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Clinical Sonography & Telecytology
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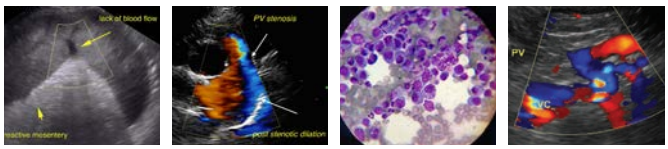

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1-800-838-4268 info@sonopath.com

PATIENT

Rocco Gascot

SPECIES

Canine

BREED

Shih Tzu

SEX

Neutered Male

AGE

14 Years

WEIGHT

13.8 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Ferrer

HOSPITAL NAME

Paseos Vet Center

REFERRING VET

Dr. Marylin Davila

INVOICE

40128

DATE

8/3/22

PRESENTING CLINICAL SIGNS

Presented as a referral for an abdominal ultrasound chronic diarrhea and anorexia. The patient presented with a history of anorexia and diarrhea since the 16th of June of 2022. Also, pt has weight loss. The patient was hospitalized at another clinic but has since been discharged. Improved but relapsed. Pt was treated with Cerenia, pantoprazole, and metronidazole.
Abnormal PE/Chem/CBC/UA Results: PE/BW: no provided

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately/mildly distended with anechoic urine. The Bladder wall largely appears normal at 0.37 cm with some subtle mucosal irregularity. The area of the trigone, ureteral papillae and proximal urethral (to a depth of 2.0 cm) appear normal with no evidence of a mass effect or calculi. Findings are most consistent with mild cystitis or lack or urine distention.

The prostate is normal in size (1.09 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 (3.92 cm) with mild pyelectasia at 0.21 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 (3.71 cm) with mild pyelectasia at 0.15 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 0.46 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.

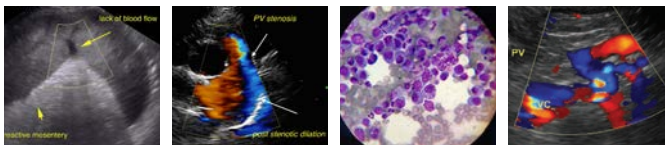
The right adrenal gland is normal in size measuring 0.34 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

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 mildly heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.



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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 presents mild fluid distention. It measures at a normal thickness of 0.36 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. 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. Jejunum wall measured 0.42 cm. Duodenum wall measured 0.58 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 (0.24 cm). Sections of colon are visualized with nonformed 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

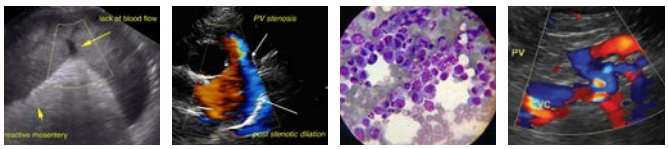
Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is a mild mesenteric lymphadenopathy present with mesenteric lymph nodes measuring 0.85, 0.83, and 0.48 cm. The omentum is of normal echogenicity.

PRIMARY FINDINGS

- 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).
- Mild mesenteric lymphadenopathy – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

SECONDARY FINDINGS

- Subjectively irregular urinary bladder wall – 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.
- Mild bilateral pyelectasia – Pyelectasia of the left/right kidney could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other.
- Subjectively heterogeneous liver – The hepatic changes are consistent with age-related parenchymal remodeling and are not considered clinically significant at this time.



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- Mildly fluid dilated stomach – correlate with feeding history. If the patient was adequately fasted, then consider the possibility of delayed gastric emptying or a partial outflow tract obstruction (none observed).

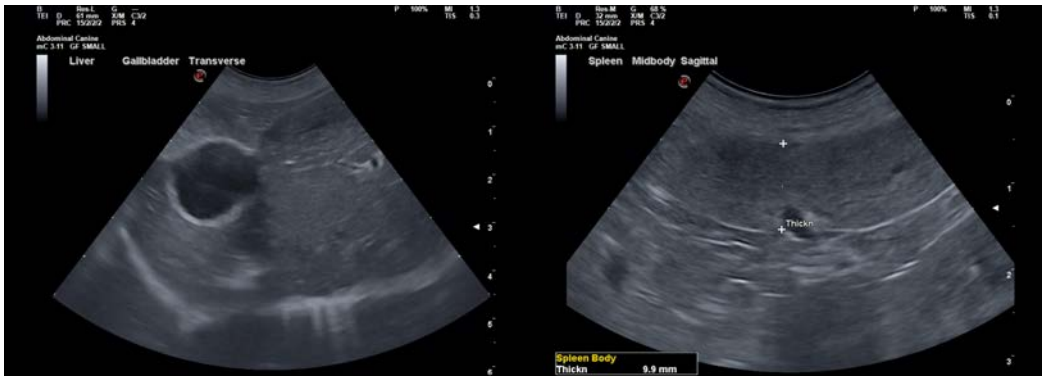
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal lesions are visualized associated with the gastrointestinal tract to explain the chronic diarrhea and inappetence reported. Unfortunately, there are many causes for diarrhea that cannot be definitively diagnosed by ultrasound alone. Correlate with current blood work (are there any metabolic changes that could be associated with diarrhea?). If not, consider primary gastrointestinal disease such as food allergy/dietary intolerance, GI parasitism, dysbiosis, chronic pancreatitis, IBD, and less likely intestinal neoplasia.

- Consider a novel protein/hydrolyzed protein prescription diet.
- Consider chronic probiotic therapy.
- Recommend a GI panel to Texas A&M with a qualitative PLI, TLI, cobalamin and folate to further evaluate the pancreas and small intestine.
- There are some prominent mesenteric lymph nodes visualized. You could consider a fine needle aspirate to look for evidence of round cell neoplasia.
- If symptoms persist despite a diet change and symptomatic therapy, consider obtaining GI biopsies.

There is very mild subjective irregularity to the urinary bladder wall, and mild pyelectasia (which could be incidental). Consider a urinalysis and culture to rule out the possibility of a urinary tract infection.

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



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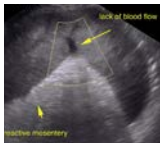
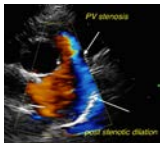
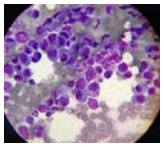
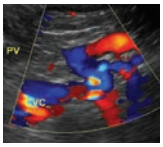

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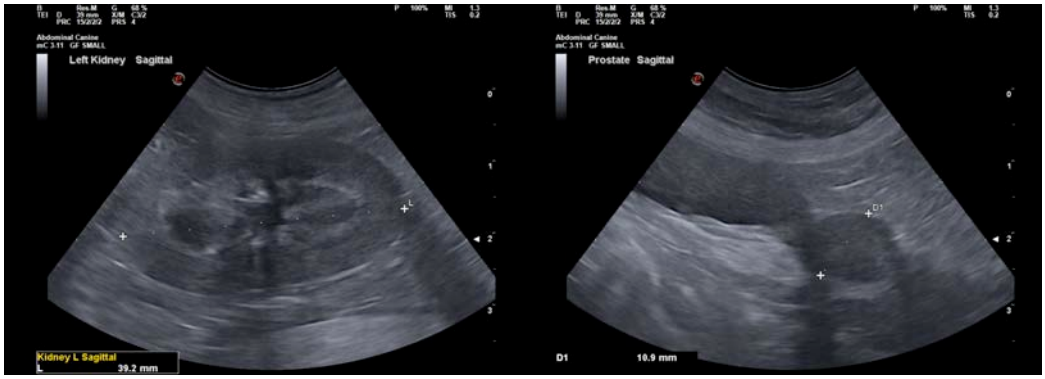

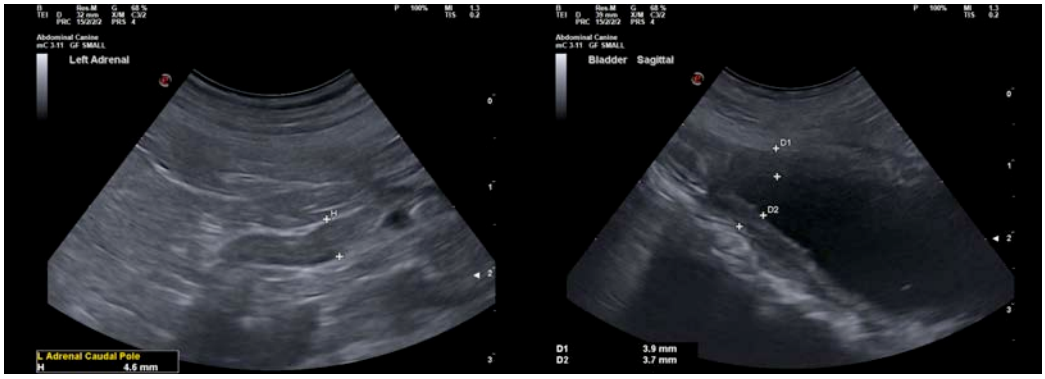

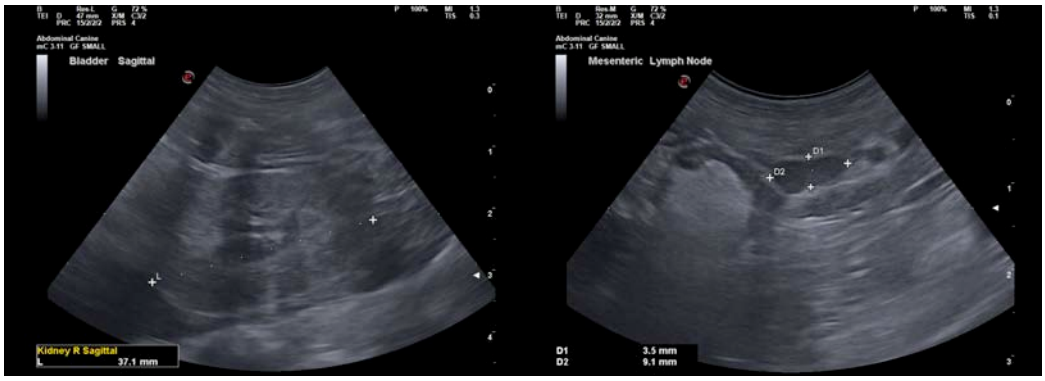

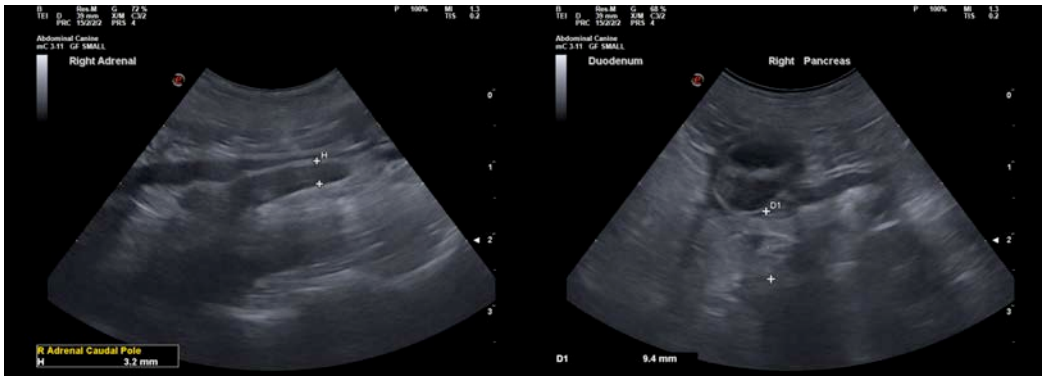

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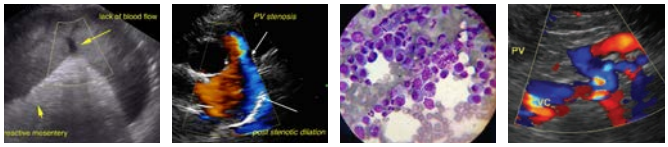

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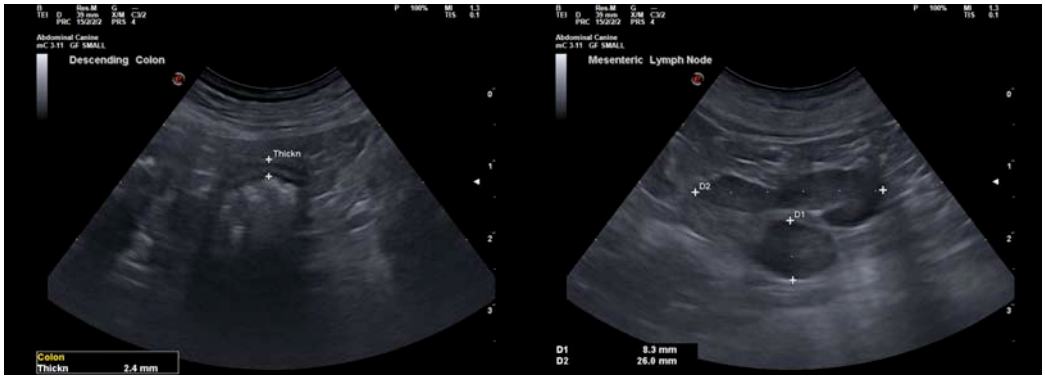

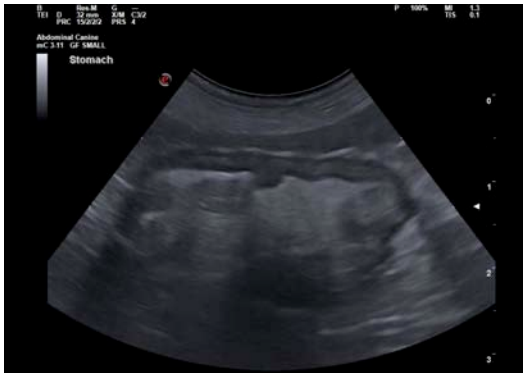

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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