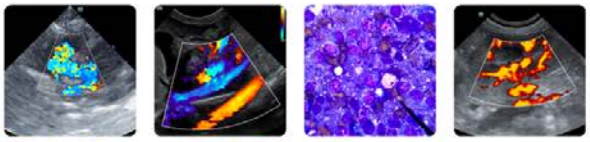

PATIENT

Odie Hammond

SPECIES

Canine

BREED

Terrier x

SEX

Neutered Male

AGE

19 Years

WEIGHT

8.8 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Sarah Green

HOSPITAL NAME

Healing Spirit Animal Wellness

REFERRING VET

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PRESENTING CLINICAL SIGNS

Presented due to acute onset anorexia, vomiting and lethargy. No diarrhea, no known exposure to toxins, dietary indiscretion or diet changes.

Abnormal PE/Chem/CBC/UA Results: Subdued, afebrile, mildly reactive on abdominal palpation. CBC: WBC=36.7 (6-17)K/uL, monocytes =2.89 (0.2-1.5), neutrophils= 32.4 (3-12) k/uL chem: ALP=252, (201-50) U/L, ALT>2000 (10-118), Tbili=1.7 (0.1-0.6) mg/dL, P=8.1 (2.9-6.6) mg/dL

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 visualized areas of prostate and surrounding tissue appear normal. Unfortunately, the prostate is not fully visualized likely due to its intrapelvic location. Correlate with rectal exam findings.

The left kidney has a normal shape and size (3.91 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.

The right kidney has a normal shape and size (3.55 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 0.32 cm at the cranial pole and 0.38 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.

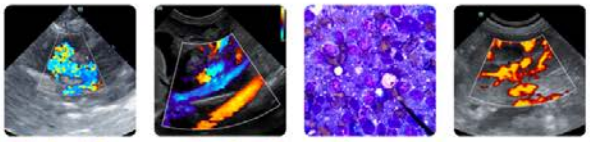
The right adrenal gland is normal in size measuring 0.46 cm at the cranial pole and 0.42 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size (1.09 cm), 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 large in size and irregular. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. There



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are numerous variably sized hypoechoic nodules throughout the parenchyma. Examples meaure 0.98 cm and 0.83 cm.

The gall bladder is large, measuring 2.76 cm x 2.63 cm, with a large amount of unorganized hyperechoic debris. The gallbladder wall appears severely thickened, measuring up to 0.48 cm in thickness. Near the gallbladder neck there is some irregular mucosal stranding and further thickening, most consistent with hypoechoic inflamed tissue, although a poorly defined mass effect cannot be ruled out.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of 0.34 cm 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 measures 0.26 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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 right limb of 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. There is no significant lymphadenopathy. The omentum is hyperechoic in the cranial abdomen.

ULTRASONOGRAPHIC FINDINGS

- Age related changes visualized associated with both kidneys.
- Pancreatic changes most consistent with chronic pancreatic remodeling +/- chronic pancreatitis.
- Large, heterogeneous, irregular liver with ill-defined hypoechoic nodules – 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. The nodules observed trend toward a more benign process but underlying neoplasia cannot be ruled out.
- Large, distended gallbladder with a large amount of intraluminal debris, a severely thickened wall, and thickening/irregularity at the gallbladder neck – Findings are most consistent with severe cholecystitis. Infiltrative neoplasia cannot be ruled out.

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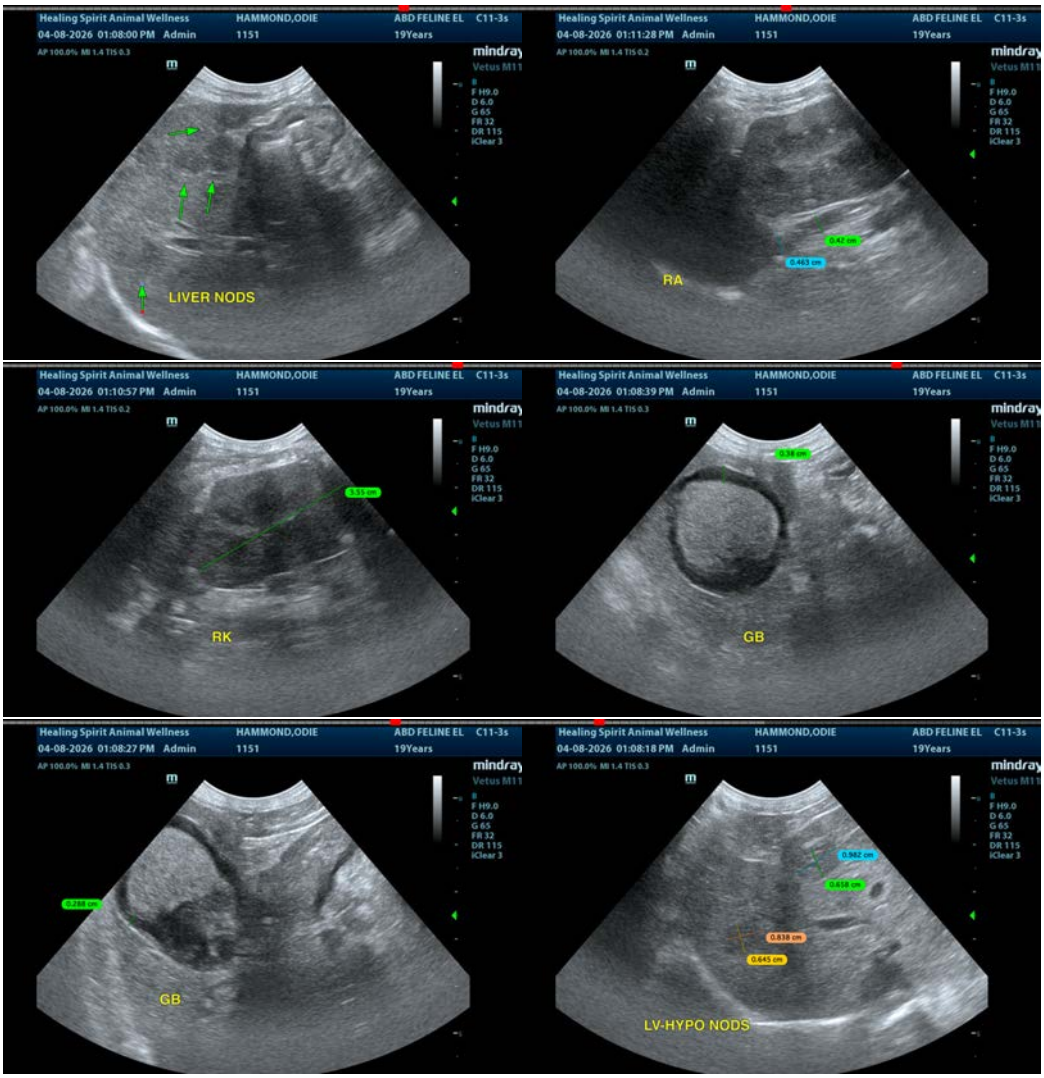
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The liver is large, irregular and rounded with hypoechoic nodules. Generally this has the appearance most consistent with a vacuolar hepatopathy, although neoplastic infiltration or similar cannot be ruled out. Recommend a fine needle aspirate of the liver (provided coagulation parameters are normal).

The gallbladder is severely distended with a large amount of intraluminal debris and severe wall thickening. This thickening is most consistent with cholecystitis and inflammation. Additionally, edema could be present, and there is some irregular tissue at the gallbladder neck most consistent with mucosal stranding/mucosal development, although an early mass lesion cannot be ruled out.

Consider cholecystectomy with samples for histopathology and culture as well as liver biopsies. If this is definitively not an option, you could consider aggressive medical therapy for cholecystitis, but typically surgical therapy is the primary treatment modality, with limited success with medical therapy alone.



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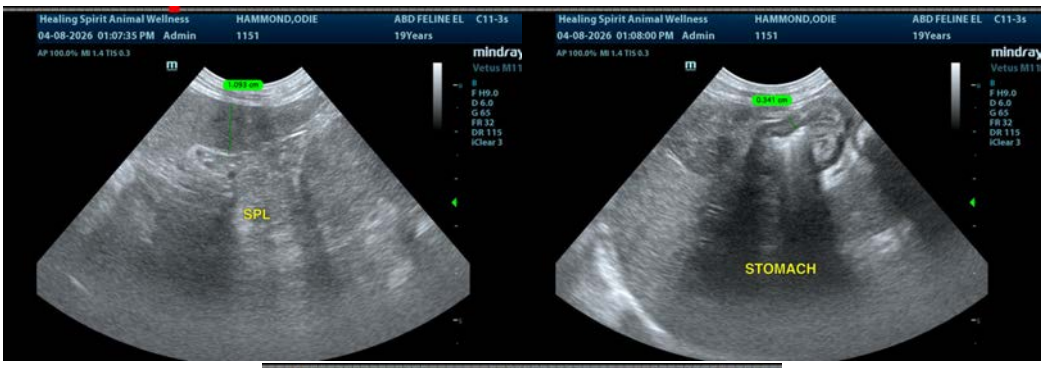

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@sonopath.com