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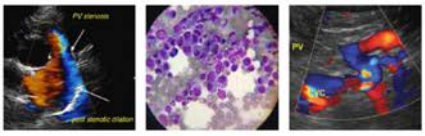

SonoPath
Clinical Sonography & Telecytology
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PATIENT

Obi Mauney

SPECIES

Canine

BREED

Shih Tzu X

SEX

Neutered Male

AGE

7 Years

WEIGHT

15 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Amy Mayhew, LVT

HOSPITAL NAME

SVS Imaging MI

REFERRING VET

Wixom Family Pet Practice

INVOICE

38523

DATE

6/8/22

PRESENTING CLINICAL SIGNS

No current medication. Patient History: Presented for weight loss (- 1.6#) and inappropriate urination and defecation.
Abnormal PE/Chem/CBC/UA Results: Abnormal Examination Findings: CBC - MONO 0.13 (0.14-1.97) Chem - P 6 (1.9-5), CHOL 424 (120-310), GGT 16 (0-14) T4 - 1.15 (1.2-4.3) UA (cysto) - SpG 1.008, pH 5, WBC 1-2+ Thinning coat over muzzle, dorusm, exterior pinnae, caudal tarsi. Skin appears normal. Diffuse muscle atrophy, prominent spinous processes.

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 (0.80 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 (4.97 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 (4.65 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 “plump” in size measuring 0.68 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/borderline “plump” in size measuring 0.67 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 normal in size with smooth peripheral margins. The parenchyma is hyperechoic and homogenous in 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 appears hyperechoic and prominent, measuring at 0.24 cm. It generally has a smooth mucosal surface. There is a moderate amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.

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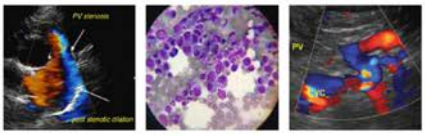

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Gastrointestinal

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 uniform diameter with minimal fluid distension. Wall appears subjectively, mildly increased. Bowel loops follow a typical curvilinear path with distinct wall layering. Duodenum wall measured 0.41 cm. Jejunum wall measured 0.36 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. In some images, the transverse colon appears somewhat thickened, measuring at a maximum of 0.40 cm with normal intact wall layering. Generally, the descending colon appears relatively normal. All sections of colon are visualized with formed fecal material and gas shadowing distally.

Pancreas

The pancreas is prominent and mottled compared to the surrounding isoechoic mesentery (particularly the right limb). 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

- Borderline “plump” adrenal glands – 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.
- 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.
- Hyperechoic liver – The diffuse hepatic changes are non-specific and can be seen with vacuolar hepatopathy, reactive change, nodular hyperplasia or, less likely, inflammatory/immune-mediated disease, infiltrative neoplasia, or other hepatopathy.
- Prominent/thickened gallbladder wall – This could represent a normal anatomic variant or cholecystitis.
- 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).
- Prominent/thickened transverse colon – Wall layering remains intact, so findings would be most consistent with inflammation of the colon.

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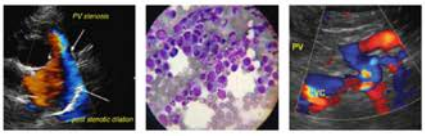

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No severe focal lesions are observed to explain the weight loss reported. Both adrenals seem somewhat "plump" for a dog of this size. If clinical signs were consistent with Cushing's, then you could consider adrenal function testing (reported symptoms do not see classic).

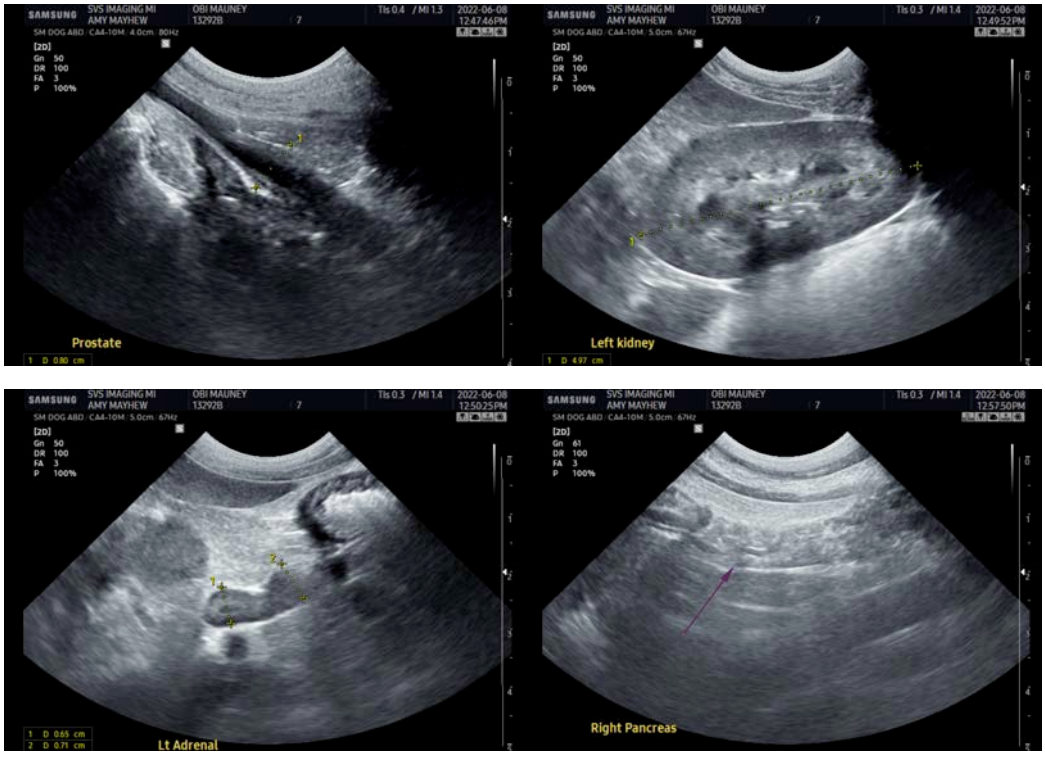
The changes reported in the liver, gallbladder and pancreas are somewhat mild and subjective. With no overt GI signs and no liver enzyme elevations reported, the significance of these changes is unclear. Continued monitoring could be considered, or if there is concern for round cell neoplasia, a fine needle aspirate of the liver and/or a GI panel to Texas A&M for a qualitative PLI, TLI, cobalamin and folate to further evaluate the pancreas and the small intestine.

The small and large bowel appeared subjectively somewhat thickened with intact wall layering. In the absence of GI signs, the significance of this is unclear. The aforementioned GI panel may be helpful to help determine the significance of these changes.

- Consider a novel protein/hydrolyzed protein prescription diet.
- Recommend probiotic therapy.
- Monitor caloric intake to ensure there has been no changes in appetite, diet, etc. to explain the weight loss.

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

Recommend urinalysis and urine protein to creatinine ratio to rule out proteinuria.



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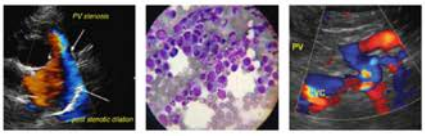

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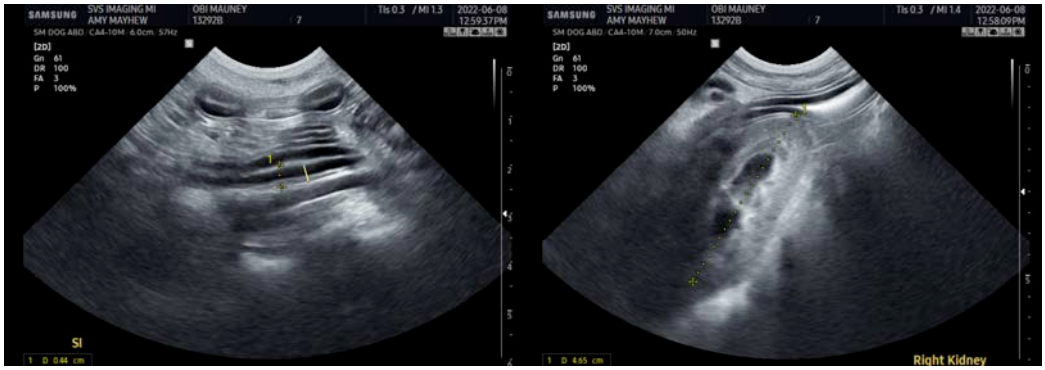

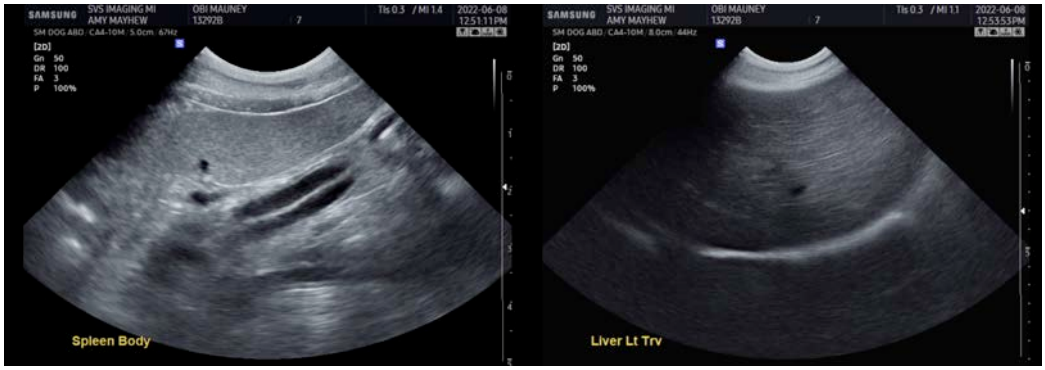

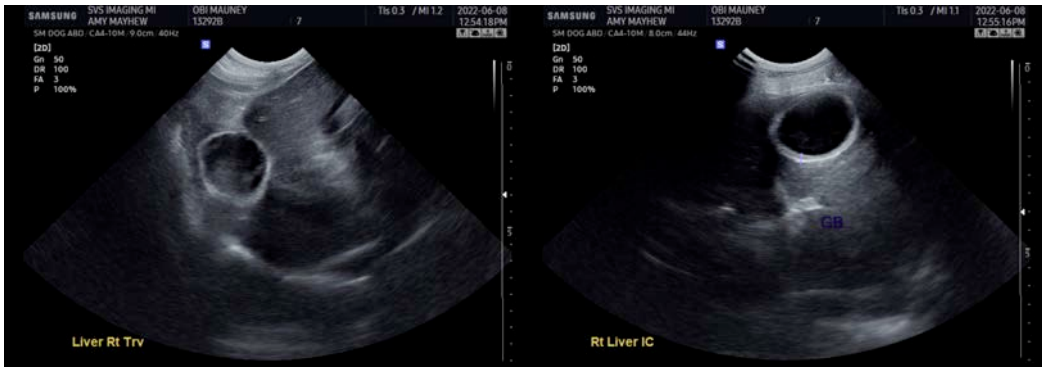

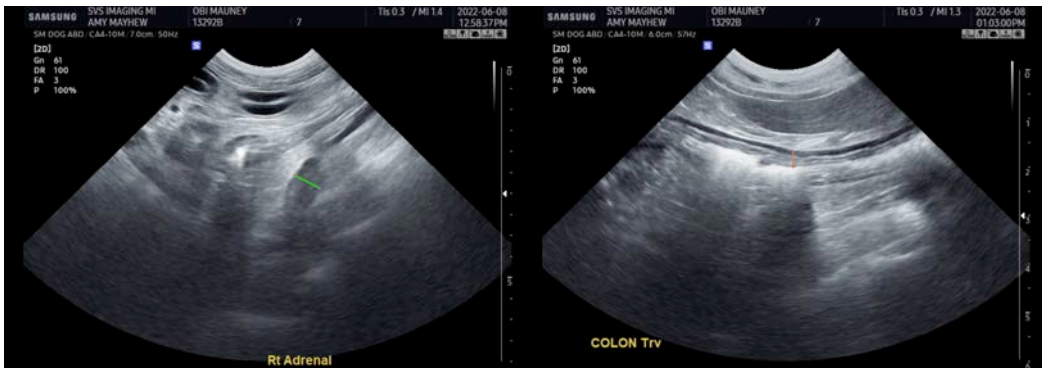

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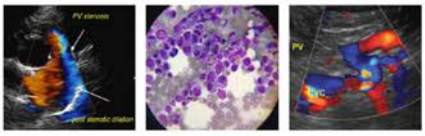

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

kathleen.sennello@sonopath.com