



**PATIENT**

Ava Dangro

**SPECIES**

Canine

**BREED**

Yorkshire Terrier

**SEX**

Spayed Female

**AGE**

14 Years

**WEIGHT**

10.6 Pounds

**INTERPRETED BY**

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

**IMAGING  
PERFORMED BY**

Jack Reese

**HOSPITAL NAME**

Willow Run VC

**REFERRING VET**

Jack Reese, DVM

**INVOICE**

15267

**DATE**

5/18/22

**PRESENTING CLINICAL SIGNS**

History: History of recurrent GI upset (suspected previous pancreatitis episodes) and recurrent UTIs. Owner noted several episodes of diarrhea and GI upset within last few months.

Abnormal PE/Chem/CBC/UA Results: Lipase 4,061 (200 - 1,800 U/L) BUN 29 (7 - 27 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 2.0 cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (4.22 cm). 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, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.16 cm). 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, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

**Adrenal Glands**

The left adrenal gland is normal in size measuring 0.48 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 0.3 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 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. While the stomach wall measures



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at a normal thickness, it appears somewhat prominent with intact layering, most consistent with gastritis.

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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. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed. This is a moderate change. The jejunum measures 0.32 cm. Mucosal speckling is observed in some areas of the small intestine.

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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 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.

**AGE**

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**Free Abdomen**

There is no free fluid or lymphadenopathy, but the omentum is hyperechoic in the cranial abdomen, the region of the pancreas and duodenum.

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**ULTRASONOGRAPHIC FINDINGS**

**Primary Findings**

- Prominent mottled pancreas. The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.
- Mildly 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.
- Subjectively thickened small intestine with mucosal speckling.

**Secondary Findings**

- Decreased corticomedullary distinction in both kidneys. The bilateral renal findings are consistent with age-related change.
- Prominent but not thickened stomach wall. Layering is intact. Findings could be consistent with gastritis.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Today's scan is relatively normal for a 14-year-old dog, but there is cranial abdominal inflammation and mucosal speckling evident, which is most consistent with primary gastrointestinal disease +/- pancreatitis. Correlate these findings with abdominal radiographs.

- I recommend a GI panel (to Texas A & M) for a qualitative PLI, TLI, cobalamin and folate
- I recommend symptomatic therapy for pancreatitis

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- If pancreatitis is thought unlikely based on the PPLI level, then consider a hydrolyzed protein/novel protein diet
- If symptoms persist despite treatment for pancreatitis/enteritis, then consider obtaining GI biopsies.

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not



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visible in the image/video clips provided.

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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.

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kathleen.sennello@sonopath.com

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