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Clinical Sonography & Telecytology
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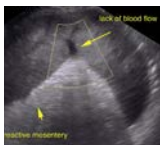
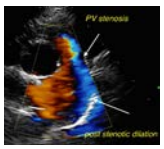
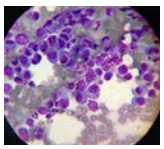
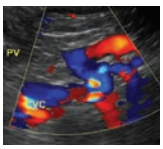





SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Gracie Turetzky

SPECIES

Canine

BREED

Lab X

SEX

Spayed Female

AGE

11 Years

WEIGHT

20.7 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Matthew Olcha

HOSPITAL NAME

East Meadow Vet Center

REFERRING VET

Dr. Matthew Olcha

INVOICE

39239

DATE

7/6/22

PRESENTING CLINICAL SIGNS

Hyporexia and lethargy ongoing for 3-4 weeks. Soft stool. Lost 3kg since May. P is on proin for incontinence and apoquel as needed for atopy.
Abnormal PE/Chem/CBC/UA Results: Hypoalbuminemia >SDMA Isosthenuria (no proteinuria noted)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly distended with anechoic urine. The mucosal surface of the urinary bladder appears somewhat irregular. The area of the trigone, ureteral papillae and proximal urethra appear free of any large mass lesions or calculi. Findings are most consistent with cystitis or lack of urine distention.

The left kidney has a normal shape and size (5.4 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 (6.0 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 region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. 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.

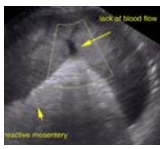
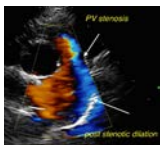
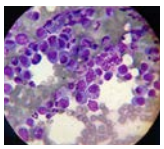
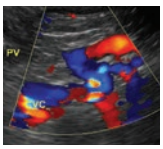
Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous 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 is not thickened and has a smooth mucosal surface. Luminal contents are primarily anechoic. The cystic and common bile ducts are normal/not visible.

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.

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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. Jejunum wall measured 0.45 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

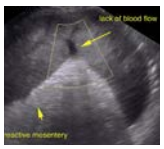
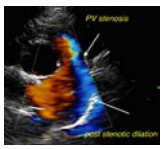
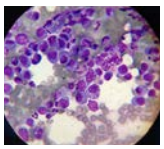
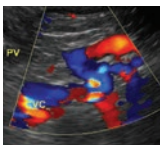
- Slightly irregular urinary bladder mucosa – The bladder mucosal changes could be consistent with cystitis or artifactual due to lack of adequate luminal distension. Bladder neoplasia cannot be ruled out but is considered unlikely in this patient.
- Heterogeneous liver – The diffuse hepatic changes 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).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No large focal mass lesions were observed. There is no free fluid evident, etc. In general, for a low albumin, we consider three primary categories. The first is renal disease (seems unlikely based on lack of significant proteinuria). The second is liver disease. This seems less likely, but the liver is slightly heterogeneous. Recommend pre- and post-prandial bile acids to evaluate liver function. The third most likely category would be a protein losing enteropathy. No focal bowel lesions were observed, but they can still be present, or this more likely represents diffuse disease.

There was subjective small bowel thickening on today's scan. If liver function is normal, consider further evaluation for this protein losing enteropathy. The most common categories of differentials would include IBD, lymphangiectasia, or intestinal neoplasia, although other differentials exist, such as GI parasitism, Addison's disease, etc. Obtaining a diagnosis is very important, as this impacts how to treat these individuals. A definitive diagnosis often requires GI biopsies.

- Consider a novel protein/hydrolyzed protein prescription diet, or if lymphangiectasia is suspected, an ultra low-fat diet.
- Consider probiotic therapy.

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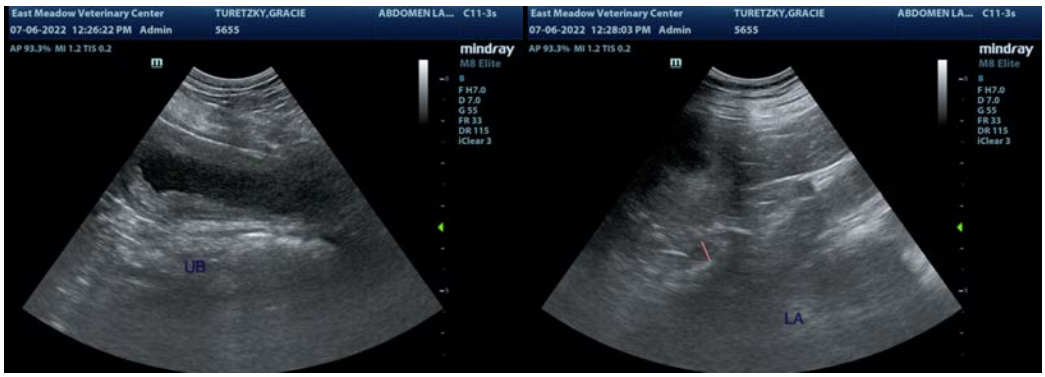
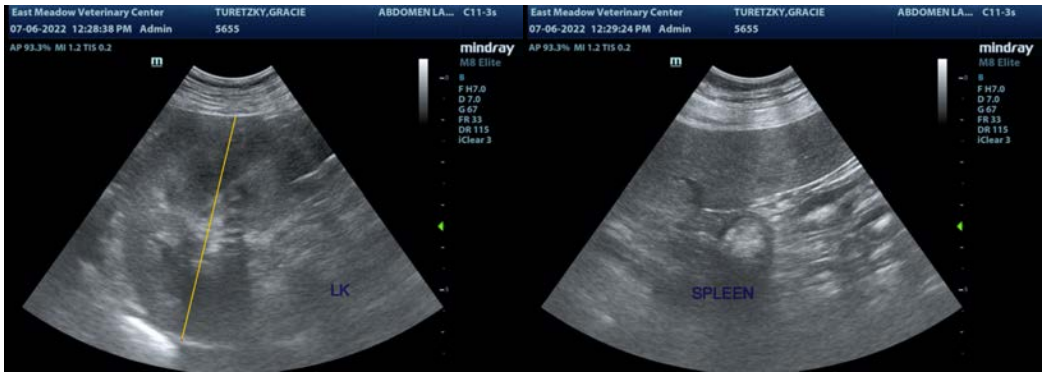
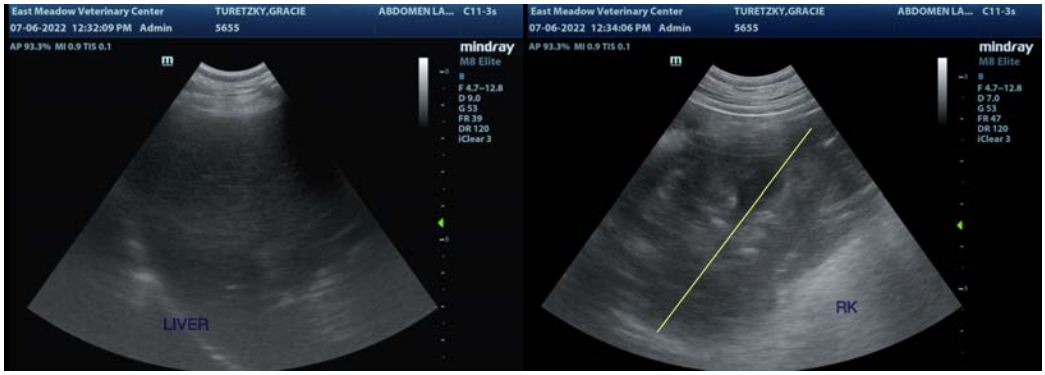
- Recommend a GI panel to Texas A&M for a qualitative PLI, TLI, cobalamin and folate to further evaluate for small intestinal disease.
- Examine the stool for any evidence of melena. If present, consider anti-ulcer therapy.
- Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.
- If low albumin levels persist, recommend obtaining GI biopsies.

The urinary bladder mucosa appears somewhat irregular and thickened. This may be due to lack of distention of the urinary bladder. Recommend urinalysis and culture to rule out a concurrent infection with cystitis.







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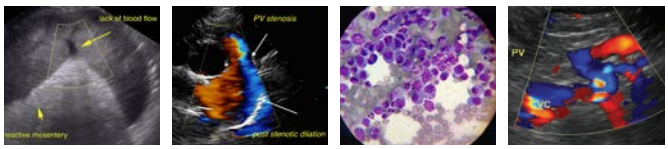

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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