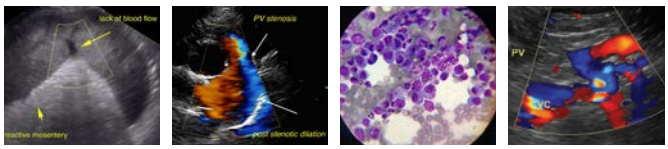
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



SonoPath.com™
1-800-838-4268 info@sonopath.com

PATIENT
Brooklyn Bucino

SPECIES
Canine

BREED
Yorkshire Terrier

SEX
Spayed Female

AGE
11 Years

WEIGHT
N/A

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

IMAGING PERFORMED BY
Kelly Vazquez

HOSPITAL NAME
Englewood Cliffs VH

REFERRING VET
Dr. Rachel Park

INVOICE
38006

DATE
5/26/22

PRESENTING CLINICAL SIGNS

On/off diarrhea even after finishing antibiotics. Elevated Alk. P. 212, fecal neg, history of pancreatitis. Just finished Amoxi 50 mgs BID.
Abnormal PE/Chem/CBC/UA Results: Alk. Phos. 212 - history of ~ 200 range since 2020.

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 (3.44 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 (3.35 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 0.55 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 0.50 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.

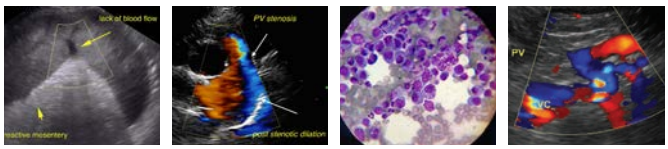
Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is 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 primarily anechoic. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach is moderately dilated with fluid and irregular shadowing material most consistent with normal ingesta and 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 layering 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 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 0.43 cm. Jejunum wall measured 0.31 cm. Visualized peristalsis appears appropriate. The proximal duodenum has a small amount of intraluminal fluid and appears somewhat corrugated and thickened. This is the area adjacent to the pancreas, and there is a lot of inflamed omentum in the region.

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, particularly in the right limb. There is no evidence of nodules or cystic lesions. There is evidence of regional mesenteric inflammation. Consistent with mild to moderate pancreatitis.

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.

PRIMARY FINDINGS

- Hypoechoic right limb of the pancreas with a large amount of peripancreatic inflammation – The pancreatic changes are most consistent with mild/moderate 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.
- Moderate ingesta in the gastric lumen – correlate with feeding history. This could be consistent with delayed gastric emptying secondary to pancreatitis, or due to a partial outflow tract obstruction (none observed).
- Focal duodenitis and corrugation of the proximal duodenum – This is likely associated with pancreatic inflammation and focal peritonitis in the cranial abdomen. A primary small intestinal lesion cannot be excluded as a possibility.

SECONDARY FINDINGS

- Decreased corticomedullary distinction in both kidneys – The bilateral renal findings are consistent with age-related change.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The pancreas appears somewhat prominent, and there is a large amount of cranial abdominal inflammation, particularly near the right limb of the pancreas and around the duodenum. This could be consistent with active pancreatic inflammation or a recent episode of pancreatic inflammation if this is resolving. Typically, you would expect to see signs of vomiting, inappetence, etc., rather than diarrhea in this situation, but this is not always predictable. Additionally, the recent antibiotics therapy could be predispose to dysbiosis.

- Recommend a GI panel to Texas A&M for a qualitative PLI, TLI, cobalamin and folate to get a quantitative measurement of pancreatic inflammation that can be followed, and evaluation for primary gastrointestinal disease and dysbiosis.

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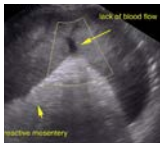
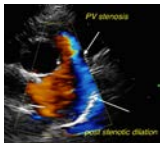
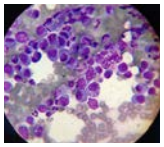
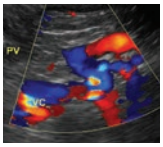

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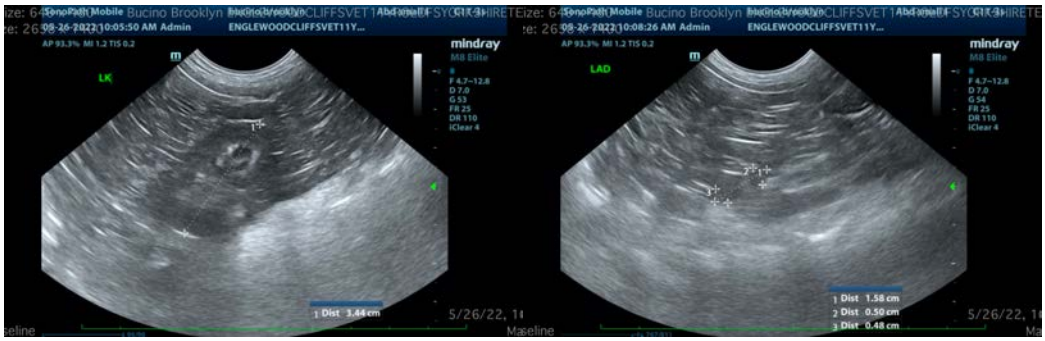
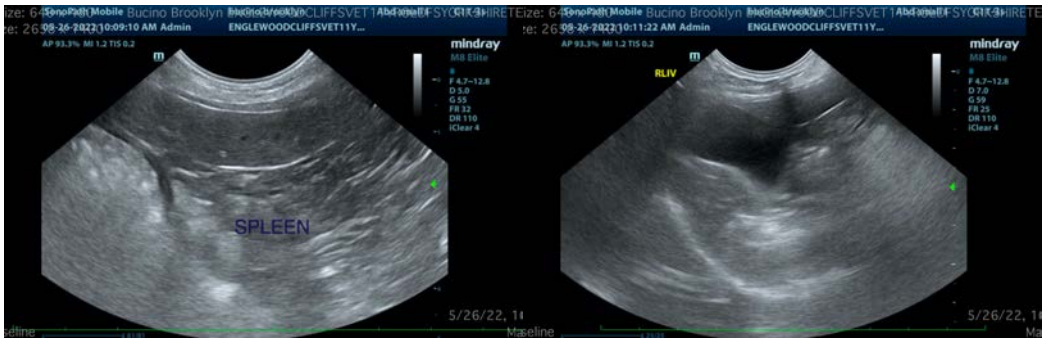
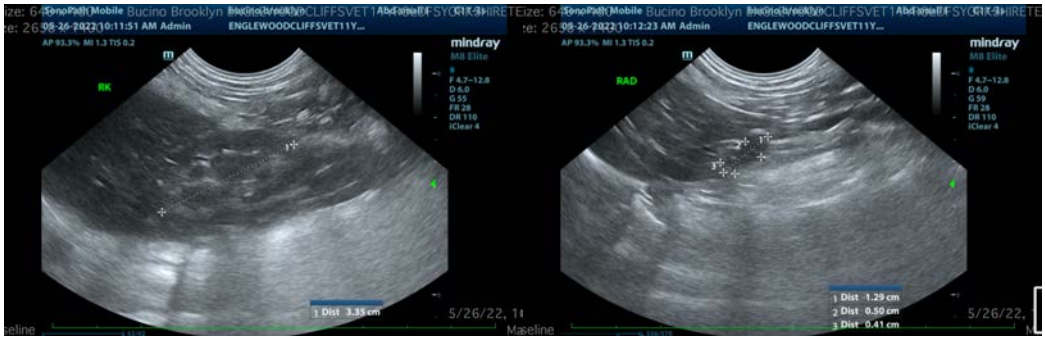
- Recommend chronic probiotic therapy.
- Recommend a low-fat diet.
- Recommend symptomatic therapy for gastroenteritis/pancreatitis.
- If symptoms persist with no response to therapy, then obtaining GI biopsies may be need to be considered.







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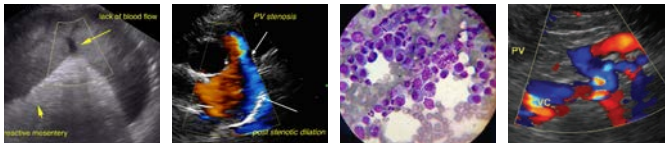

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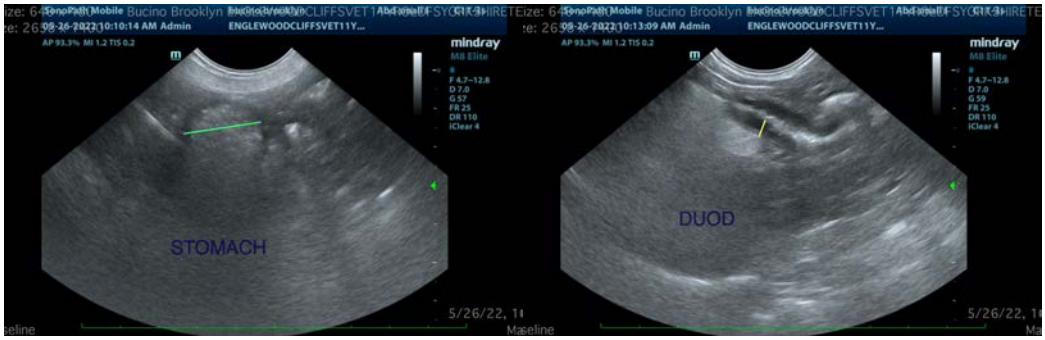

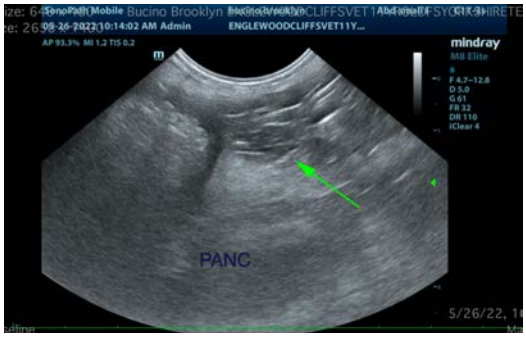

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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kathleen.sennello@sonopath.com