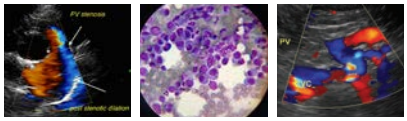
IMAGING PERFORMED BY

IntraPet.com



SonoPath

Clinical Sonography & Telecytology

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DATE

6/1/22

PATIENT

Clooney McDonals

SPECIES

Canine

BREED

Shih Tzu

SEX

Neutered Male

AGE

10/2/07

WEIGHT

11.6 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Andi Parkinson RDMS

HOSPITAL NAME

Taylorsville Vet Clinic

REFERRING VET

Dr. Bray

INVOICE

38147

PRESENTING CLINICAL SIGNS

Vomiting bile.

Current Medications: None.
Lab Results: CBC: WNL, Thrombocytosis likely related to stress
Chem: Elevated NaCl related to dehydration, Mild Hypoalbuminemia, loss is likely (PLE vs PLN), Mild CK elevation likely related to blood draw
UA: WNL, Not PLN, UPC 0.1. TT4: WNL, cPL is normal, not pancreatitis.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

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 (3.77 cm) with pinpoint non-obstructive nephroliths. 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, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.21 cm) with pinpoint non-obstructive nephroliths. 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, 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 0.59 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. It is irregular in shape. The blood flow through the hilus and splenic parenchyma appears normal. There is a slightly hyperechoic solid mass effect towards the tail of the spleen measuring 2.94 cm x 2.05 cm.

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 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. Jejunum wall measured 0.24 cm. Duodenum wall measured 0.33 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 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.

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.

ULTRASONOGRAPHIC FINDINGS

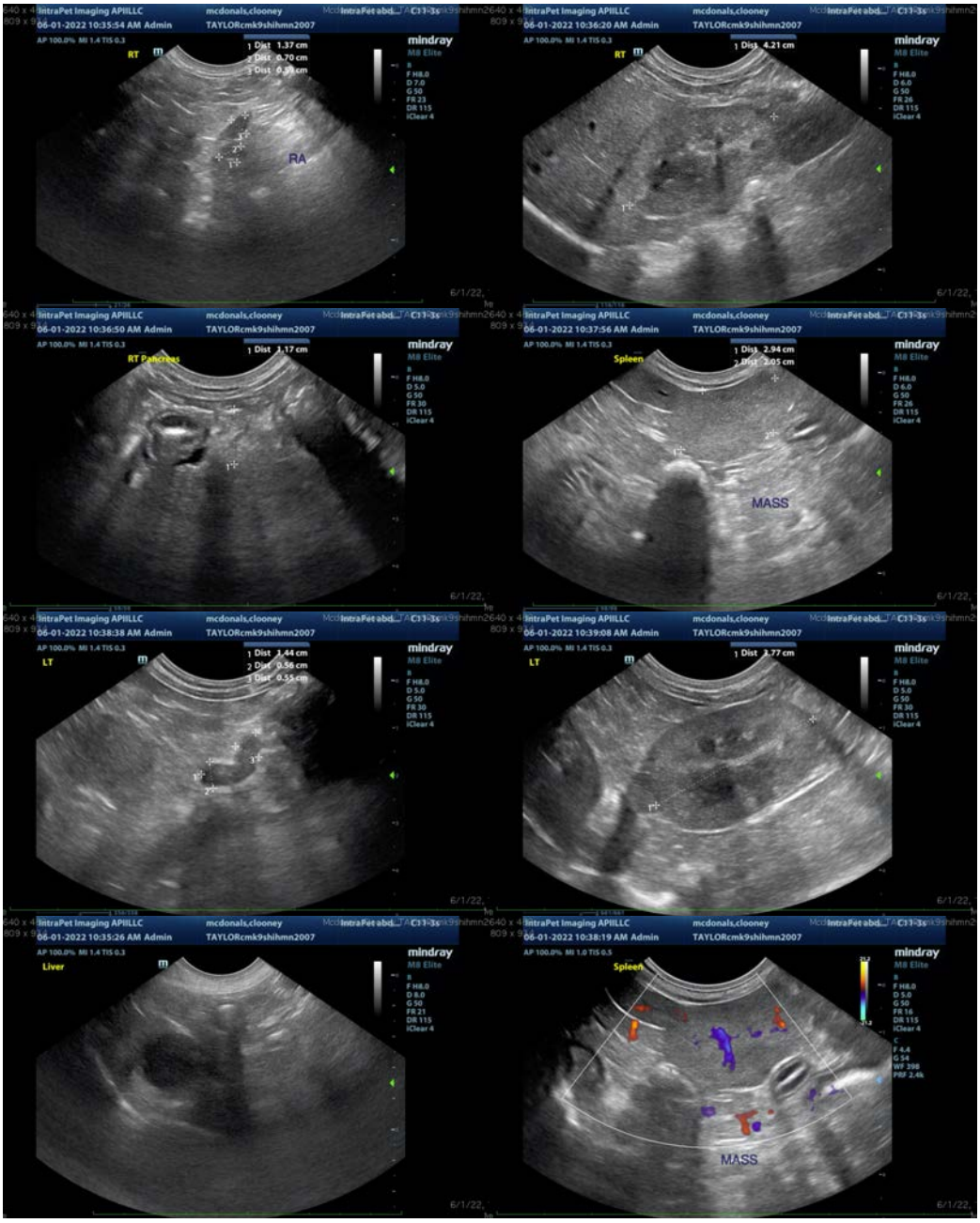
- Moderate sized solid splenic mass – This lesion could represent a benign or neoplastic lesion.
- Decreased corticomedullary distinction in both kidneys with pinpoint non-obstructive nephroliths – The bilateral renal findings are consistent with age-related change.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A source for the low albumin reported is not definitively identified. The bowel looks relatively normal, as does the liver. Consider a liver function test to look for liver disease as a cause for the low albumin levels reported. Additionally, considered a GI panel to Texas A&M for a qualitative PLI, TLI, cobalamin and folate to look for additional evidence of underlying intestinal disease.

A mass lesion is visualized on the spleen. This is a non-cavitated lesion and there is no evidence of surrounding inflammation or fluid, so I feel that previous hemorrhage is unlikely, and this lesion is likely incidental. Options moving forward would include splenectomy for both diagnostic and therapeutic purposes, or a fine needle aspirate with continued monitoring with the knowledge that rupture would be a possibility.

Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.



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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