



PATIENT PRESENTING CLINICAL SIGNS

Miss Molly King

History: short of breath, coughing, decreased appetite but will eat meal with chicken on board heart murmur increased from grade 4 to ~grade 5 with thrill. no wheezes noted significant redundant tracheal membrane. heart very reverse D shaped Previous echo done Nov 1/22. Current Medications Gabapentin, Benazapril, Vetmedin, Prednisone

SPECIES

Canine

BREED

Havanese

Abnormal PE/Chem/CBC/UA Results: HR 120 RR 30 Radiographic Findings x-ray report shows a mildly enlarged heart and redundant tracheal membrane as already suspected/known as well as her bladder stones. Additionally, her liver is slightly enlarged.

SEX

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Female Spayed

Urinary System

AGE

12 years

The urinary bladder is moderately distended with echogenic urine. The urinary bladder wall is diffusely thickened and irregular, with maximal irregularity in thickness occurring in the apical region (where it measures approximately 0.73 cm) with adherent mineralizations. Additionally, there is a large, mobile, shadowing mineralization most consistent with a large calculus (measuring approximately 1.35 x 1.61 cm). The area of the trigone, ureteral papillae and proximal urethra appear free of any calculi or mass lesions.

WEIGHT

8.6 kg

The left kidney has a normal shape and size (4.48 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. Numerous nonobstructive cortical mineralizations/nephroliths are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

INTERPRETED BY

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

The right kidney has a normal shape and size (5.03 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. Numerous nonobstructive cortical mineralizations/nephroliths are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal

IMAGING PERFORMED BY

Kelly Reschny

Adrenal Glands

HOSPITAL NAME

Beattie PH Ancaster

The left adrenal gland is normal in size (0.53 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.

REFERRING VET

Davis

The right adrenal gland is normal in size (0.61 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.

INVOICE

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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.

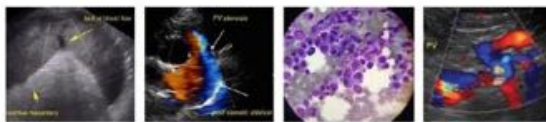
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Liver

The liver is subjectively 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 has irregular polypoid projections and there is a moderate amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.


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Gastrointestinal

The stomach is moderately dilated with fluid and irregular shadowing material most consistent with normal ingesta and gas. 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 layering 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 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 (0.38 cm) and the jejunum measured as normal (0.27 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

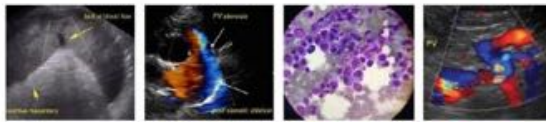
The area of the pancreas is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

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
Primary Findings

- Irregular thickened mineralization apical bladder wall with cystic calculi – Recommend urinalysis and culture. Correlate the size of the stone with radiographs. Recommend continued monitoring of the irregular area of the urinary bladder wall, if an underlying neoplastic process cannot be ruled out.
- Nonobstructive mineralizations/nephroliths visualized in both kidneys – Hyperechoic foci are visualized in the kidney most consistent with nephroliths. There is no current evidence of obstructive disease. Correlate findings with abdominal radiographs, urinalysis, and culture. Continued monitoring is warranted for progression/obstruction.
- 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.
- Moderate gallbladder polyps - The significance of the gall bladder polyps and debris is unclear. This could represent an early mucocele, cholestasis, or chronic inflammation, or could be an incidental finding.
- Moderate shadowing ingesta within the gastric lumen - Correlate with the feeding history and abdominal radiographs. If the patient was adequately fasted consider such differentials as delayed gastric emptying, a partial outflow tract obstruction (none seen) or ingested foreign material.



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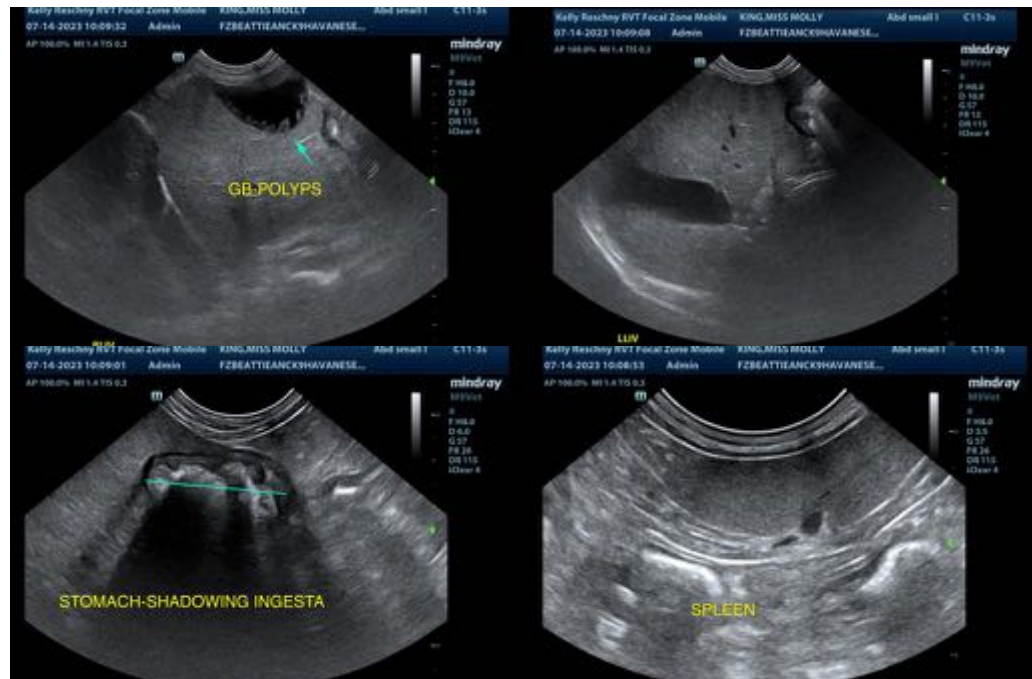
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

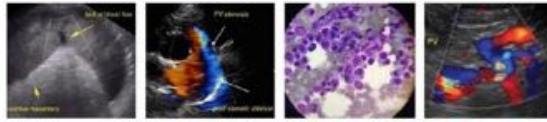
There are several irregularities noted on today's examination, none of which would definitively cause an acute decrease in appetite. Consider the possibility of more advanced cardiac disease and shortness of breath as a significant factor.

There is a bladder stone and a thickened, irregular, mineralized bladder wall noted. Correlate with clinical signs (Does this patient has pollakiuria, stranguria, etc.?). Recommend a urinalysis and culture. If an infection is present, recommend treatment and reevaluation of the urinary bladder on antibiotics to see if some of the irregular and wall thickening resolves, as I cannot rule out the possibility of a concurrent mass effect. Ideally, the stone would be removed and the bladder wall biopsied, but correlate this with the other issues at hand, as I'm not sure if this is causing a clinical issue at this time. Additionally, correlate with abdominal radiographs to ascertain the size of the stone, and if it could be removed via cystoscopy, etc.

The liver is large and heterogenous with no focal lesions. This is a nonspecific finding. Correlate with lab-work. If there is concern about liver function, consider pre-and postprandial bile acids. There is a moderate amount of debris in the gallbladder and some small gallbladder polyps, but minimal surrounding inflammation. Ursodiol and a course of antibiotics, given in conjunction with probiotics (spaced 2 hours apart) could be considered for treatment of possible cholecystitis, if liver enzyme elevations are present.

There is a moderate amount of shadowing ingesta within the gastric lumen. Correlate this with the feeding history. If the patient was fasted, then consider such differentials as delayed gastric emptying or a partial pyloric outflow tract obstruction (none observed).





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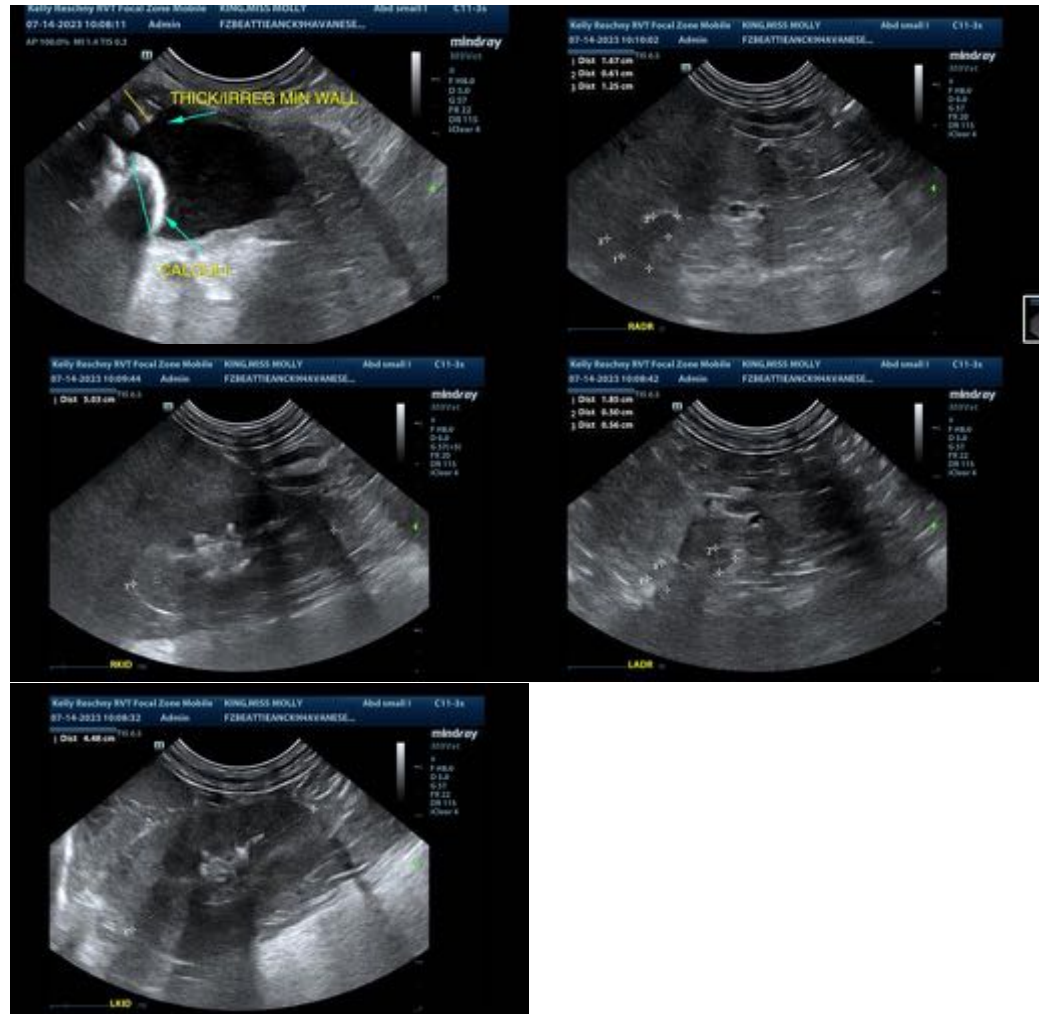
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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