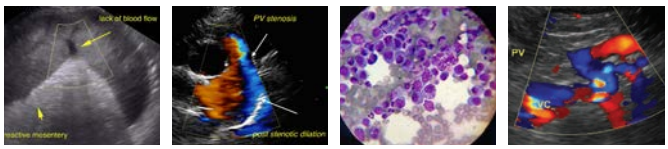


SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Fleet Wilson

SPECIES

Canine

BREED

Ciarn Terrier

SEX

Neutered Male

AGE

12.5 Years

WEIGHT

10.6 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Trudeau

HOSPITAL NAME

Petworks VH

REFERRING VET

Dr. Trudeau

INVOICE

43882

DATE

7/11/23

PRESENTING CLINICAL SIGNS

Chronic vomiting & diarrhea - intermittent. Recently with fresh blood in vomit & stools. In the past has lasted ~24hours and self resolved, recently occurring more frequently and more intense. His appetite declines significantly as well. Currently on Sucralfate & famotidine - may add in cerenia/metronidazole over Canada day weekend if persisting.

Abnormal PE/Chem/CBC/UA Results: CBC - NSF Chem - mild increase ALT and mild decrease in Phos - otherwise NSF 4Dx - neg

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 (0.85 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 (4.38 cm) with numerous small cortical cysts, the largest of which measures approximately 0.89 cm and has some surrounding hyperechoic tissue. Others visualized measure 0.47 cm and 0.52 cm. Overall echogenicity is slightly hyperechoic with mildly reduced 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 (4.5 cm) with numerous small cortical cysts, one of which measures at 0.44 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 normal in size measuring 0.32 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.

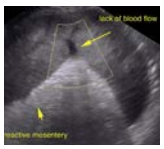
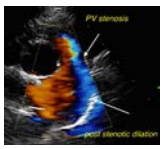
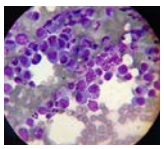
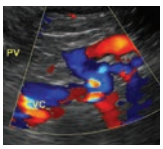
The right adrenal gland is normal in size measuring 0.49 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

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, and echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of

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the vasculature and biliary tract appear normal. An ill-defined hyperechoic nodule is visualized on the left side measuring 1.5 cm in diameter.

The gall bladder lumen is significantly distended. Some areas of the wall appear mildly thickened with adherent debris. There is a large amount of primarily non-organized echogenic debris. There is no evidence of bile duct dilation.

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. On several views there is a somewhat ill-defined hypoechoic region visualized associated with the gastric wall, measuring approximately 1.29 cm x 1.60 cm. This has the appearance of possible artifactual thickening, but is repeatable in many images. Recommend continued monitoring.

The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal fluid distension. Wall thickness is increased. Bowel loops follow a typical curvilinear path. Some areas have reduced detail of wall layering. Duodenum wall measures 0.51 cm. Jejunum wall measures 0.48 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 pancreas is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

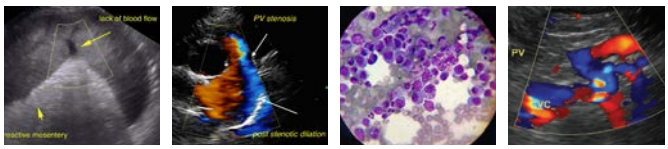
Free Abdomen

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

- Decreased corticomedullary distinction in both kidneys with numerous small cortical cysts – Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis. One of the cystic regions in the left kidney is surrounded by hyperechoic mesentery, creating a “nodule effect”. Recommend continued monitoring of this lesion.

- Heterogeneous liver with ill-defined hyperechoic nodule – 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 appearance of the hyperechoic nodule trends towards a benign etiology.



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- Moderate/large amount of hyperechoic gallbladder debris with some debris adhered to the gallbladder wall – A large amount of debris is evident in the gall bladder with no evidence of a mucocele or associated inflammation at this time. This could represent an early mucocele or cholestasis, with minimal evidence of associated inflammation at this time. Continued monitoring of labwork and ultrasound are warranted for progression of this lesion. Ursodiol therapy could be considered.

- Focal hypoechoic region to the gastric wall – The significance of this is unclear. This could represent artifact, focal edema, inflammation, or less likely an early mass effect.

- Diffuse thickening of the small intestine – The bowel wall thickening could be consistent with inflammation, edema, or infiltrative neoplasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The small bowel appears diffusely thickened with intact wall layering. This could be consistent with an inflammatory process, but biopsies would be necessary to confirm.

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, then GI biopsies may be indicated.

On several views, there is a focal hypoechoic region of the stomach wall. Initial evaluation is suggestive of an artifactual lesion, but it is repeatable in some views, so consider reevaluation of this area in the future (8-12 weeks) to confirm that it is not changing/progressing. If surgical biopsies are pursued for the GI tract, recommend gross evaluation of this region and possible biopsy.

Both kidneys have age related change and numerous small cortical cysts. These are likely benign in nature, but continued monitoring is warranted.

There is a large amount of debris in the gallbladder, and some of this debris appears adhered to the gallbladder wall with minimal wall thickening or surrounding inflammation. Consider starting Ursodiol and monitoring the liver values and gallbladder debris for possible progression of this lesion.

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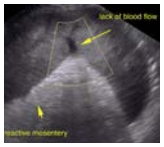
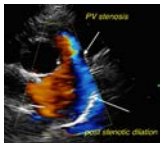
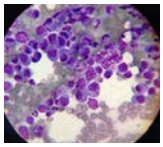
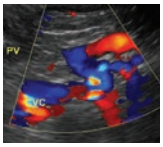

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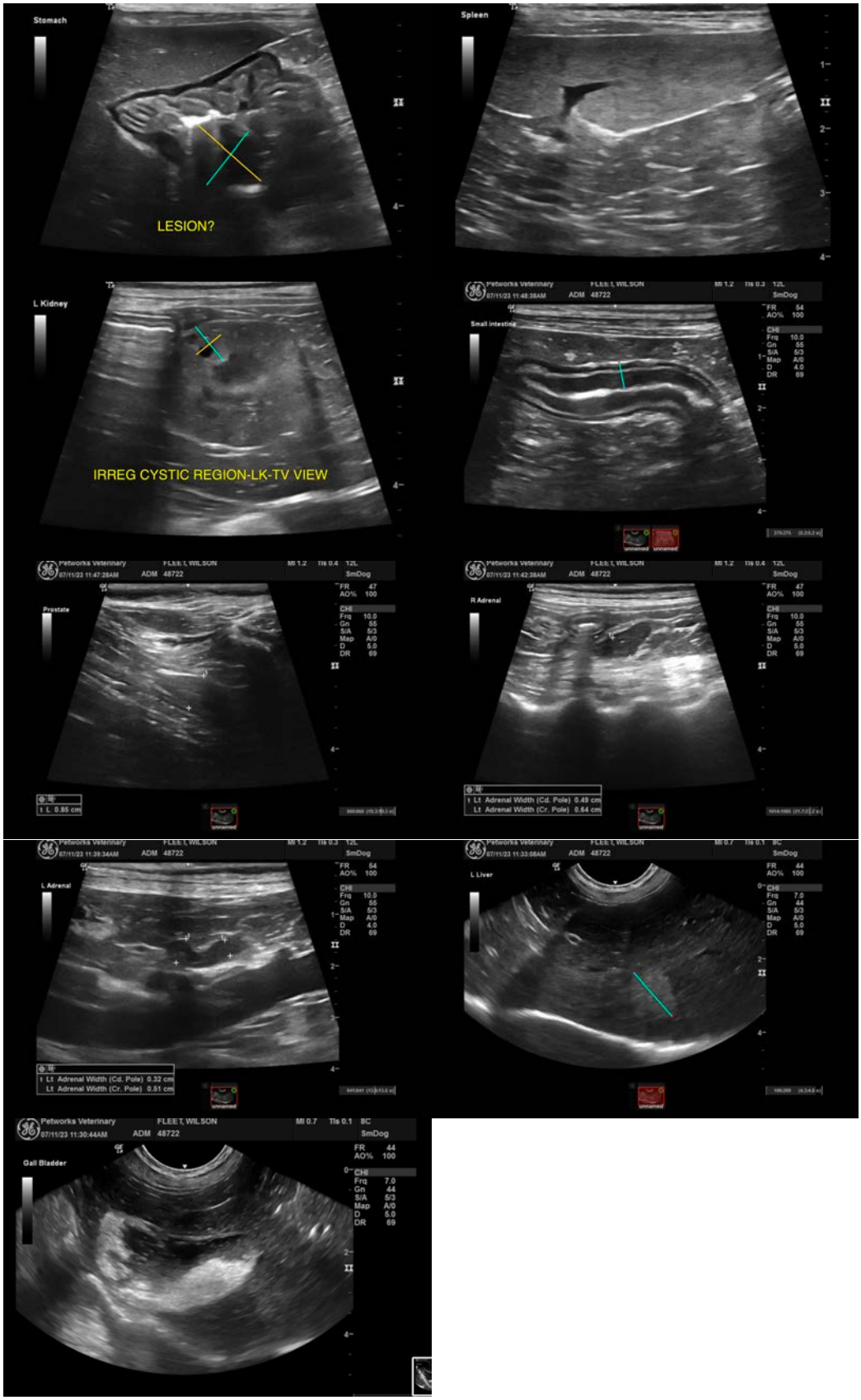

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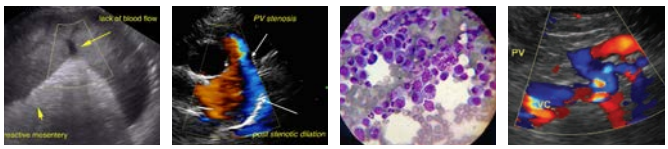

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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