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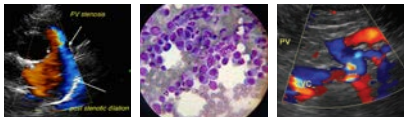

SonoPath

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DATE

6/24/22

PATIENT

Holly Briggs

SPECIES

Canine

BREED

Staffordshire Bull Terrier X

SEX

Spayed Female

AGE

6/22/11

WEIGHT

65.4 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Rachel Brilhart RDMS

HOSPITAL NAME

Animal Emergency Hospital

REFERRING VET

Dr. Saubier

INVOICE

39058

PRESENTING CLINICAL SIGNS

Referral from North East Animal Hospital-Beginning Monday started with decreased appetite and now has completely stopped eating. Did vomit but only one Tuesday morning. Weak. wobbly / lehtargic. Seen rDVM - Xrays and BW BW – elevated ALT 636 and ALKP 322U/L SDMA elevated 20 BUN & Crea wnl. CPL normal 4Dx negative. CBC - platelets low WBC, lymphocytes and neutrophils low. Per owner has a history of gastrointestinal upset happens approx. every 2 months. Also has history of elevated liver values - had abdominal US in 2019 in Oregon - owner to emal previous records. Also history of Mast cell tumors. Fenced in yard - no known foreign ingestions. Does have toys that she chews - none ingested per owner. No diet changes

Current Medications: Dextrose, Famotidine, Unasyn, Buprenorphine.
Lab Results: See attached.
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 left kidney has a normal shape and size (7.55 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 (6.23 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.

Adrenal Glands

The left adrenal gland is normal/borderline enlarged in size measuring 0.86 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 borderline enlarged 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 subjectively normal in size. The spleen echotexture is heterogenous and mildly mottled, 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 large in size, and normal in 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 appears somewhat thickened, measuring 0.34 cm. Luminal contents are primarily anechoic. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains minimal luminal contents. The stomach wall appears somewhat diffusely thickened, measuring at 0.84 cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate, but slightly diminished, 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. The duodenum measured as normal (between 0.3-0.5cm in wall thickness) and the jejunum measured as normal (between 0.2-0.47cm.) 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.

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

- Borderline bilateral adrenomegaly – 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.

- Mildly mottled spleen – 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.

- Large, 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.

- Thickened, prominent gallbladder wall – could be consistent with inflammation or cholecystitis.

- Diffusely thickened gastric wall – The stomach wall thickening could be consistent with inflammation, edema, infiltrative neoplasia, imaging artifact due to rugal folds, other.

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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

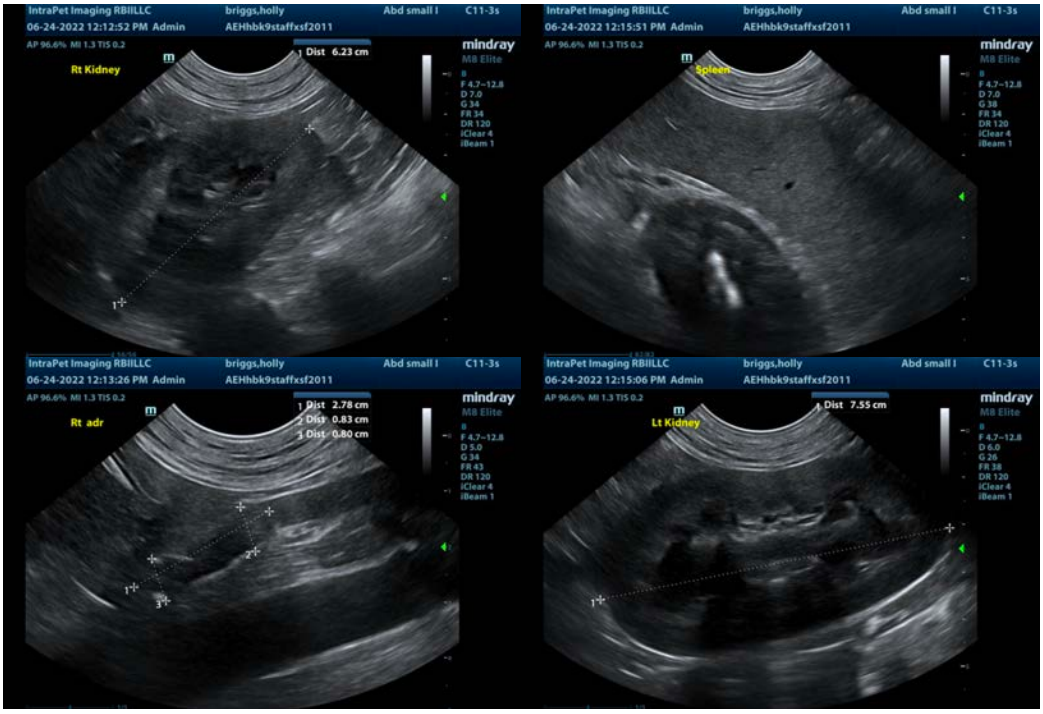
There are numerous non-specific lesions visualized on today's scan, but it is difficult to determine if any of these are definitively associated with why this pet is not feeling well. The liver is large and heterogeneous and the gallbladder wall is thickened. These findings could be consistent with hepatobiliary disease. Recommend a liver function test and fine needle aspirate of the liver. Additionally, recommend Leptospirosis testing and consider a course of antibiotics for possible cholecystitis. If liver function is abnormal and cytology is not helpful, consider obtaining a hepatic biopsy for histopathology.

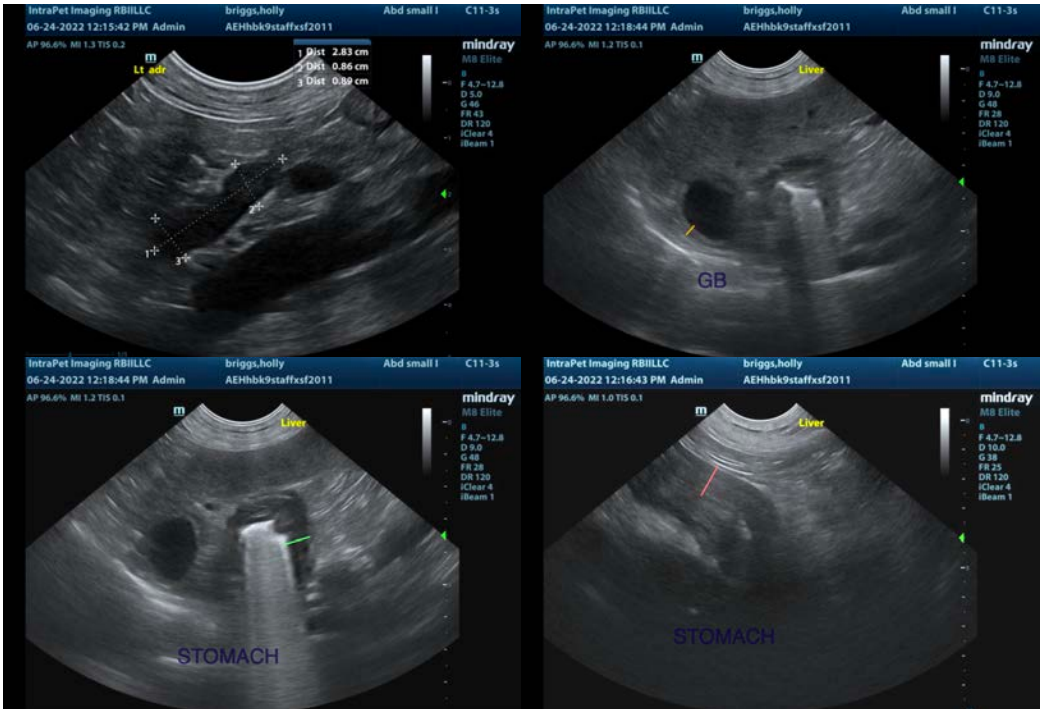
Both adrenal glands are "plump". This could be indirectly causing some of the liver enzyme elevations. If there are signs of Cushing's disease, consider adrenal function testing.

The spleen appears somewhat prominent and mottled. Recommend a fine needle aspirate.

The significance of the prominent, subjectively thickened gastric wall is unclear. Recommend the above diagnostics. If symptoms of possible gastritis/gastric upset persist, consider obtaining biopsies of the gastric wall.

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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