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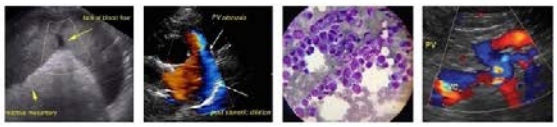

THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Bijou Giblin

SPECIES

Canine

BREED

Longhaired Chihuahua

SEX

Spayed Female

AGE

11 Years

WEIGHT

7 Poulnds

INTERPRETED BY

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

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Martindale AC

REFERRING VET

Dr. Kennedy

INVOICE

40929

DATE

9/1/22

PRESENTING CLINICAL SIGNS

Attending DVM: Dr. Jennifer Kennedy History: Vomiting ++ Lethargic, not herself. Dehydrated Blood in stool started Saturday night- resolved on tylosin. Losing weight. Current Treatment/Medications: SQ fluids 150ml once daily, Clavaseptin 50mg BID, Tylosin 30mg TID
Abnormal PE/Chem/CBC/UA Results: Lab/Xray Results: CBC wnl Biochem m3 elevated kidney values- SDMA 40, creat 429, urea 33.4 Phos m3 elevated, glob high 54 (25-45), amylase >2500 TT4 low 7 (13-51) UA USG 1.020, ph 7.0, pro 500, bld 50 wbc >50/hpf, rbc 19/hpf, bacteria rods & cocci present cPL normal Negative for lepto

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 (3.11 cm) with numerous small cortical cysts. Overall echogenicity is slightly hyperechoic with poor 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 (3.8 cm) with small cortical cysts. Overall echogenicity is slightly hyperechoic with poor 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 0.42 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 0.40 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 significantly distended. Some areas of the wall appear mildly thickened with adherent debris. There is a large amount of primarily non-organized echogenic debris. There is no evidence of bile duct dilation. There is mildly hyperechoic mesentery surrounding the area of the gallbladder.

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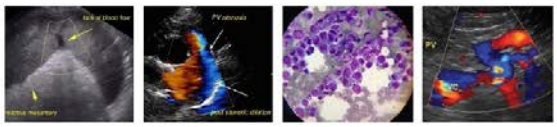

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Gastrointestinal

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 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 measures 0.35 cm. Jejunum wall measures 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 prominent and hypoechoic as 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

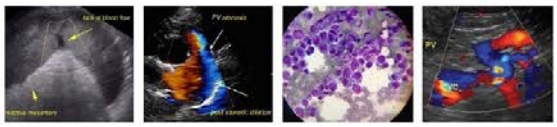
Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum appears hyperechoic in the cranial abdomen.

ULTRASONOGRAPHIC FINDINGS

- Decreased corticomedullary distinction in both kidneys with small cortical cysts – Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis.
- Hypoechoic, prominent pancreas – The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Mildly 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. This can also be associated with age related remodeling.
- Large gallbladder sludge – A large amount of debris is evident in the gall bladder with no evidence of a mucocele. There is evidence of moderate associated inflammation at this time. This could represent an early mucocele or cholestasis, with minimal evidence of associated inflammation at this time. Continued monitoring of labwork and ultrasound are warranted for progression of this lesion. Ursodiol therapy could be considered.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal lesions associated with the gastrointestinal tract are visualized. The pancreas is visible but does not appear overtly inflamed. Unfortunately, this does not rule out the possibility of underlying gastrointestinal disease, as there are many causes for vomiting that cannot be diagnosed by ultrasound alone.



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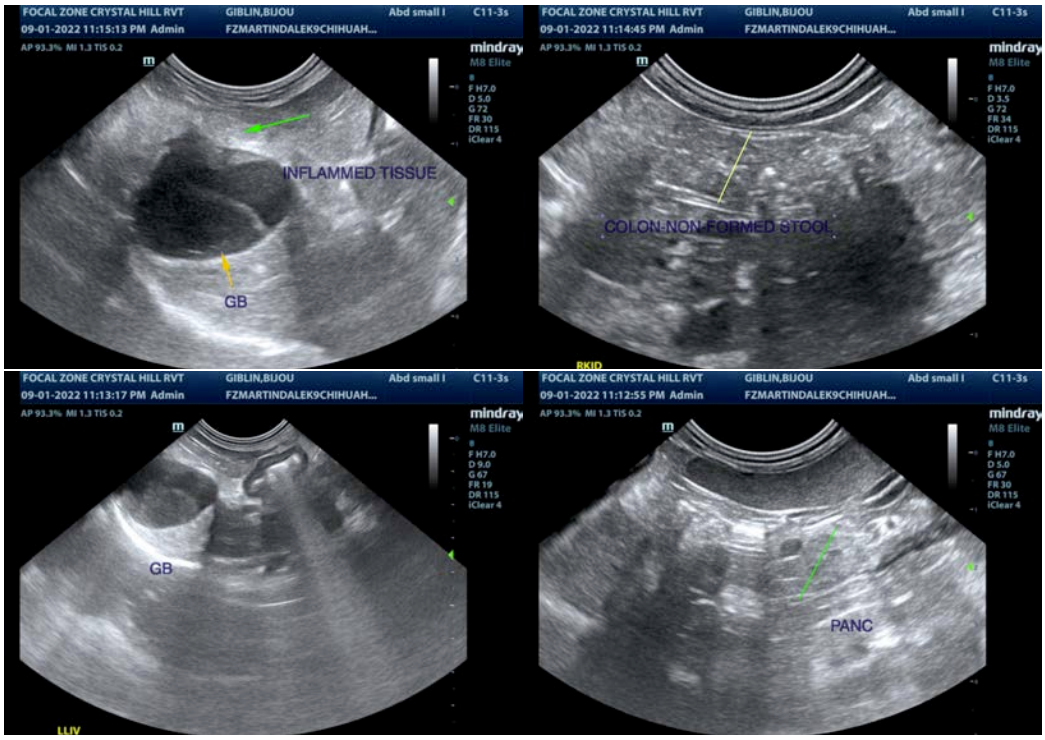
- Correlate findings with abdominal radiographs. Serial imaging may be necessary if ingested foreign material is suspected (this was not seen but cannot be definitively ruled out).
- Recommend general therapy for acute gastroenteritis, including probiotics, nausea medications, etc.
- A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.
- If symptoms persist, consider further evaluation, possibly even GI biopsies if chronic symptoms have been present.

Additionally, the gallbladder has a large amount of intraluminal debris. Some of this is adhering to the gallbladder wall. Subjective evaluation calls this a moderate to large amount of debris, and I would likely recommend medical treatment with Ursodiol and close monitoring. On some images, there is apparent inflammation around the gallbladder, which is concerning. Recommend close monitoring of liver values and consider reevaluation of the gallbladder in 24-48 hours due to the surround inflammation and the possibility that this could progress to a surgical lesion. If this inflammation is associated with the GI tract, then hopefully it will improve with clinical treatment. Recommend starting Ursodiol with likely lifelong therapy.



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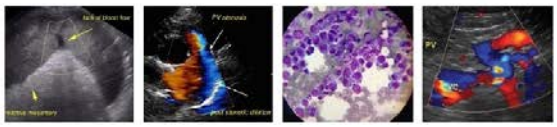

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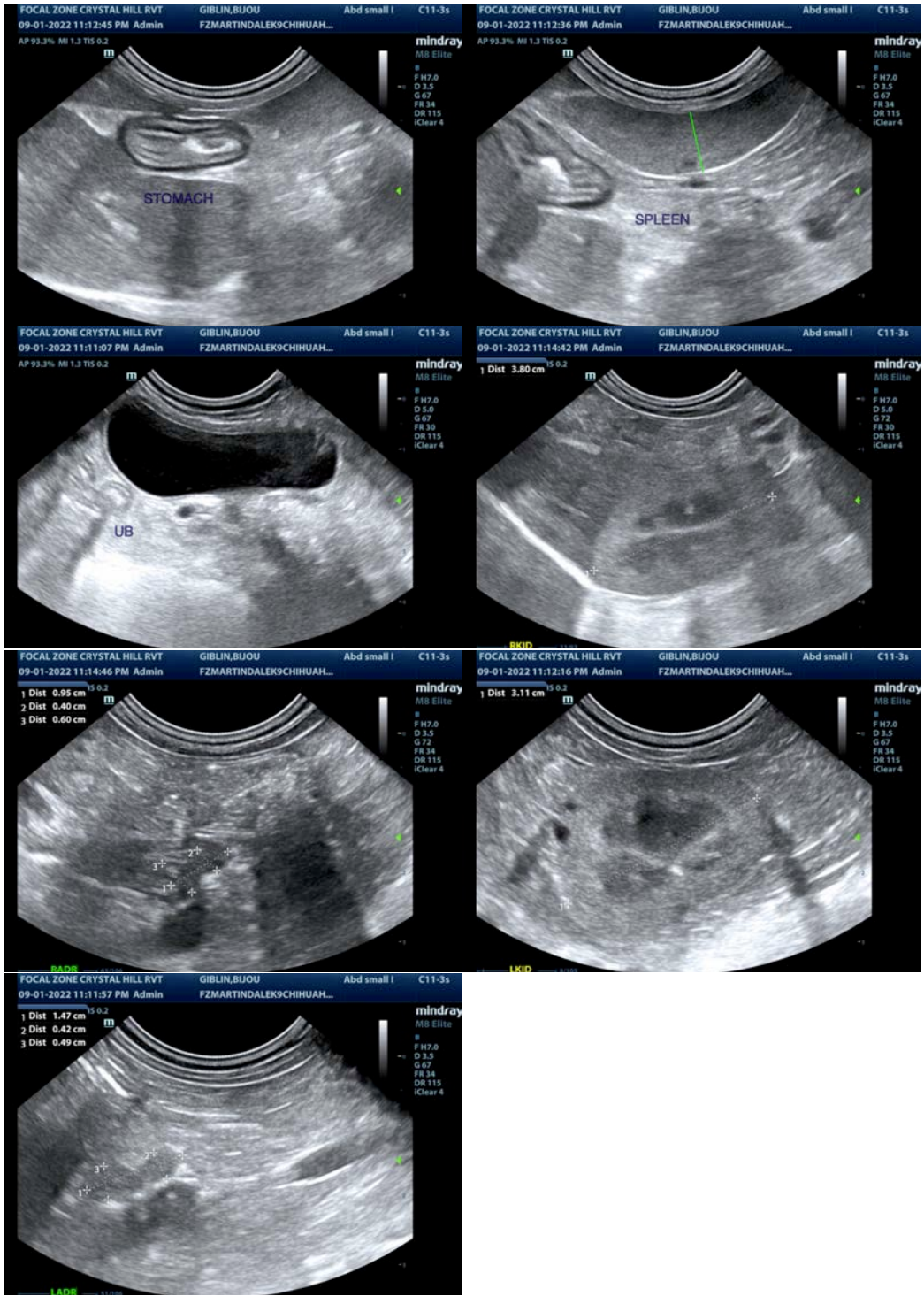

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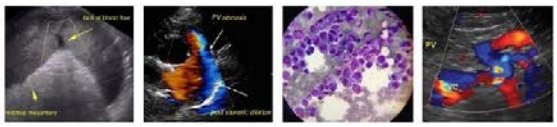

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

kathleen.sennello@sonopath.com