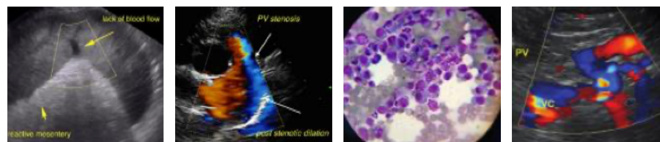
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Frenchy Schmitt

SPECIES

Canine

BREED

Schnoodle

SEX

Female Spayed

AGE

7 years, 4 mos

WEIGHT

16.8 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Shari Reffi, CVT

HOSPITAL NAME

Westwood Reg. VH

REFERRING VET

Dr. Giammanco

INVOICE

13539

DATE

6.30.23

PRESENTING CLINICAL SIGNS

History: Pancreatitis + on CPL snap and elevated liver and kidney values. Current Meds: Cerenia, Famotidine, Unasyn, Buprenex, Metronidazole

Abnormal PE/Chem/CBC/UA Results: RBC 9.79 (8.87 H); HCT 67.6 (61.7 H); HGB 23 (20.5 H); RETICS 148.8 (110 H); WBC 18.99 (16.76 H); NEUTS 13.46 (11.64 H) BANDS SUSPECTED; MONO 1.56 (1.12 H); EOS 0.01 (0.06 L); GLUCOSE 166 (143 H); CREAT 2.6 (1.8 H); BUN 40 (27 H); PHOS 8.7 (6.8 H); CHL 107 (109 L); TP 9.2 (8.2 H); ALB 4.2 (4.3 H); GLOB 5.0 (4.5 H); ALT 179 (125 H); ALP 700 (212 H); BILI 1.0 (0.9 H); CHOL 394 (320 H); AMYL >2500 (1500 H); LIPASE 5664 (1800 H); SNAP cPL Abnormal

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. There is the appearance of a small anechoic, circular/cystic structure in the dorsal apical area of the urinary bladder. This could be consistent with some accumulated debris, or a urethral diverticulum. It measures at 1.20 x 1.53 cm.

The left kidney has a normal shape and size (4.76 cm). Overall echogenicity is normal with adequate 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 (4.91 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.

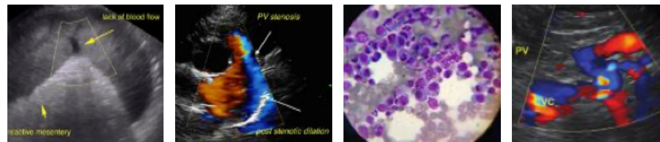
Adrenal Glands
The left adrenal gland is normal in size (0.73 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size (0.56 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 large 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 gall bladder 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.



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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 (0.45 cm), jejunum (0.36 cm) and ileum have a uniform diameter with minimal fluid distension. Wall appears subjectively, mildly increased. Bowel loops follow a typical curvilinear path with distinct wall layering. 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. The descending colon appears somewhat corrugated and thickened (up to 0.36 cm) with some intraluminal fluid and intact wall layering. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The pancreas is large and hypoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is evidence of regional mesenteric inflammation. Consistent with (mild/moderate or severe) 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.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Irregular cystic-appearing structure visualized in the dorsal apical area of the urinary bladder – This could be consistent with a urethral diverticulum. Alternatively, this could be an irregular accumulation of debris, etc.

- Hypoechoic prominent left and right lumen of the pancreas, with mildly reactive surrounding mesentery - The pancreatic changes are most consistent with mild pancreatitis/pancreatic infiltration. Recommend fPLI testing and continued monitoring for improvement or possible development of a pancreatic abscess. Consider fine needle aspirate if not improving.

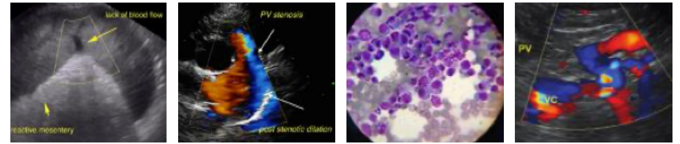
- Large heterogenous liver - The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy.

- Subjectively thickened small intestine - The mild small intestinal wall changes may be a normal variant in this patient or could be consistent with an inflammatory process (e.g., inflammatory bowel disease).

- Thickened/corrugated descending colon – Findings are most consistent with colitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Th pancreas appears somewhat prominent in both the left and right limbs. It does not appear overtly



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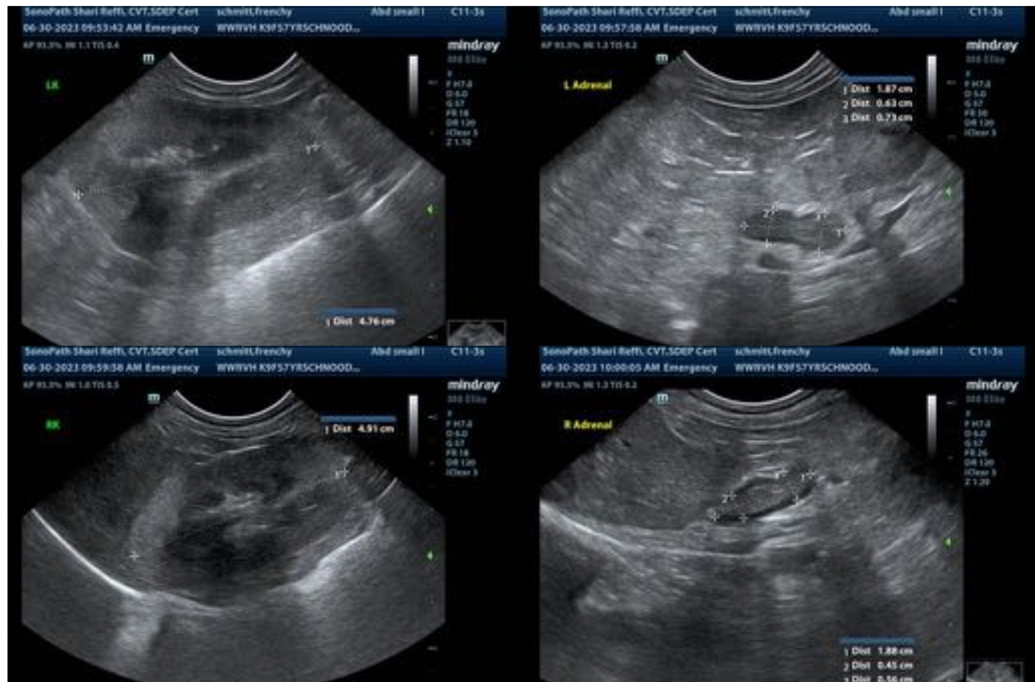
swollen, but does have some reactive mesentery in the area. These changes are most consistent with mild pancreatitis. Unfortunately, the appearance of the pancreas does not always correlate with the severity of symptoms present. Recommend continued medical treatment for pancreatitis. Additionally, the suggestion of diffuse small intestinal thickening and a corrugated thickened colon wall, and significance of the colonic changes is uncertain. Continued monitoring for developing diarrhea, etc. is warranted. If chronic gastrointestinal signs are present, you could consider an upper and lower GI endoscopy to biopsy the small and large bowel.

If not already done, recommend a fasting triglyceride and cholesterol level, when this has resolved to determine if this patient has hyperlipidemia, and if additional medical therapy is warranted.

The liver is large and heterogenous. A breed-specific vacuolar hepatopathy is suspected, but a liver function test, +/- fine-needle aspirate could be considered.

There is a cystic structure visualized in the dorsal apical region of the urinary bladder. This is suspicious for a urethral diverticulum. If there is a history of recurrent UTIs, then additional evaluation would be warranted, with a contrast study, etc. If there is no such history, then this may be incidental and continued monitoring is warranted. Additionally, you could have an accumulation of intraluminal debris which could mimic this appearance A urinalysis and culture can be considered.



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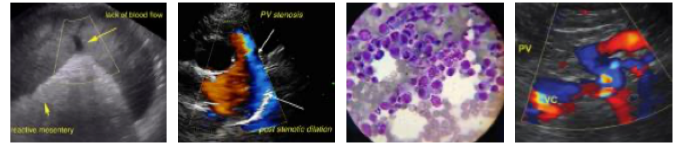

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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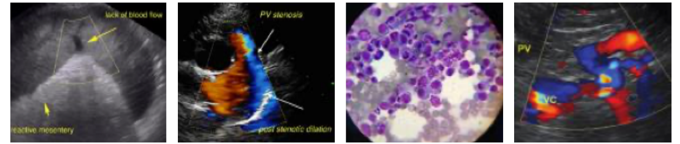

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