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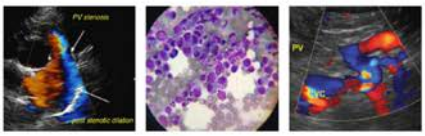
fredgromalak@gmail.com



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PATIENT

Lily Stark 274108

SPECIES

Canine

BREED

Beagle

SEX

Spayed Female

AGE

9 Years

WEIGHT

13.6 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VET

WVRC – Dr. Sevde

INVOICE

39298

DATE

7/8/22

PRESENTING CLINICAL SIGNS

Presented for evaluation of progressive inappetence. Lily was boarded over the weekend approx 2 weeks ago. No concerns reported and she appeared normal for the first few days she was home. Over the past week she had become progressively inappetence. Initially she was sniffing her food and eating slower than progressively eating less. Normally eats FROMM. She last ate a normal meal on Friday. Her owners have been tempting her since. Last offered chicken. She will eat a bite here and there but not much. Recheck with rDVM on 7/6: Had vomited that morning - this was a small amount of chicken that Lily had eaten as well as some food from 36-48 hours prior Treated supportively with maropitant 15 mg SC, metoclopramide 2.5 mg SC Owner reports no improvement after this and interested in pursuing AUS
Abnormal PE/Chem/CBC/UA Results: rDVM 7/5: - 2 view abdominal rads (uploaded): stomach is normal axis, on lateral the pylorus appears slightly distended with fluid or mass but less concerning on VD -rDVM BW: Hct 48%, WBC 7.9 K/uL, Plt 252 K/uL Glu 81, BUN 7, Cre 0.7, Alb 3.7, Glob 2.6, ALT 2.6, Chol 308, ALT 52, ALKP 272 (H normal 131) tT4 <0.5 (L)

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 left kidney has a normal shape and size (5.6 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 (5.93 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 0.41 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 large 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. There are occasional ill-defined hypoechoic nodules visualized in the parenchyma, examples measure 0.33, 0.54, and 0.94 cm x 0.75 cm.

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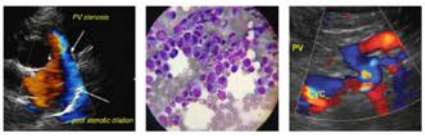

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The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are primarily anechoic. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains mild fluid. 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 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 0.43 cm. Jejunum wall measured 0.31 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. An occasional mesenteric lymph node is visualized, one measures 0.43 cm. The omentum is of normal echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Hyperechoic liver with ill-defined hypoechoic nodules – 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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes observed on today's scan are relatively mild and non-specific. An obvious cause for the reduced appetite and occasional vomiting is not readily apparent. There is a small amount of fluid within the gastric lumen, but no obvious evidence of an obstructive process, although small foreign objects can sometimes be difficult to visualize. Continued monitoring and serial imaging is warranted. Additionally, you could consider primary gastrointestinal disease or pancreatitis, which is not evident on today's scan.

- Consider a novel protein/hydrolyzed protein prescription diet.
- Consider a GI panel to Texas A&M with a qualitative PLI, TLI, cobalamin and folate to further evaluate the pancreas and small intestine.
- If symptoms persist, you could consider obtaining GI biopsies in an effort to rule out foreign material and look for primary gastrointestinal disease.

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

The liver is slightly hyperechoic with some ill-defined nodules, and there is a mild elevation in ALP. This could be an incidental finding, but if there is concern for liver dysfunction, you could consider pre- and

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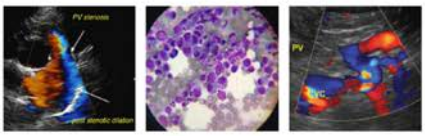

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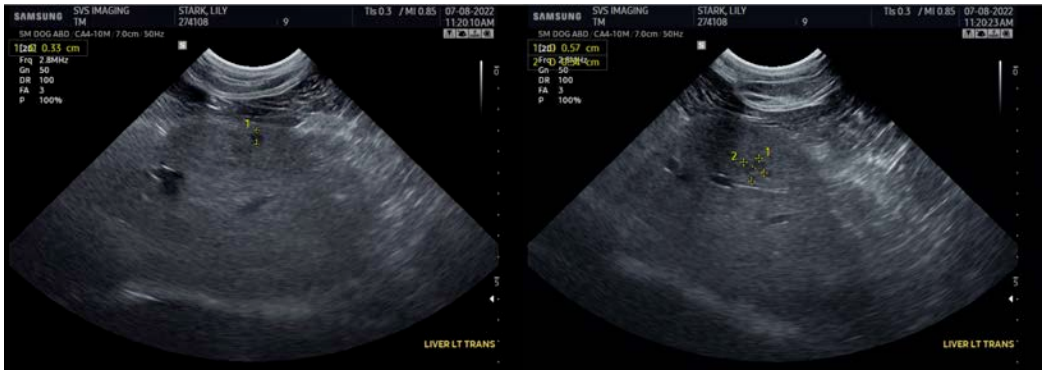
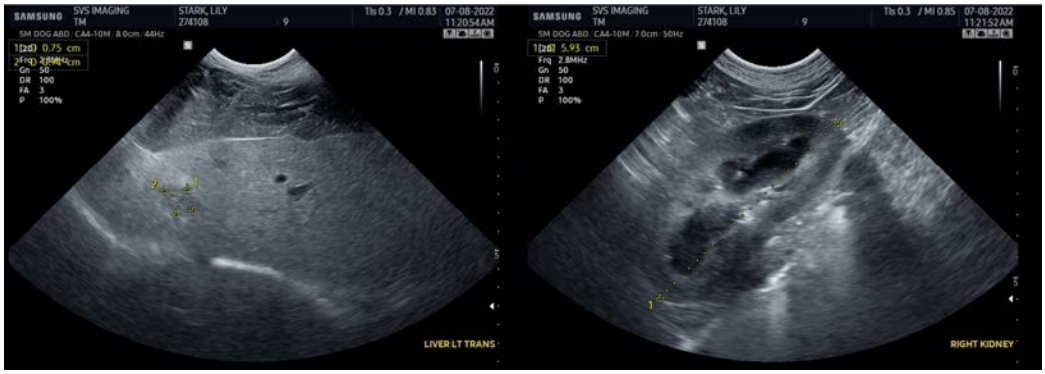
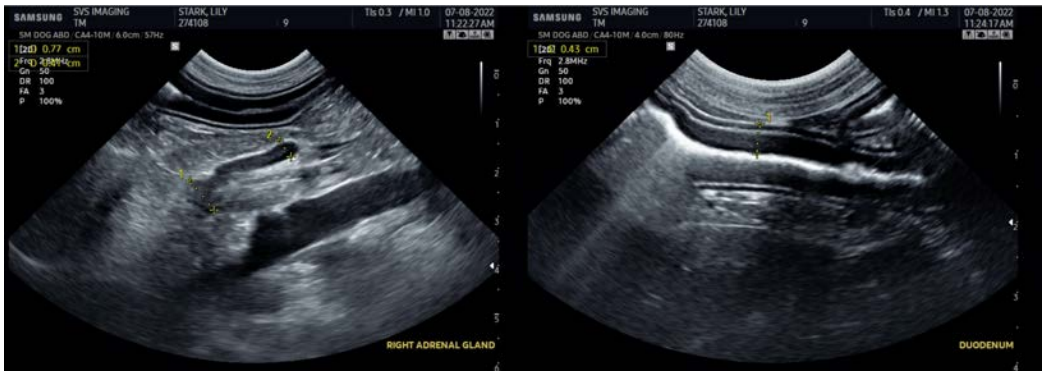
post-prandial bile acids and a fine needle aspirate of the liver. For now, recommend general therapy for acute gastroenteritis.







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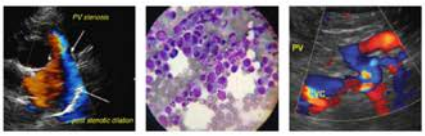

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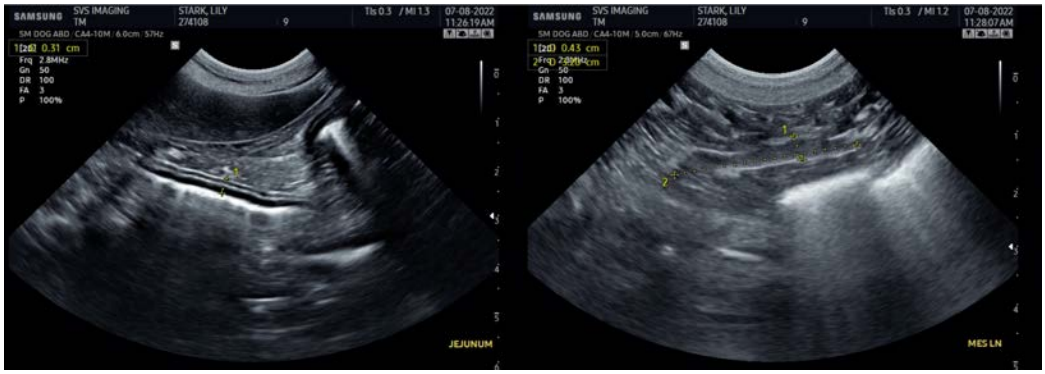

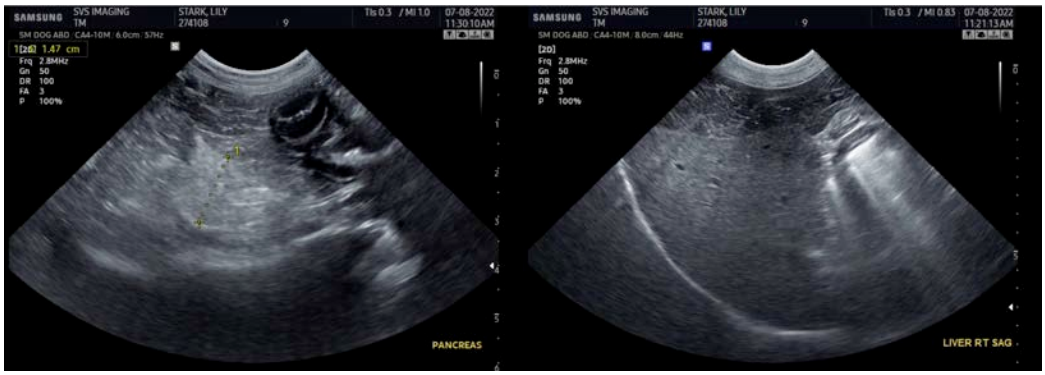

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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