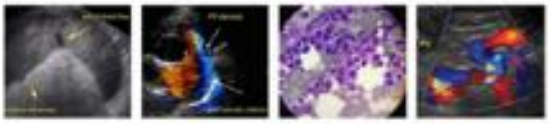

PATIENT

Ginger Weldon

SPECIES

Canine

BREED

Yorkshire Terrier

SEX

Spayed Female

AGE

12 Years

WEIGHT

6.32 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

MountainView AH

REFERRING VET

Dr. Katie Weldon

INVOICE

13480

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PRESENTING CLINICAL SIGNS

P was seen for ascites in Feb 2018 and was diagnosed via biopsies with lymphangiectasia and IBD. P has been on Royal Canin HP and Atopica since then. (Was also on shorter-term prednisone in the beginning but has been off the pred for about 4 years.) She has been overall doing well, but recent bloodwork at her annual physical exam showed elevated liver enzymes and elevated globulin levels. P has been overall doing well but may be more lethargic lately. P is NOT PU/PD. P is also on Tacrolimus ophthalmic drops for immune-related non-ulcerative keratitis or episcleritis since August of 2022.

Abnormal PE/Chem/CBC/UA Results: Bloodwork Results: ALT = 150 (high) AST = 37 (WNL) AlkP = 221 (high) TP = 9.3 (high) Glob = 6.1 (high) Alb = 3.2 (WNL) Cholest = 372 (sl high) WBC WNL HCT = 58.0 (sl high) T4 = 2.2 (WNL) HWT = negative U/A Results: S.G. = 1.020 pH = 6.0 1+ protein 0-2 WBC 0-2 RBC occ fine granular casts

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 (3.03 cm), with nonobstructive nephroliths (one of which measures 0.40 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 (3.50 cm) with nonobstructive nephroliths, and a patchy hyperechoic area most consistent with a previous renal infarct. 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.

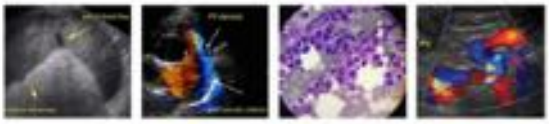
Adrenal Glands

The left adrenal gland is normal in size measuring 0.49 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 0.39 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.



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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 are numerous ill-defined hyper- and hypoechoic nodules visualized throughout the parenchyma.

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.

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 (0.35 cm), jejunum (0.30 cm) and ileum have a uniform diameter with moderate fluid distension. Wall thickness is increased (enter measurement if given). Bowel loops follow a typical curvilinear path. Some areas have reduced detail of wall layering with mucosal speckling evident. 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 in the right limb, 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.

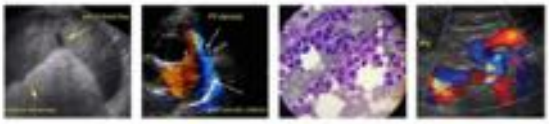
Free Abdomen

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

Primary Findings

- Decreased corticomedullary junction in both kidneys with nonobstructive nephroliths - The bilateral renal findings are consistent with age-related change.
- Prominent mottled right limb of the pancreas - The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Small hypoechoic nodule visualized associated with the spleen - There is a non-cavitated, hypoechoic splenic nodule visualized. Differentials include lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or



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histopathology would be necessary to get a definitive diagnosis.

- Heterogenous liver with ill-defined hyper- and hypoechoic nodules – 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 nodules observed trend toward a more benign process, but underlying neoplasia cannot be ruled out.
- Subjectively thickened small intestine with mild mucosal surface - Bright mucosal speckling has been postulated to represent dilated lacteals or focal accumulations of mucus, cellular debris, etc. in the mucosal crypts.

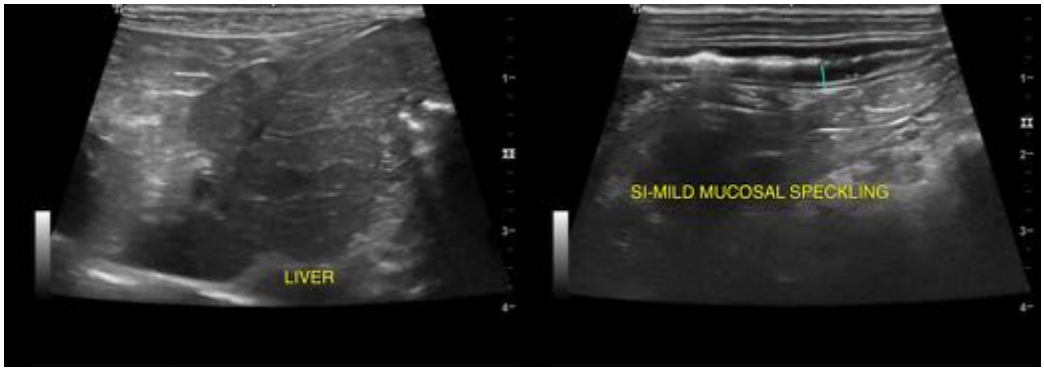
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal lesions are visualized associated with the liver to explain the liver enzyme elevations reported. The liver is diffusely heterogenous. Some of this could represent age-related remodeling. The appearance of the hyper- and hypoechoic nodules trends toward a benign process (regenerative nodules), etc., cut an underlying neoplastic process cannot be definitively ruled out. If further evaluation is desired, consider a liver function test and a fine-needle aspirate of the liver (provided coagulation parameters are normal).

The changes described in both kidneys are consistent with chronic age-related renal disease. A blood pressure, urinalysis, and culture should be obtained as a baseline. The pancreas is somewhat prominent. Correlate this with a quantitative PLI level. The changes observed on today's scan are most consistent with remodeling and previous episodes of inflammation, but mild current inflammation cannot be ruled out.

The changes observed associated with the small intestine are relatively mild and consistent with the diagnosis of lymphangiectasia and IBD.

You could consider obtaining peak and trough cyclosporin levels with chronic Atopica therapy, as this could theoretically increase the risk for infectious hepatitis, etc. Additionally, you could have a reactive hepatitis secondary to chronic gastrointestinal inflammation. Consider chronic probiotic therapy to help reduce "leaky gut" issues. In my experience, protein-losing enteropathies tend to progress as the patient ages, so the normal albumen levels are very encouraging.



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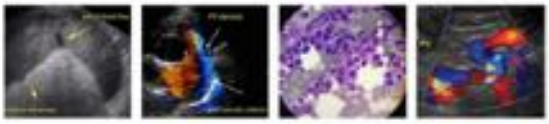

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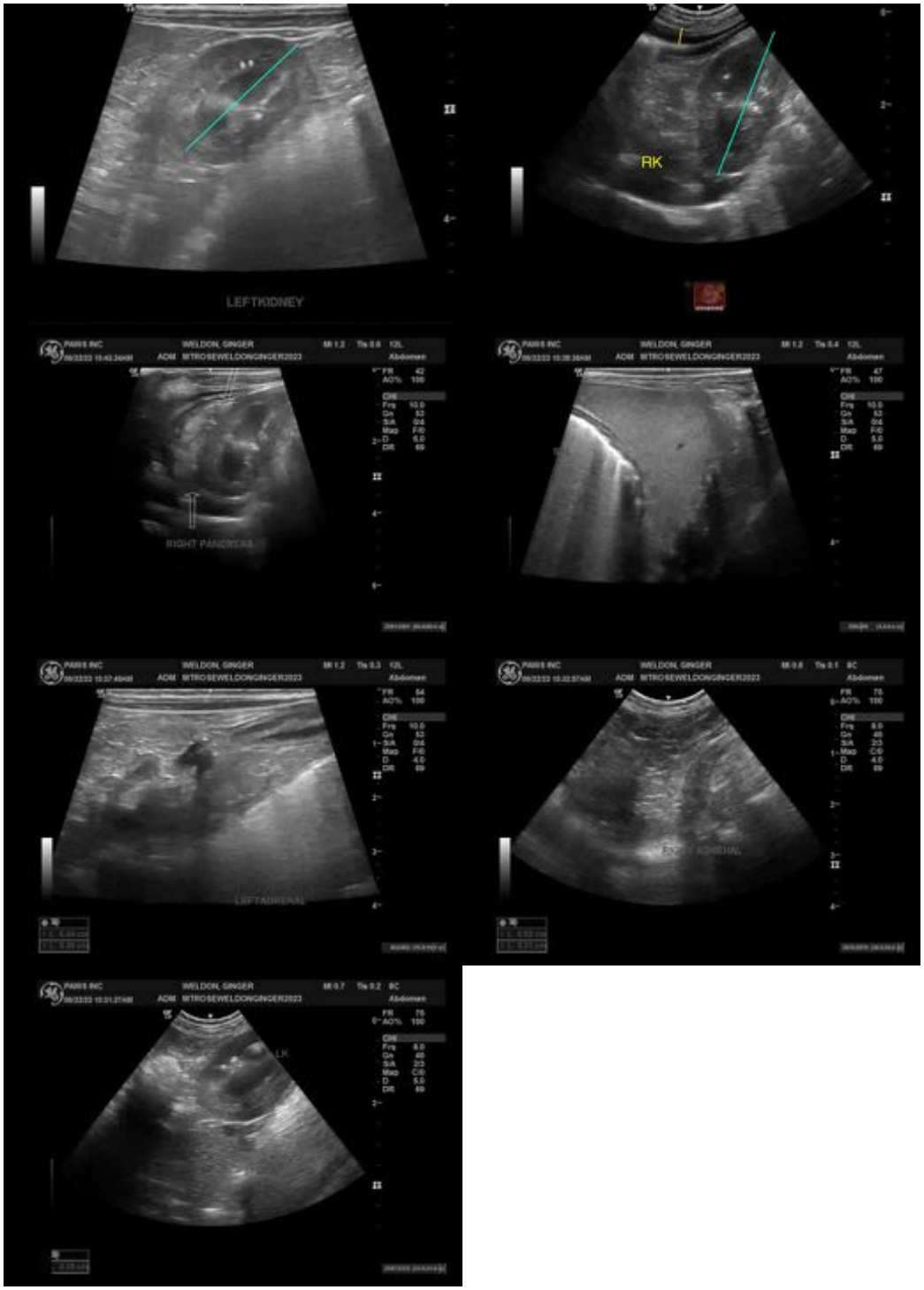

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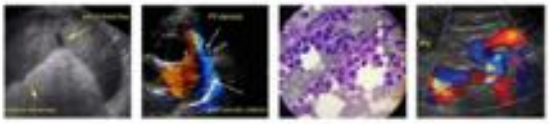

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@sonopath.com