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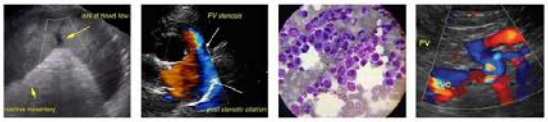

IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Ava Nunes

SPECIES

Canine

BREED

Yorkie

SEX

Spayed Female

AGE

4 Years

WEIGHT

5.3 Pounds

INTERPRETED BY

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

IMAGING BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

Monte Vista AH

REFERRING VET

Dr. Alexandra Moore

INVOICE

40536

DATE

8/16/22

PRESENTING CLINICAL SIGNS

Patient has chronic intermittent history of hematochezia/mucoid soft stools per O. Occasionally she vomits (frothy bilious fluid) after missing a meal (very picky, always has been). Now that she is eating the new dog food (O doesn't know brand specifics) and they are not changing diet often or giving extra treats/etc her GI symptoms have improved.

Abnormal PE/Chem/CBC/UA Results: Spec CPL (1067)-AND marked elevation of the TLI.(numbe r not provided) Fecal- No Ova or Parasites seen. Negative for Hookworm, Whipworm, and Roundworm Antigen. Fecal PCR- Negative for Cryptosporidium/Giardia/Salmonella/ Circovirus/Coronavirus/Parvo/Distemper/Campylobacter/C. Dificile. Positive for C. perfringens Alpha Toxin (CPA) gene (3 thous/g), low levels of CPA gene copies present. Negative for C. perfringens Enterotoxin and CpnetE/F toxin. A: Clostridium perfringens alpha gene copies are low- unlikely this toxin is contributing to diarrhea, however hematochezia consistent with clostridium. CBC- HCT High (57.6), Reticulocytes High (160), All Else WNL. Chemistry Panel- All WNL. Hemolysis 2+, In absence of anemia likely due to collection artifact. Total T4- Normal (2.7). UA- Pending urine from O. A: Moderate Reticulocytosis-

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 (3.01 cm) with mild corticomedullary rim sign. 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 (3.04 cm) with corticomedullary rim sign. 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 0.35 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 0.33 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.

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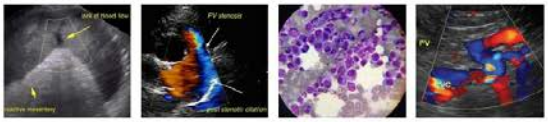

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Liver

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 gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a moderate amount of non-organized echogenic debris. 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.

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. Duodenum wall measured 0.42 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 right limb of the pancreas is large and hypoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is evidence of regional mesenteric inflammation. Consistent with mild/moderate pancreatitis.

Free Abdomen

There is scant free abdominal fluid visualized in the region of the right limb of the pancreas. No lymphadenopathy. The omentum is hyperechoic in the region of the pancreas.

ULTRASONOGRAPHIC FINDINGS

- Hypoechoic, prominent right limb of the pancreas with surrounding hyperechoic mesentery – The pancreatic changes are most consistent with mild/moderate pancreatitis/pancreatic inflammation. Recommend PLI testing and continued monitoring for improvement or possible development of a pancreatic abscess. Consider fine needle aspirate if not improving.

- Mild corticomedullary rim sign visualized in both kidneys – Clinical significance uncertain, can be seen in normal patients and in cases of ethylene glycol toxicity, chronic interstitial nephritis, and leptospirosis.

- Moderate gallbladder debris – The significance of the aggregated gallbladder sludge is unclear. This could represent an early mucocele, cholestasis, or may be secondary to

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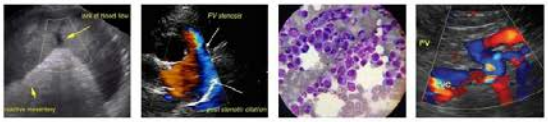

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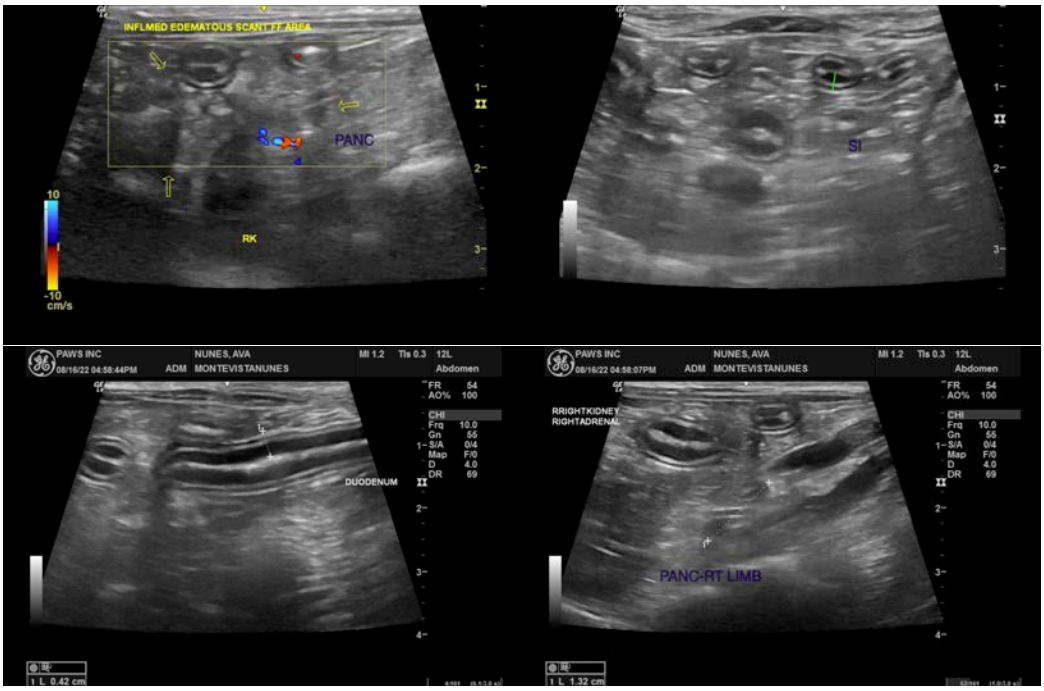
fasting.

- Subjective small intestinal thickening – 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).
- Scant free abdominal fluid.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The right limb of the pancreas appears large and hypoechoic with surrounding edema and inflammation, most consistent with active or resolving pancreatic inflammation. Recommend treatment for pancreatitis with low-fat diet, pain medications, nausea medications, etc., and following a quantitative PLI level.

The small intestine subjectively appears slightly prominent. This could be normal for this individual or could be an indicator of underlying small intestinal disease. Consider a GI panel to Texas A&M for a qualitative PLI, TLI, cobalamin and folate to further evaluate the pancreas and small intestine. It is possible that this patient would do better on a novel protein/hydrolyzed protein prescription diet. If she is a very picky eater, you could consider consultation with a veterinary nutrition service that will create a specific recipe for a novel protein and ultra low-fat diet to address both possible dietary sensitivities and pancreatitis. This can be a homecooked diet, which helps with picky eaters. If this patient is doing better on recent diet change, you could consider maintaining the current diet plan along with medical management for pancreatitis and reevaluating PLI levels in the next few weeks.



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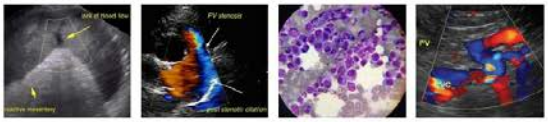

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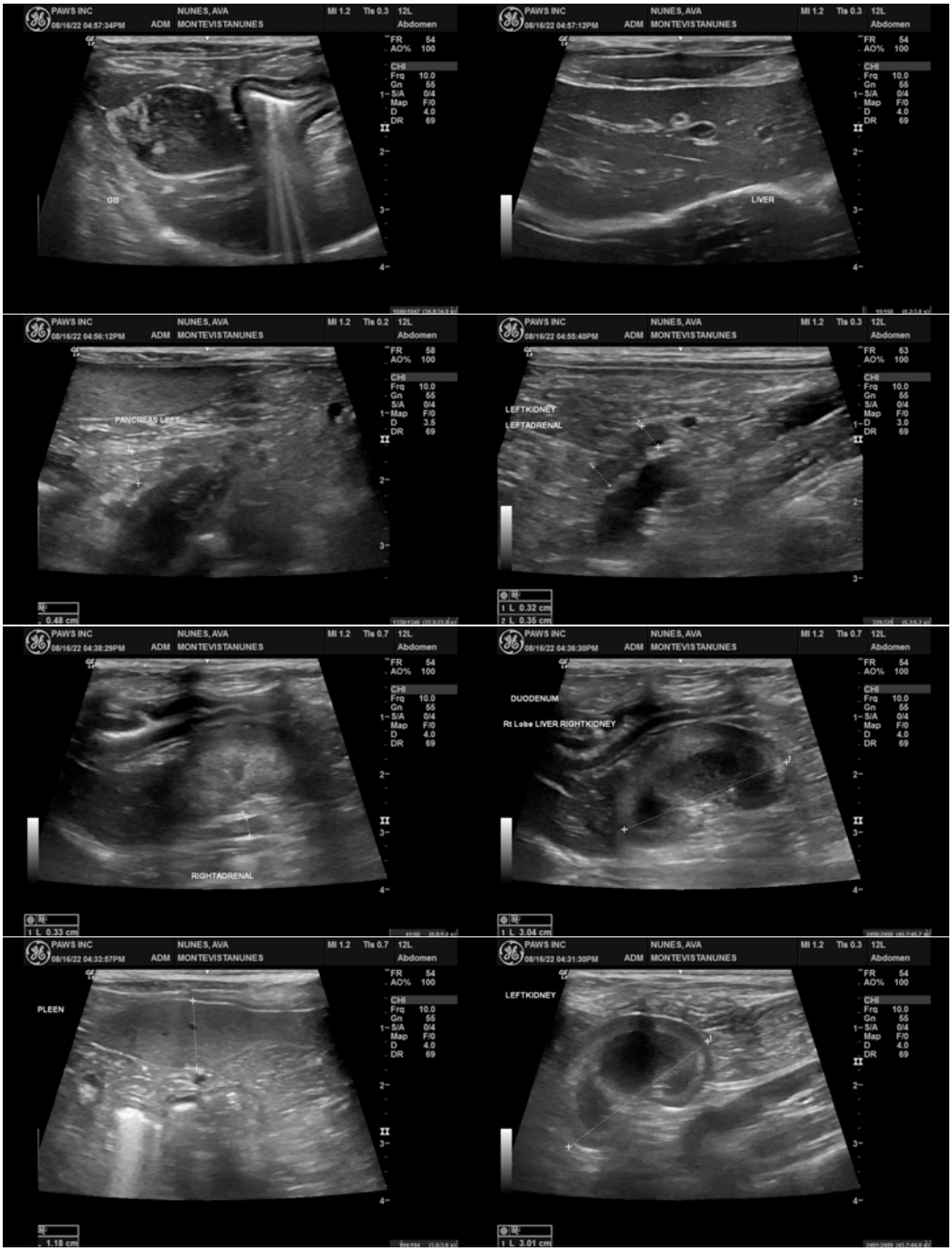

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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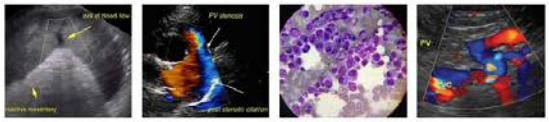

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Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

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kathleen.sennello@sonopath.com