IMAGING PERFORMED BY

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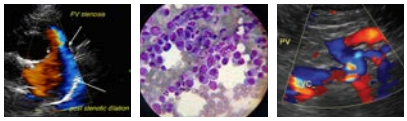

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DATE

9/1/21

PATIENT

Joey Groft

SPECIES

Canine

BREED

Miniature Schnauzer

SEX

Neutered Male

AGE

12/9/09

WEIGHT

15 Pounds

INTERPRETED BY

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

HOSPITAL NAME

Airpark AH

REFERRING VET

Dr. Kable

INVOICE

25127

PRESENTING CLINICAL SIGNS

History: Came to see us this week after a workup at another vet's office for 1.5 months of severe diarrhea and occasional vomiting. After trying multiple things, they started a steroid trial and ZD diet. This has helped significantly but the problems continue to a degree. The other vet recommended a workup for possible IBD vs Neoplasia and mentioned lymphangiectasia as a possibility due to the somewhat refractory nature of the case. They performed radiographs one week apart on two separate occasional within the last few weeks which were WNL according to O/record. I agree with the other DVM that higher level diagnostics are needed, and O prefers to get an ultrasound prior to going to internal medicine if they can avoid referral.

Current Medications: Prednisone 5mg tablets PO BID, Carafate 0.5gram PO TID, ZD diet.
Lab Results: Not provided by the veterinarian.
Radiographs: WNL.
Date of Previous IntraPet Ultrasound: No previous IntraPet scans.
Sedation: not needed
Stat Report: not requested

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 prostate is normal in size (1.3 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 (4.58 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. Pinpoint non-obstructive nephroliths were present. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.5 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. Pinpoint non-obstructive nephroliths were present. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.43 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 0.62 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 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.

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. Some have reduced detail of wall layering and foggy mucosa. Duodenum wall measures 0.49 cm. Jejunum wall measures 0.4-0.32 cm. Visualized peristalsis appears appropriate. While a focal mass lesion is not visualized, there are some bowel loops that appear significantly more thickened, and the mucosa is foggy with reduced detail of layering as compared to other bowel loops. There is generalized thickening of the small intestine.

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 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
Evaluation of the peritoneal cavity did not revealed scant anechoic fluid around abnormal bowel loops. No subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is generally of increased echogenicity around abnormal section of small intestine.

PRIMARY FINDINGS

- Thickened areas of small intestine with foggy mucosa and reduced detail of wall layering – The bowel wall thickening could be consistent with inflammation, edema, or infiltrative neoplasia. A reduction in the detail of wall layering favors either severe intestinal disease or neoplastic infiltration. Biopsy is recommended.

- Large, 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. A component of this is likely a steroid hepatopathy.

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

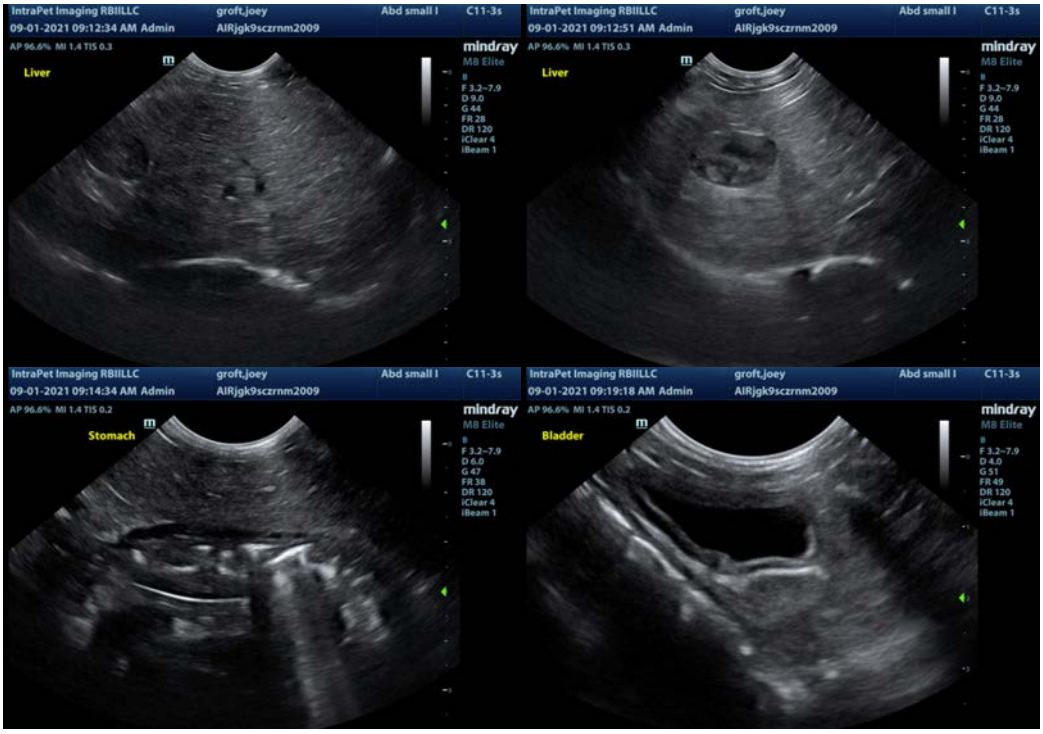
SECONDARY FINDINGS

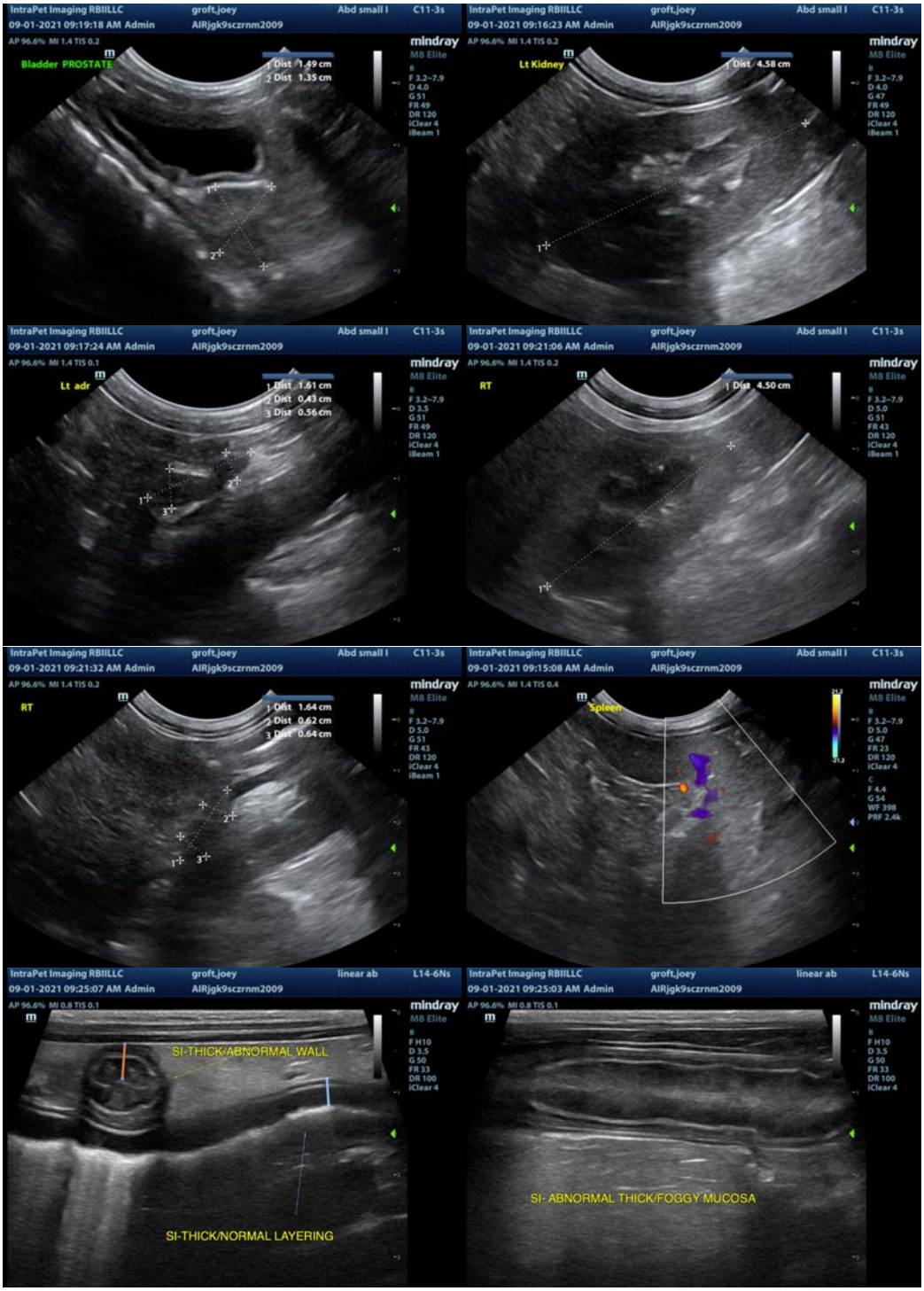
- Prominent, slightly mottled pancreas – The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

- Scant free fluid – correlate with albumin levels. If normal, could be reactive to local enteritis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There are significant bowel changes observed, most consistent with severe IBD or lymphangiectasia, although a neoplastic process cannot be ruled out. Consider a GI panel with an fPLI, B12 and folate to Texas A&M University to evaluate for B12 deficiency, dysbosis, etc. Recommend a probiotic, and if possible start to taper off the Prednisone in anticipation of either surgical (provides full thickness biopsies of desired areas) or endoscopic (less invasive, less desirable samples) biopsies in order to obtain a diagnosis and optimally treat. Recommend referral to an internal medicine specialist to aid with compliance, as this will be a challenging case to manage without more inflammation.

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groft,joey
Abd small I
C11-3s
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Bladder PROSTATE
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2 Dist 1.35 cm
mindray
M8 Elite
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Spleen
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L14-6Ns
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SI-THICK/NORMAL LAYERING
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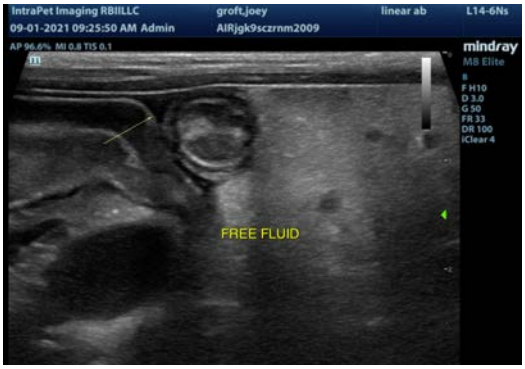
SI- ABNORMAL THICK/FOGGY MUCOSA



The information and recommendations provided are based on the images presented by the referring veterinarian. 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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