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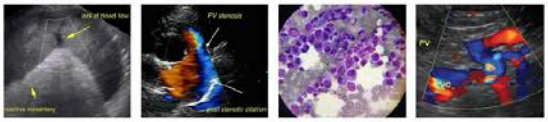

IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Nilla Huber

SPECIES

Canine

BREED

Lab

SEX

Spayed Female

AGE

11 Years

WEIGHT

67.8 Pounds

INTERPRETED BY

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

IMAGING BY

Loetitia Saint-Jacques, I VT

HOSPITAL NAME

MountRose AH

REFERRING VET

Dr. Katie Weldon

INVOICE

37937

DATE

5/24/22

PRESENTING CLINICAL SIGNS

Nilla has a history of not eating well in the AM in 2020. Was ultrasounded for this previously on 12/08/2020, where it was noted that the spleen was mottled and there may be possible IBD. Owner elected NOT to needle aspirate or biopsy the spleen. P was placed on Royal Canin Ultamino, and the symptoms went away.

In August of 2021, P was again not been interested in food in the AM. Another ultrasound showed minimal progression of the splenic nodules, some nodules in the liver, and mesenteric lymphadenopathy. The GI tract had normal layering. Symptoms went away with metronidazole for about 1 month, then came back.

Most recently, the P again is not wanting to eat. Recent bloodwork showed an elevated Spec cPL at 1360, SDMA mildly elevated at 18. Urine SG = 1.014.

P is currently on Adequan and ProHeart 6, along with continued Royal Canin Ultamino.

PHYSICAL EXAM:

WNL, aside from mild age-related lenticular sclerosis and lipomas.

LABORATORY FINDINGS (5/13/22):

Spec cPL elevated at 1360
SDMA mildly elevated at 18
Urine SG = 1.014.

REASON FOR ULTRASOUND:

- Evaluate for causes of inappetence.
- Evaluate pancreas for pancreatitis, and spleen, liver, and GI tract for progression of issues.

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 left kidney has a normal shape and size (5.9 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.

The right kidney has a normal shape and size (3.75 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.

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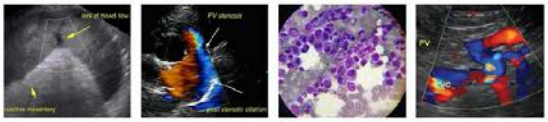

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Adrenal Glands

The left adrenal gland is normal in size measuring 0.59 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 0.51 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. The spleen echotexture is heterogenous and mottled, the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. There are some areas with indistinct focal hyperechoic lesions. One such area measures approimxately 2.5 cm x 1.4 cm.

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. There is a 1.28 cm x 1.18 cm hypoechoic nodule visualized. This is the same lesion visualized previously, which measured 1.8 cm x 1.33 cm (8/5/2021).

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. In some imaging, there is a prominent common bile duct measuring up to 0.4 cm. No obvious obstructive process is visualized, and I am unable to follow it all the way to the duodenal papilla.

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. Duodenum wall measured 0.49 cm. Jejunum wall measured 0.36 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 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.

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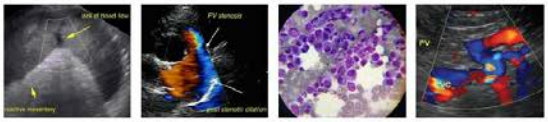

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Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is a visible mesenteric lymph node measuring 0.51 cm in width. The omentum is of normal echogenicity.

Other

A brief view of the heart was submitted. No significant pericardial effusion was seen.

PRIMARY FINDINGS

- Mottled spleen with irregular focal hyperechoic mottling – The diffuse splenic changes are non-specific and could be consistent with lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis. The description of the spleen is fairly similar to that of the last two scans. It is possible that the hyperechoic lesions are more prevalent on today's scan. These have the appearance of benign myelolipomas, but a fine needle aspirate would be necessary to rule out the possibility of a neoplastic process.

SECONDARY FINDINGS

- Prominent, mottled pancreas – The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

- Heterogeneous liver with small hypoechoic nodule – 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 description of the liver is similar to that from the previous scan, and the nodule is approximately the same size.

- Mild bile duct dilation – correlate with current bloodwork findings. No obvious obstructive process is visualized. If liver enzymes are elevated, consider continued monitoring of the bile duct.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Today's scan appears relatively stable to the previously reported scans. The spleen is mottled and fairly stable, possibly with some progression of the hyperechoic lesions, and the liver is heterogeneous and has a stable hypoechoic nodule. Correlate these findings with current bloodwork results, current symptoms, and thoracic imaging. If GI signs are persisting despite a diet change and empirical therapy for pancreatitis, etc., then consider obtaining GI biopsies.

ADDENDUM ADDED 6/1/22

This is an addendum based on reevaluation of this case, given the new information of the current history provided.

The lesions observed in the spleen and liver appear relatively stable. A fine needle aspirate would

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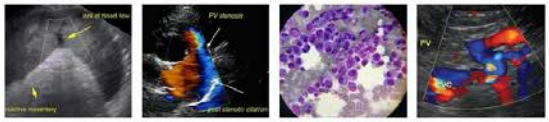

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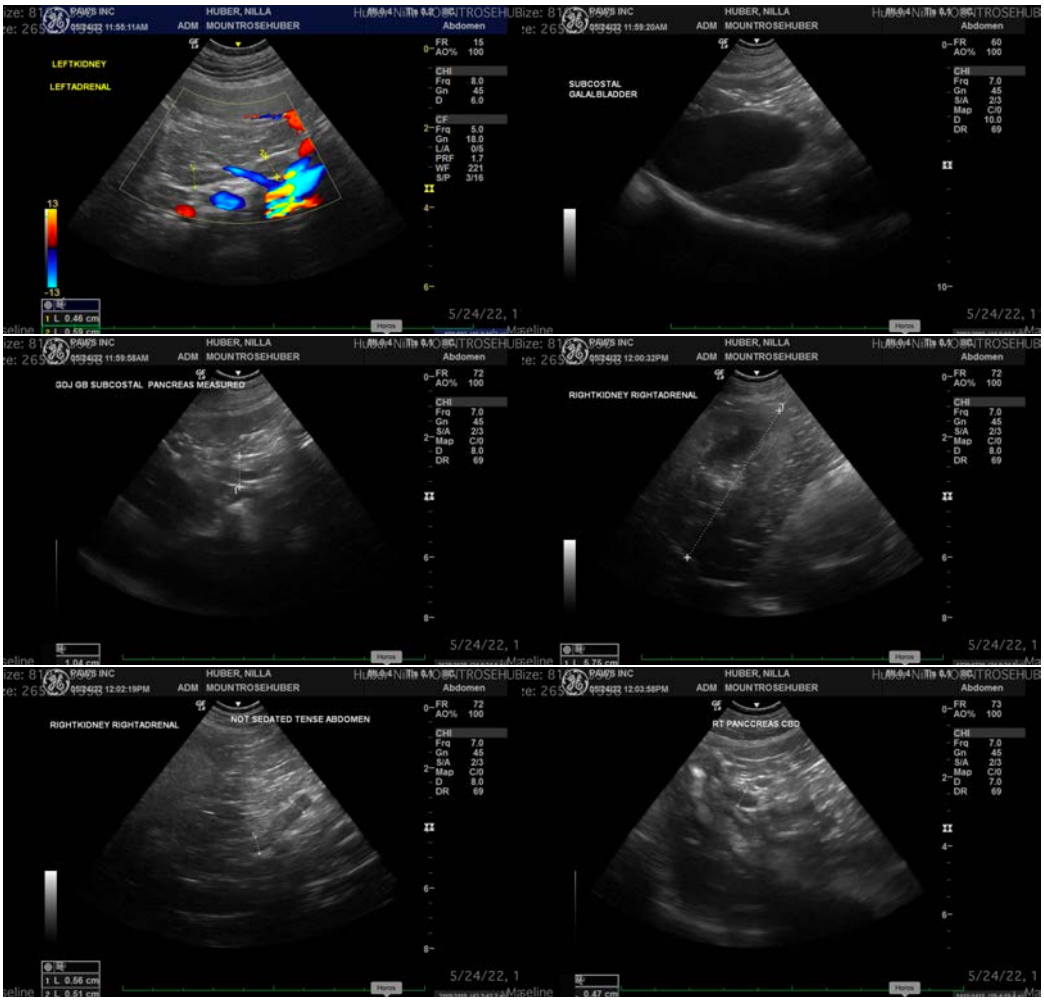
be necessary to more definitively determine what is going on, but based on the chronicity of these issues, I suspect they could be incidental(?). The current bloodwork provided in the history does not explain the decrase in appetite, and if the bilirubin is normal, I suspect the bile duct dilation is not significant, but should be monitored. Most likely cause for inappetence with normal bloodwork and a relatively normal ultrasound would be a flare up of IBD or progressive gastrointestinal disease. If supportive care for acute gastroenteritis/pancreatitis does not relieve these symptoms, biopsies of the GI tract could be considered. Additionally, thoracic radiographs are recommendd to rule out concurrent intrathoracic disease.



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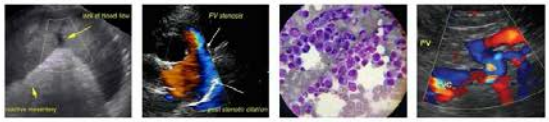

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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