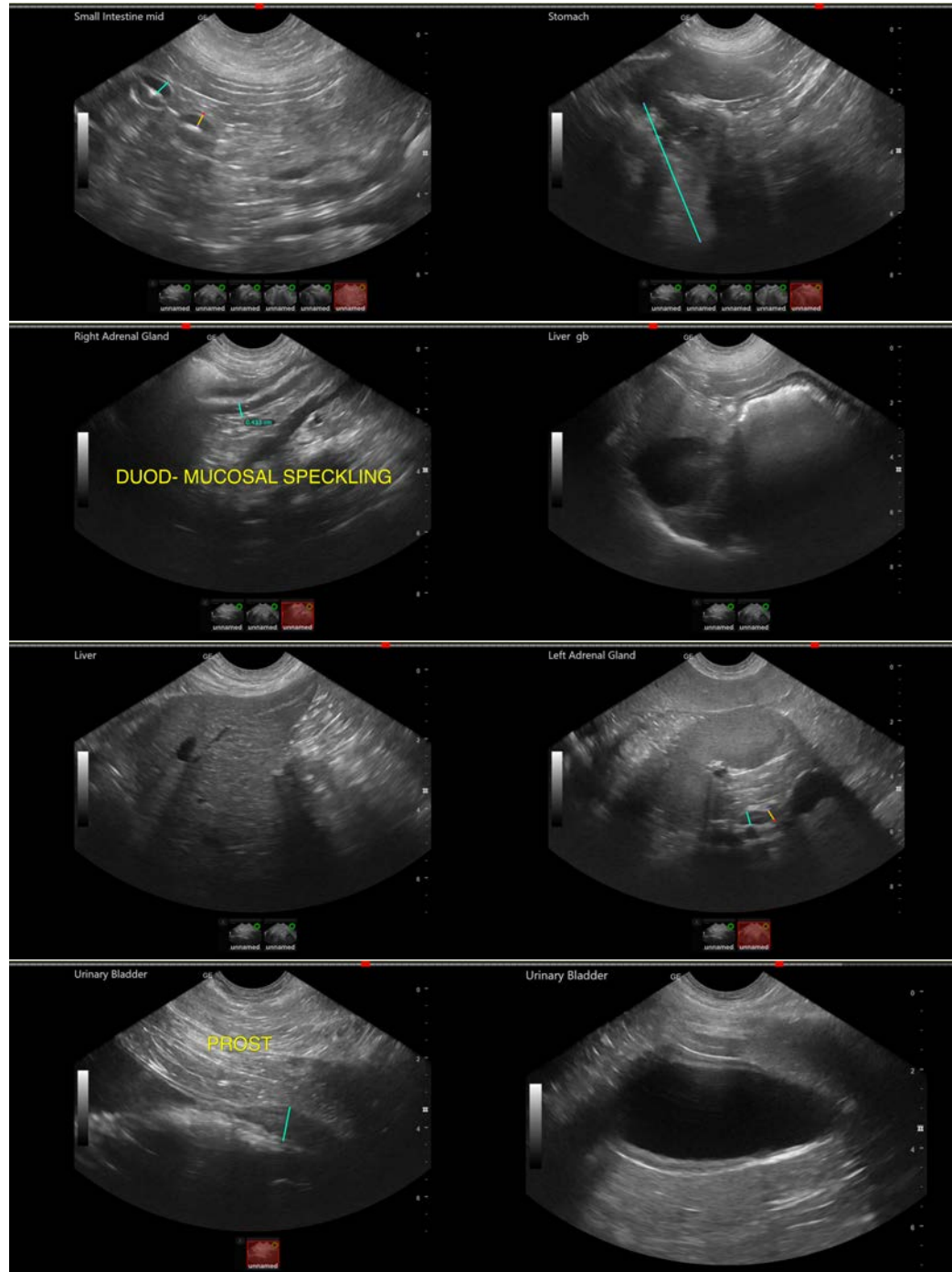
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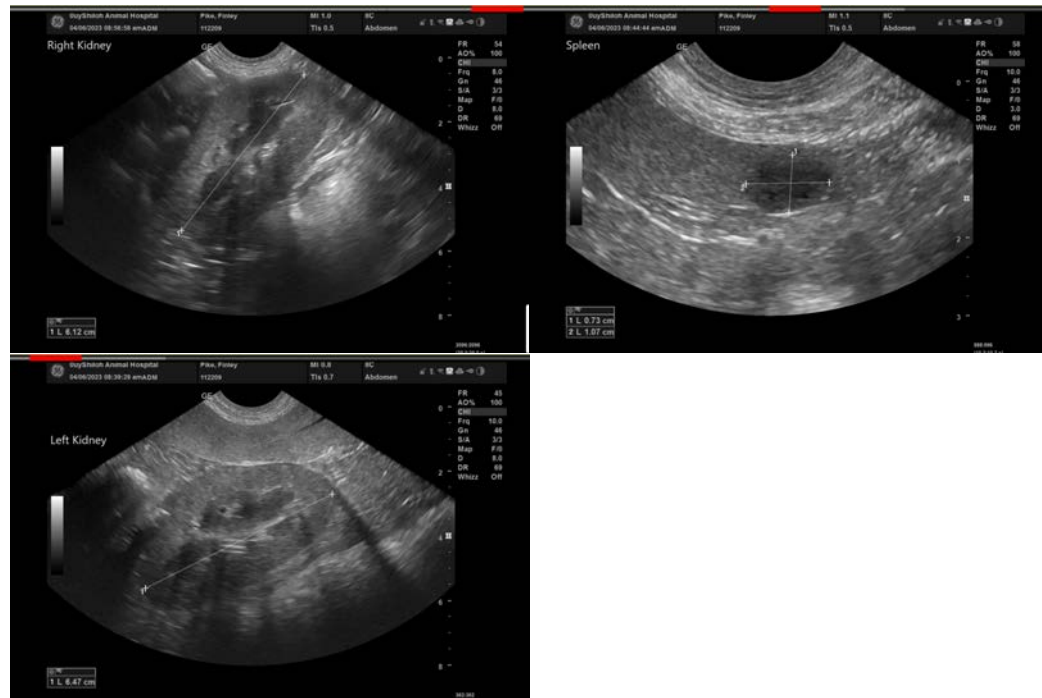
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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