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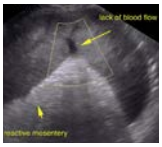
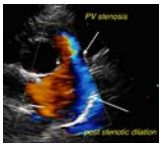
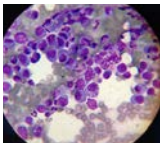
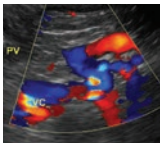





SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Maggie May Senko

SPECIES

Canine

BREED

Maltese X

SEX

Spayed Female

AGE

10

WEIGHT

4.3 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Alastair Westcott

HOSPITAL NAME

Dr. Alastair Westcott

REFERRING VET

Dr. Alastair Westcott

INVOICE

44902

DATE

8/23/23

PRESENTING CLINICAL SIGNS

Presented for continued, relatively voluminous and homogeneous diarrhea that is orange in color. This started in mid July of this year. Was seen in the beginning of August and at that time diagnostics were declined but she was placed on a trial course of metronidazole for 7 days. There was a partial response and improvement of the stool with the metronidazole. He had reverted back to diarrhea pretty soon after the metronidazole was finished. There is no vomiting and is maintaining good appetite. There is no obvious PU/PD. Her energy levels are quite good. There is no coughing, sneezing.

Abnormal PE/Chem/CBC/UA Results: Salient features severe hypoproteinemia with hypoalbuminemia and pan hypoproteinemia. This is significant and to the point where osmotic support may be required. There is associated hypocalcemia. Normal CBC and leukogram **Urinalysis:** Adequately concentrated Otherwise unremarkable Newly auscultated/acquired heart murmur very faint on the right side

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 (3.28 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal 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 (3.5 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

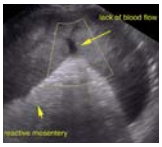
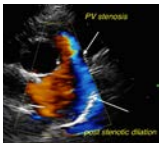
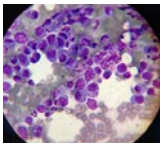
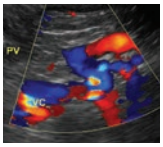
Adrenal Glands

The left adrenal gland is normal in size measuring 0.51 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 0.56 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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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 mild and primarily anechoic. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains mild to moderate ingesta. It measures at a normal thickness of 0.40 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. There is a hypoechoic, somewhat ovoid structure visualized within the gastric lumen measuring approximately 1.1 cm. This is most consistent with some form of ingesta (medication/pill?), although a mucosal structure cannot be definitively ruled out.

The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal fluid distension. Wall thickness is increased. Bowel loops follow a typical curvilinear path. Some areas have reduced detail of wall layering. Duodenum wall measures 0.51 cm. Jejunum wall measures 0.49 cm. There is very subtle mucosal striations visualized. 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 distended with nonformed liquid fecal material. There is no observed focal or generalized colon wall thickening or loss of layering. Colon wall measures 0.10 cm in the descending colon.

Pancreas

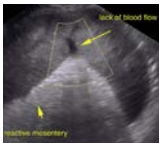
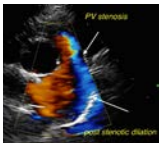
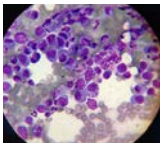
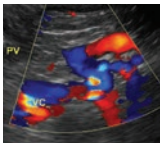
The pancreas is prominent and mottled compared to the surrounding isoechoic mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

There is a small amount of abdominal fluid. No lymphadenopathy. The omentum is diffusely hyperechoic.

ULTRASONOGRAPHIC FINDINGS

- Prominent, mottled pancreas – The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Hypoechoic structure visualized within the gastric lumen – There is a small amount of ingesta visualized along with this structure, which is non-shadowing. I suspect this is some form of ingested material, although a hypovascular tissue structure cannot be ruled out. Recommend continued monitoring.
- Diffusely thickened small intestine with occasional very subtle mucosal striations – The bowel wall thickening could be consistent with inflammation, edema, or infiltrative neoplasia.

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- Small volume free abdominal fluid.

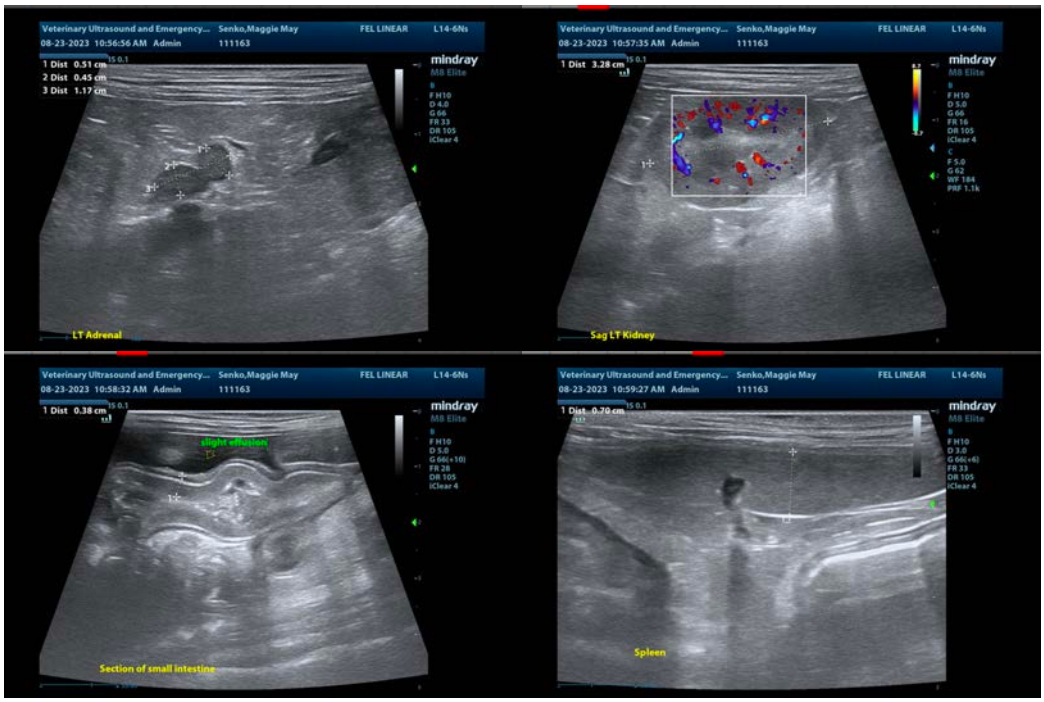
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes visualized in the small bowel are consistent with the protein losing enteropathy suspected. No focal mass lesions are observed. The primary differentials would be severe IBD, lymphangiectasia, or round cell neoplasia (neoplasia less likely). Unfortunately, these can only be differentiated with GI biopsies, although the treatment strategies can be very different. If the patient is stable enough, consider obtaining endoscopic GI biopsies. If the patient is not stable, then consider stabilization with an anti-inflammatory dose of steroids, and if there is improvement, endoscopic biopsies at that time. Depending on the diagnosis, a hypoallergenic versus an ultra low-fat diet could be considered.

Additionally, recommend a GI panel to Texas A&M for a qualitative PLI, TLI, cobalamin and folate, as many of these patients have low B12 levels, concurrent dysbiosis, etc.

The nature of the hypoechoic structure visualized in the stomach is unclear. It appears relatively hypovascular and there is some ingesta visualized within the gastric lumen. Consider the possibility of ingested material uphill, etc. If this structure persists, I cannot rule out the possibility of a hypovascular mucosal structure, but this seems less likely.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.



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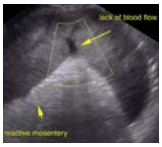
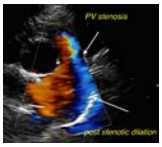
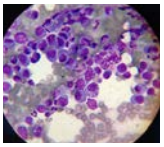
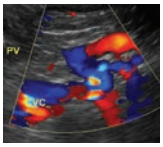

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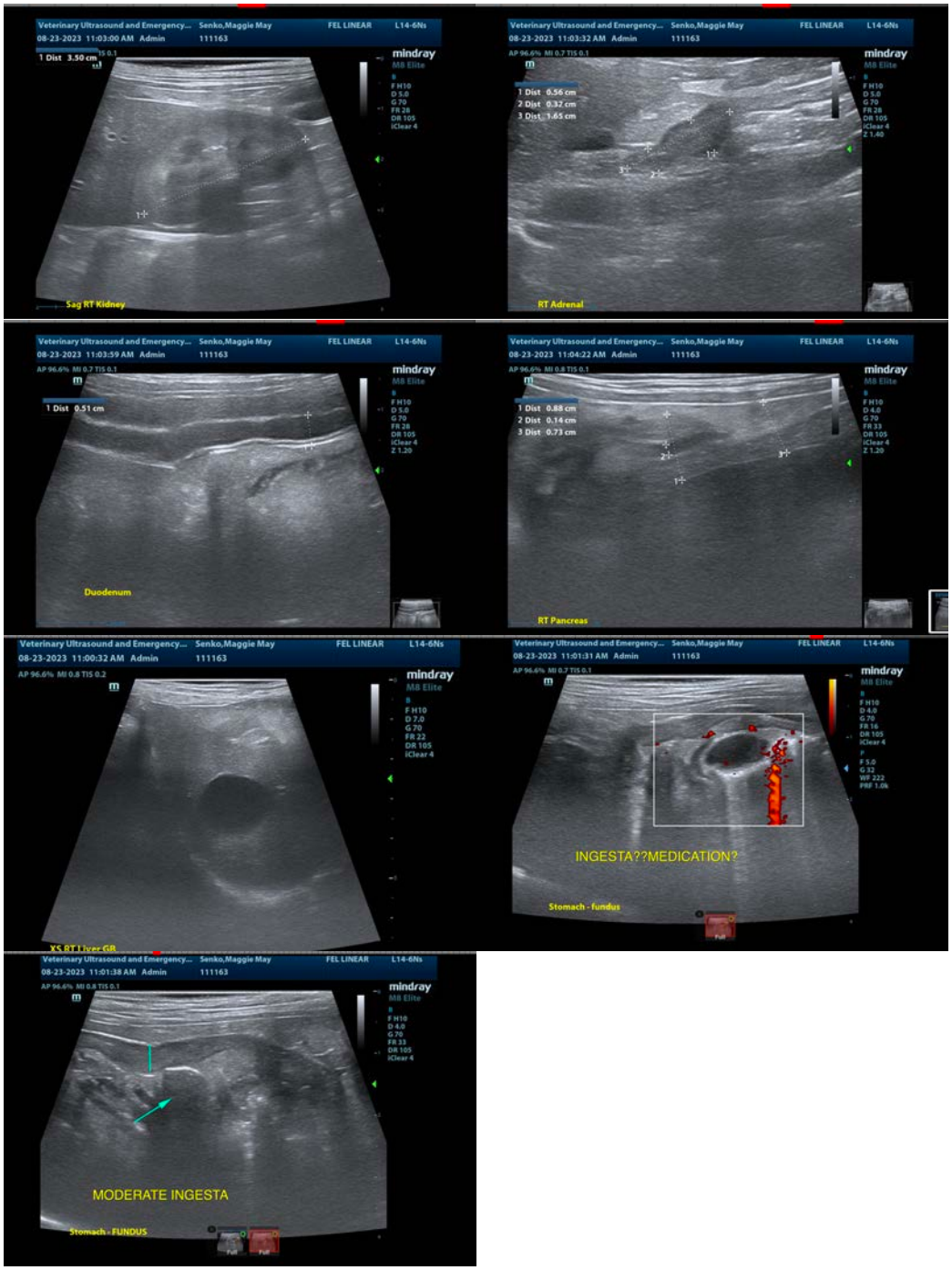

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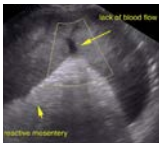
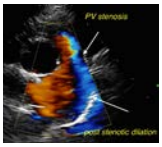
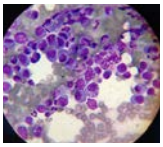
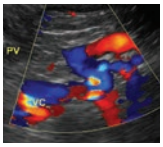

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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