SonoPath
Clinical Sonography & Telecytology
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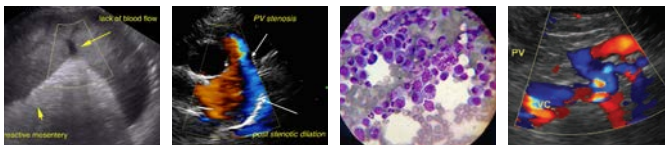

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Wabo Randise

SPECIES

Canine

BREED

Shih Tzu

SEX

Neutered Male

AGE

14 Years

WEIGHT

13 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Shari Reffi, CVT

HOSPITAL NAME

Millburn Vet Hospital

REFERRING VET

Dr. Mosquera

INVOICE

43154

DATE

6/14/23

PRESENTING CLINICAL SIGNS

Decreased appetite and diarrhea. Mass palpated in mid abdomen. Current meds: Proviable, Metronidazole.

Abnormal PE/Chem/CBC/UA Results: Pending

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 prostate is normal in size (0.77 cm) and shape for this neutered male dog. The parenchyma is homogenous and the external margins are smooth. The prostatic urethra appears normal with no evidence of irregularity, invasion, mass effect or calculi.

The left kidney has a normal shape and size (3.97 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 (4.08 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 borderline large and slightly irregular, measuring 0.42 cm at the cranial pole, 0.92 cm at the caudal pole, and 1.81 cm in length. It is observed in its normal position cranial to the left renal artery. It is slightly irregular in appearance in that the caudal pole is larger than the cranial pole, but no distinct nodule is visualized.

The right adrenal gland is normal/borderline large in size measuring 0.83 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 large, irregular, and heterogeneous. The blood flow through the hilus and splenic parenchyma appears normal. There is a somewhat ill-defined iso- to hyperechoic solid mass effect visualized measuring 2.65 cm x 3.32 cm, which deforms the splenic capsule. Additionally, there is a hypoechoic nodule visualized measuring 0.52 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. 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 mild and primarily anechoic. The cystic and common bile ducts are normal/not visible.

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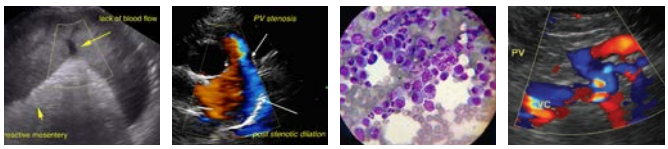

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Gastrointestinal

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 measures 0.24 cm. Duodenum wall measures 0.49 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 region of the right limb of the pancreas is prominent, hypoechoic and mottled compared to the surrounding isoechoic mesentery. Adjacent to the stomach the pancreas appears somewhat patchy with a prominent pancreatic duct and some surrounding inflammation. Additionally, there are isoechoic nodules in the region, which could be local lymph nodes or represent pancreatic nodules.

Free Abdomen

There is a small amount of free abdominal fluid. There are occasional prominent lymph node, particularly in the cranial abdomen in the region of the pancreas, measuring 1.4, 0.72 and 0.60 cm. The omentum is somewhat hyperechoic in the cranial abdomen.

Other

The right auricle and pericardium were visualized and were unremarkable. No obvious pathology is visualized. If cardiac function evaluation is desired a full echocardiogram is warranted.

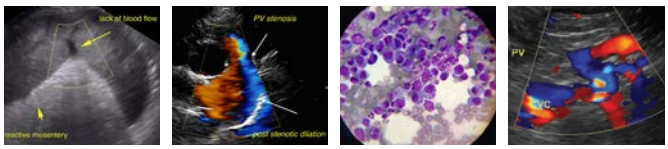
PRIMARY FINDINGS

- Borderline bilateral adrenomegaly with an irregularly shaped left adrenal – The bilateral adrenomegaly could be consistent with bilateral hyperplasia (e.g., secondary to pituitary-dependent hyperadrenocorticism), bilateral infiltrative neoplasia, inflammatory adrenal disease, other. Correlation with clinical findings is recommended.

- Iso- to hyperechoic splenic mass with a hypoechoic nodule – The splenic lesions visualized could represent benign or neoplastic processes. Consider a fine needle aspirate.

- Hypoechoic, mottled, irregular/slightly nodular pancreas – The pancreatic changes are most consistent with mild 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.

- 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.



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- Mild cranial abdominal lymphadenopathy – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- Small volume free abdominal fluid.

SECONDARY FINDINGS

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

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal lesions are visualized associated with the gastrointestinal tract to explain the diarrhea reported. The pancreas does appear prominent and irregular, as well as mottled and hypoechoic in some regions with some mild surrounding hyperechoic mesentery. Additionally, there are some isoechoic nodules in the region, which could represent enlarged lymph nodes in the region or pancreatic nodules. Consider empirical treatment for pancreatitis and correlate these findings with a qualitative cPLI level. If symptoms persist, you could consider a fine needle aspirate of the pancreas.

There is a large iso- to slightly hyperechoic mass effect visualized associated with the spleen. Consider a fine needle aspirate of this lesion, as it could represent a benign or neoplastic process.

Correlate these findings with lab work. If metabolic disease is thought to be an unlikely source of the chronic diarrhea, then consider a primary enteropathy.

Consider such differentials as food allergy/dietary intolerance, GI parasitism, pancreatitis, dysbiosis, recurrent dietary indiscretion, IBD and less likely neoplasia, etc….

- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks)
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc.. to further evaluate for pancreatic/small intestinal disease.
- Recommend chronic probiotic therapy.
- If symptoms are persistent despite taking these measures and primary gastrointestinal disease is thought likely, consider obtaining GI biopsies.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.

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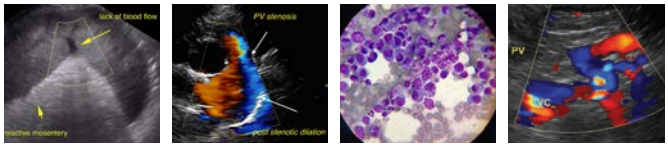

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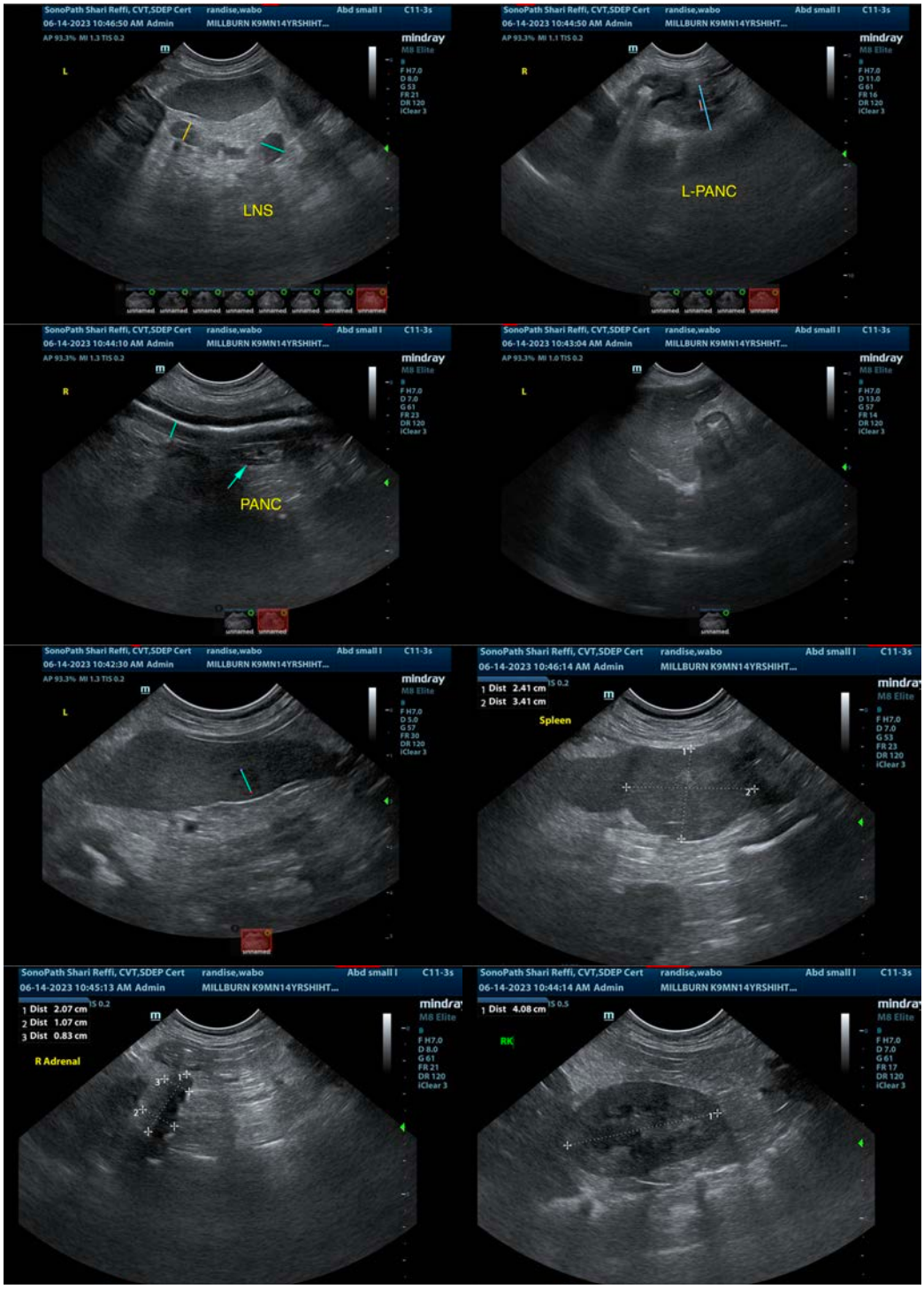

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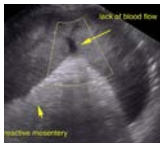
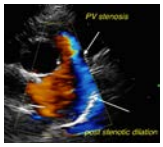
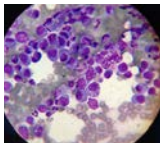
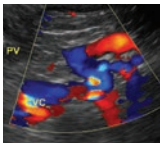

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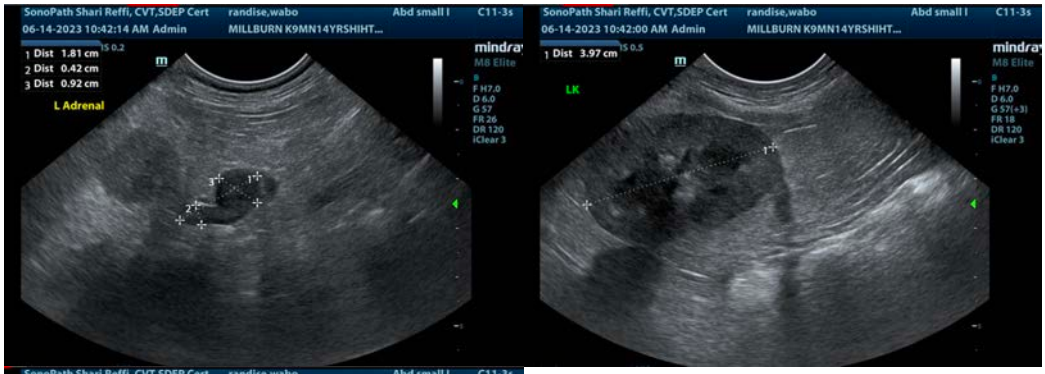

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

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