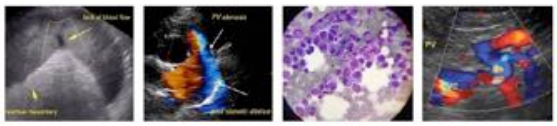


PATIENT

Sachi Aldrich

SPECIES

Canine

BREED

Beagle

SEX

Spayed Female

AGE

11 years

WEIGHT

42 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Kelly Reshny, RVT

HOSPITAL NAME

St Catharines AH

REFERRING VET

Dr. Masoud

INVOICE

94868

DATE

12/22/21

PRESENTING CLINICAL SIGNS

History of pancreatitis, elevated liver enzymes, hospitalized for 2 days on IVF and meds but still anorexic 'currently on metronidazole, sulcrate, fortiflora, mirtazapine
Abnormal PE/Chem/CBC/UA Results: severely elevated ALP, chol, T prot, stress leukogram, cPLi severely elevated

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with echogenic urine. The bladder is diffusely thickened and irregular measuring 0.3 cm in width. There is a small, pedunculated mass effect in the apex of the urinary bladder that measured 0.69 x 0.37 cm. This is most consistent with an inflammatory polyp but. Neoplastic lesion cannot be ruled out. The area of the trigone, ureteral papillae and visible urethra (to a depth of 2cm) appears free of mass effects and cystic calculi.

The left kidney has a normal shape and size (5.98 cm). Overall echogenicity is slightly hyperechoic with poor 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 (5.72 cm). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. Numerous small cortical cysts were noted. 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 large in size measuring 0.93 cm at the cranial pole, 0.91 cm at the caudal pole and 2.45 cm in length. 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.

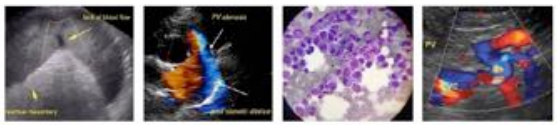
The right adrenal gland is large in size measuring 1.3 cm at the cranial pole, 1.09 cm at the caudal pole and 2.98 cm in length. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with 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 large in size, and echogenicity with smooth peripheral margins. The parenchyma is severely heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the



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vasculature and biliary tract appear normal. There is a small, irregular 0.99 cm hypoechoic structure that is most consistent with hepatic cysts visualized. The gallbladder lumen is moderately distended. The wall of the gallbladder 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 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. The duodenum measured as normal (0.42 cm) and the jejunum measured as normal (0.37 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 is of normal uniform echogenicity.

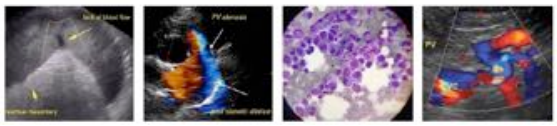
Heart

A brief view of the heart was submitted. No pericardial effusion was seen.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS:

- Large, severely heterogenous 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.
- Bilateral adrenomegaly. The bilateral adrenomegaly could be consistent with bilateral



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hyperplasia (e.g., secondary to pituitary-dependent hyperadrenocorticism), bilateral infiltrative neoplasia, inflammatory adrenal disease, other. Correlation with clinical findings is recommended.

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

- Diffusely thickened urinary bladder with echogenic urine and suspected polyp. The findings are most consistent with diffuse cystitis although underlying neoplasia cannot be ruled out. I recommend urinalysis and culture as well as continued monitoring of the mass effect.

SECONDARY FINDINGS:

- Decreased corticomedullary distinction in both kidneys. The bilateral renal findings are consistent with age-related change.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The liver is very large and heterogenous. Additionally, the adrenal glands are large. These findings would be typical for possible pituitary dependent hyperadrenocorticism, but the clinical signs do not fit with this diagnosis. Even though the the changes in the pancreas were mild, I would consider treatment for pancreatitis as the ultrasonographic findings do not always correlate with the clinical symptoms exhibited.

- Consider GI panel to Texas A&M with a qualitative PLI, TLI, cobalamin and folate to further evaluate the pancreas and small intestine for concurrent disease.
- Recommend symptomatic therapy for pancreatitis with pain medication, nausea medication, fluids, etc. and continue monitoring of the pancreas with ultrasound.

There is significant bladder wall thickening and what appears to be a small polyp. I recommend urinalysis and culture as this can make some pets not feel well, particularly if they have an early ascending infection. With the degree of change in the bladder I would reculture on antibiotics in 2 weeks and treat for a total of four. Recheck bladder changes with ultrasound at 4 weeks. If the changes have not resolved further diagnostics may be recommended

Additionally, you can consider further evaluation of the liver with a liver function test and a FNA of the liver as there could be a primary hepatopathy going on and rarely vacuolar hepatopathy can progress to cause significant liver dysfunction, which can result in this pet not feeling well. Additionally, consider a blood pressure evaluation.

If this pet starts to feel better and has clinical symptoms consistent with Cushing's disease you can consider adrenal function testing once the primary illness and stress of the illness has passed. Consider three view thoracic radiographs to rule out any concurrent intrathoracic disease.

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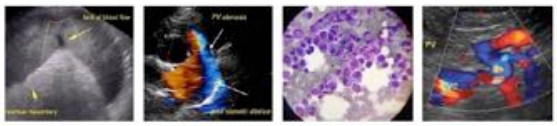

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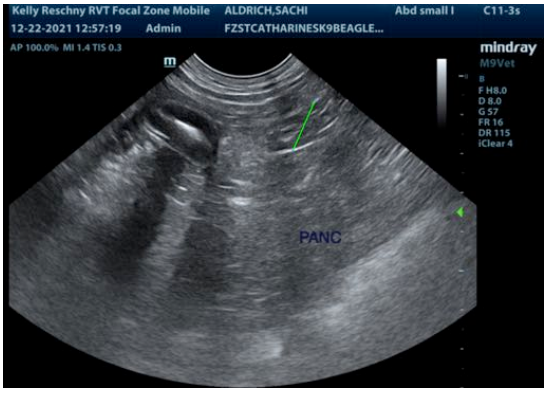

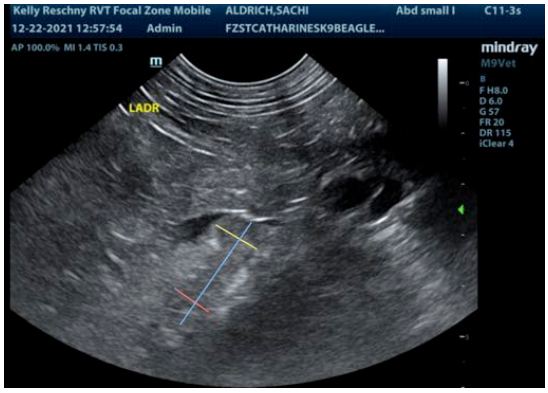

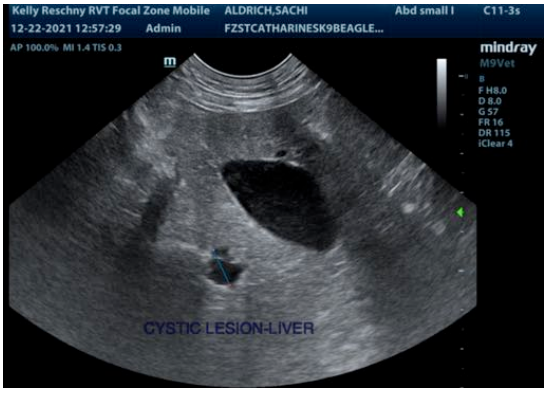

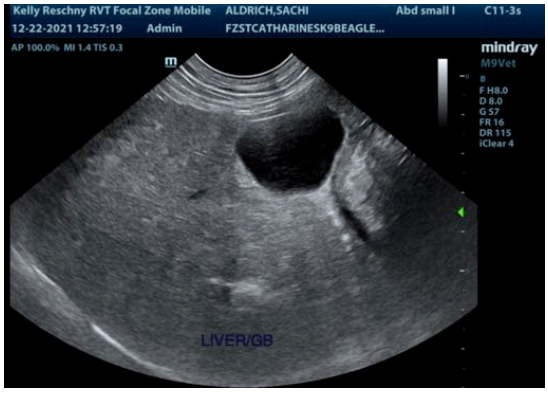

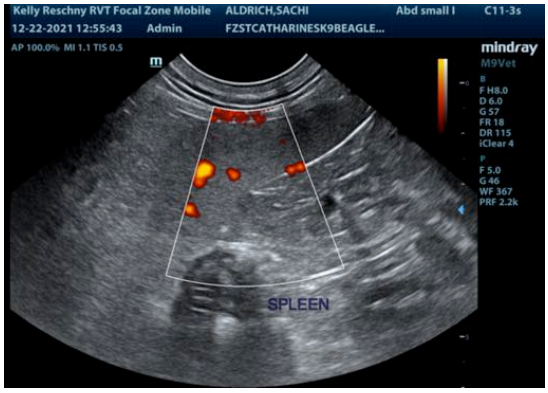

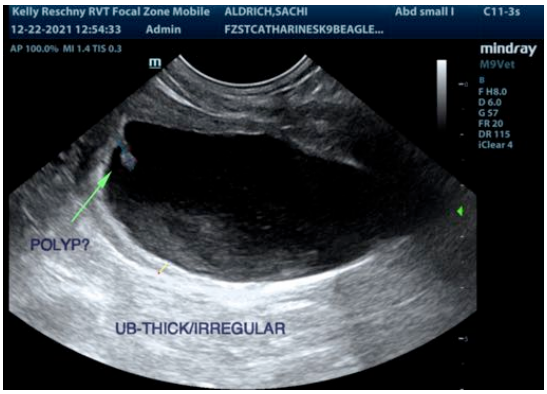

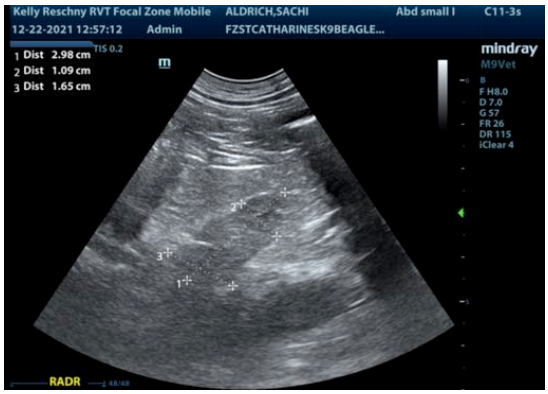

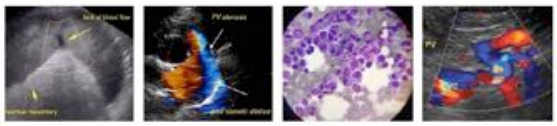

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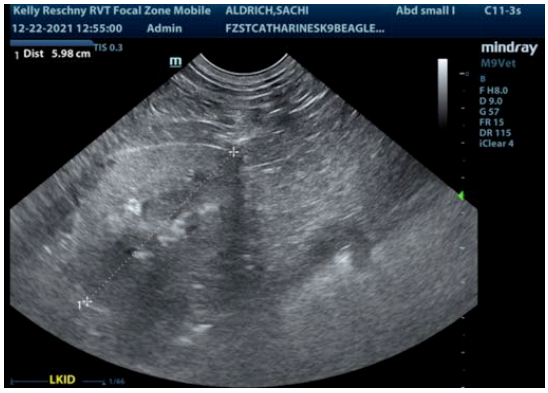

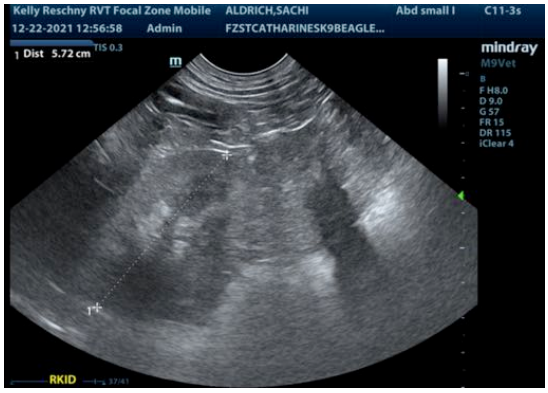

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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kathleen.sennello@sonopath.com