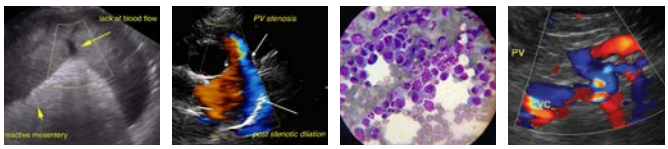
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Rocky Bajakian

SPECIES
Canine

BREED
Yorkshire Terrier

SEX
Neutered Male

AGE
8 Years

WEIGHT
15.4 Pounds

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

IMAGING PERFORMED BY
Kelly Vazquez

HOSPITAL NAME
Northvale Vet Clinic

REFERRING VET
Dr. Stefanie Simon

INVOICE
39885

DATE
7/27/22

PRESENTING CLINICAL SIGNS

Patient presents for abdominal ultrasound after vomiting black emesis and having black stool on Sunday with anorexia, better now, no treatment or medications given. No current meds.
Abnormal PE/Chem/CBC/UA Results: CBC/Chem: WNL. Fecal and 4DX all negative.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly distended with anechoic urine. Much of the wall appears normal, but there is an area that appears diffusely thickened, measuring at 0.78 cm. The area of the trigone, ureteral papillae and proximal urethra appear normal with no evidence of a mass lesion or calculi. Findings could be consistent with focal cystitis or a mass lesion, but most likely are consistent with lack of urine distention. Recommend reevaluation with a full bladder.

The prostate is normal in size (0.50 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 (3.67 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 (3.27 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 measuring 0.47 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 0.36 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.

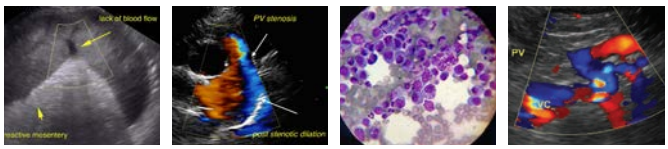
Spleen

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 the vasculature and biliary tract appear normal. There are very ill-defined, hypoechoic lesions within the liver, consistent with hypoechoic nodules measuring 0.53, 0.50, 0.65 cm.

The gallbladder 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 is moderately dilated with gas and a small amount of fluid/ingesta/irregular shadowing material. It measures at a normal thickness of 0.33 cm 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. The entirety of the stomach cannot be evaluated due to shadowing intraluminal contents.

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. Duodenum wall measured 0.37 cm. Jejunum wall measured 0.33 cm. Visualized peristalsis appears appropriate. In some images, there is a section of bowel that appears somewhat thickened, measuring 0.52 cm in wall thickness, and wall layering appears somewhat distorted and ill-defined.

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

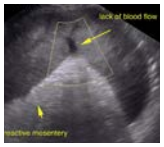
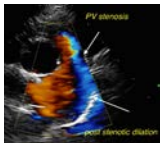
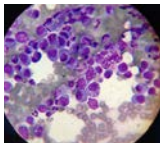
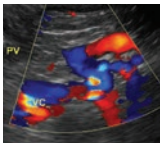
Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Area of thickened urinary bladder wall – could be consistent with focal cystitis or an early mass lesion. Alternately, this could be artifact due to lack of urine distention. Recommend urinalysis, culture, and reevaluation with a distended bladder.
- Heterogeneous liver with ill-defined hypoechoic nodules – 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.
- Small amount of intraluminal gastric material with significant gas interference – correlate with feeding history and abdominal radiographs. If the patient was adequately fasted, this could represent delayed gastric emptying or ingested intraluminal material.
- Focal area of small intestine that appears thickened and has reduced distinction of wall layering – 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).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A focal lesion involving the bowel or gastric wall is not readily visualized. Some of the gastric wall cannot be readily evaluated due to interference from intraluminal gas, so a gastric lesion cannot be ruled out. Correlate with abdominal radiographs. While no focal bowel mass is observed, there is a section of small intestine that appears somewhat thickened with reduced detail of wall layering. This could be due to

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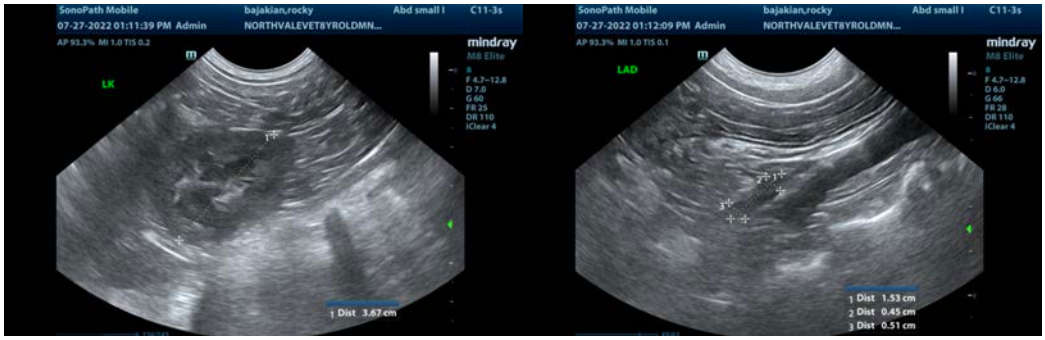
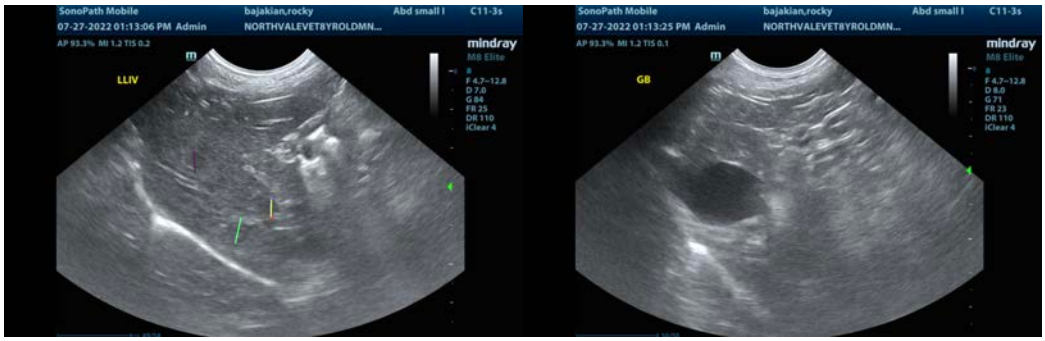
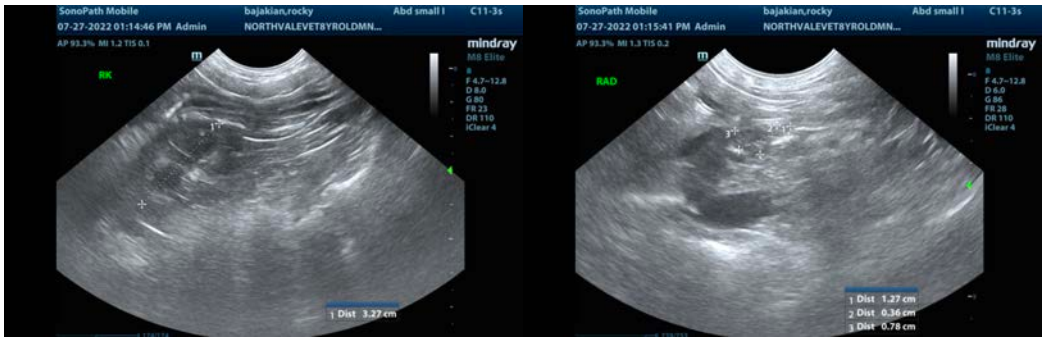
inflammation, edema, or even infiltration of neoplastic cells, etc. Consider treatment for acute gastric ulceration and enteritis with IV fluids, antibiotics, and anti-ulcer therapy. Recommend bloodwork and ACTH stimulation test, and radiographs. If symptoms persist, consider upper GI endoscopy. Additionally, consider reimaging of the abdomen to reevaluate the thickened section of bowel observed. If this persists or has progressed, surgical evaluation may be necessary.

There is some mild focal thickening of the urinary bladder wall. Recommend reevaluation of the urinary bladder with a fully distended bladder to determine if the lesion persists. If it does, recommend urinalysis and culture +/- intrahepatic catheterization, etc. to look for evidence of neoplastic disease.

The liver is somewhat heterogeneous with ill-defined nodules. The appearance of these nodules trends towards a more benign process, but underlying neoplasia cannot be ruled out as a possibility. If liver enzyme elevations are present, consider a liver function test and a fine needle aspirate of the liver.







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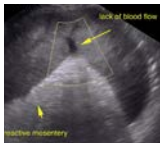
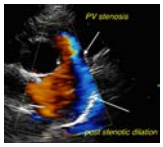
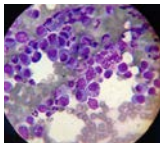
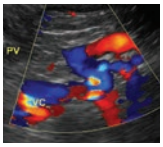

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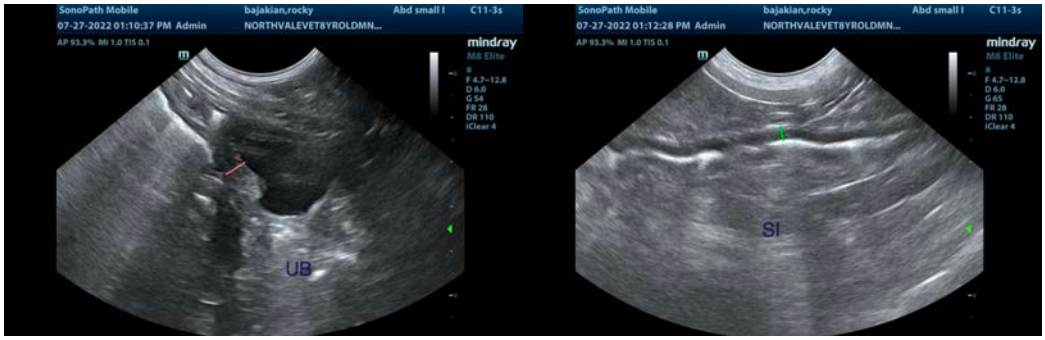

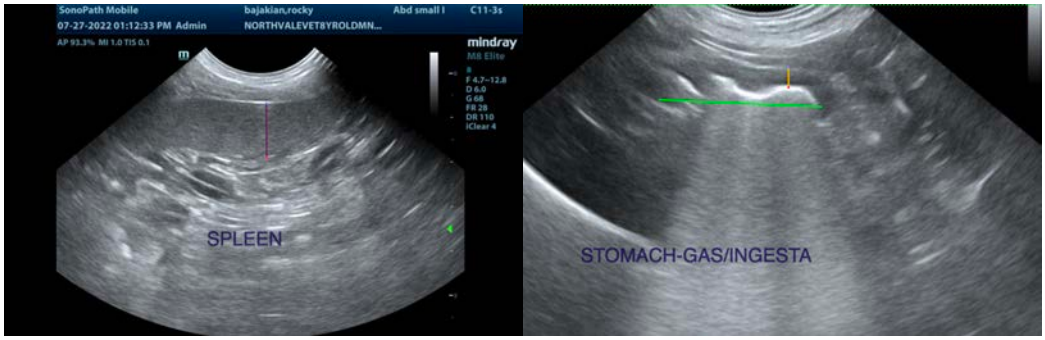

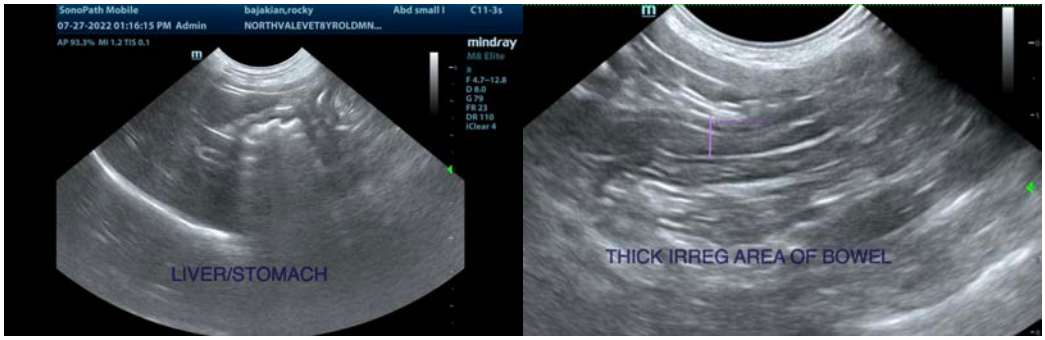

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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kathleen.sennello@sonopath.com