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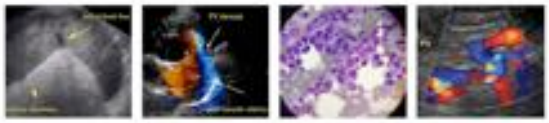


IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Phoebe Lane

SPECIES

Canine

BREED

Poodle Mix

SEX

Spayed Female

AGE

6 years

WEIGHT

16 Pounds

INTERPRETED BY

Lisa Carioto, DVM, DVSc, Diplomate ACVIM

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT

HOSPITAL NAME

Donner Truckee VH

REFERRING VET

Dr. Vannini

INVOICE

31117

DATE

6/20/22

PRESENTING CLINICAL SIGNS

History: 1-2 mths HX of intermittent GI signs. Slowing down per owner- PSL 741- All else BW WNL

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with anechoic contents. The wall is smooth and regular. No abnormalities are noted with the trigone and urethra, and there is no evidence of sediment, cystoliths, polyps or a mass.

Kidneys

The **left** kidney measures 4.33 cm. The capsule is smooth. The normal definition of the cortico-medullary junction is preserved. Very mild mineralizations are present in the diverticulae and pelvis. There is no evidence of nephroliths or pyelectasia. The surrounding mesentery is not hyperechoic.

The **right** kidney measures 4.26 cm. The capsule is smooth. The normal definition of the cortico-medullary junction is preserved. Very mild mineralizations are present in the diverticulae and pelvis. There is no evidence of nephroliths or pyelectasia. The surrounding mesentery is not hyperechoic.

Aortic bifurcation/trifurcation

No abnormalities observed.

Adrenal Glands

The **left** adrenal gland measures 0.51 cm at the cranial pole, 0.54 cm at the caudal pole. No abnormalities are noted with the gland's overall architecture, echogenicity or echotexture. The phrenico-abdominal vein and surrounding vasculature and mesentery are unremarkable.

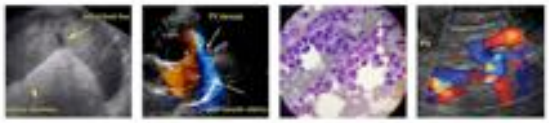
The **right** adrenal gland 0.53 cm at the cranial pole, 0.46 cm at the caudal pole. Corticomedullary definition is well preserved. No abnormalities are noted with the gland's overall architecture, echogenicity or echotexture. The phrenico-abdominal vein and surrounding vasculature and mesentery are unremarkable.

Spleen

The spleen is within normal limits in size, architecture, echotexture, and echogenicity. The capsule is smooth. No abnormalities are observed with its vasculature, i.e. congestion and thrombi are not identified.

Liver

There are no obvious signs of hepatomegaly. The liver's borders are smooth, but mildly rounded. It is within normal limits in echogenicity i.e. it is hypoechoic to the spleen. A coarse or granular echotexture



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is observed throughout. Focal lesions are not observed. The walls of the portal veins are more prominent than usual which may be suggestive of inflammation. No abnormalities are observed with the hepatic veins. The mesentery surrounding the liver is severely hyperechoic.

The gallbladder (GB) is mildly dilated, which is considered normal for a fasted animal. A trivial amount of free floating and inspissated echogenic material is noted. The GB wall is within normal limits in thickness and echogenicity. The portions of the cystic and/or common bile ducts observed are not dilated or tortuous, i.e. there are no signs of an obstruction. No abnormalities are observed with the duodenal papilla.

Gastrointestinal

Gas and a small amount of ingesta are present within the lumen. The gastric wall is within normal limits in thickness and the wall layers are well defined. No abnormalities are observed with peristalsis.

The small intestinal wall thickness, including the duodenum, is within normal limits, and the definition of the wall layers is preserved. No abnormalities are noted with the ileocecal colic junction.

The colonic wall is within normal limits. Gas and slightly soft stools are present within the lumen.

Pancreas

The **left limb** is prominent with areas of hypoechogenicity. Its contours are slightly irregular. A large number of pinpoint and punctate hyperechoic foci are scattered throughout the parenchyma. These hyperechoic foci may represent fat, mineralization and amyloid deposition, as well as fibrosis. Fibrosis may occur secondary to age and previous episodes of pancreatitis. The surrounding mesenteric fat is moderately hyperechoic in a heterogeneous pattern (multifocal areas of hyperechogenicity within the omentum). Overt signs of neoplasia are not noted.

The **right limb** and the associated changes are not as prominent as the left limb.

Other

Lymph nodes

Within normal limits.

Abdominal effusion is not visualized.

Heart

A brief video clip of the heart was submitted. Pericardial and pleural effusion are not identified. A mass is not observed on evaluation of the cardiac chambers. No obvious abnormalities with chamber size or contractility (measurements not performed).

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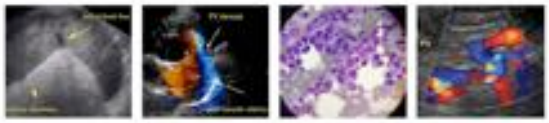

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ULTRASONOGRAPHIC FINDINGS

- **Pancreas**: Mild active pancreatitis is suspected, as well as changes suggestive of fibrosis, i.e. previous episodes of pancreatitis. Other possibilities include mineralization, fat and amyloid deposition. Signs of overt neoplasia are not appreciated.
- **Gastrointestinal (GI) tract**: Overt abnormalities are not observed with the GI tract other than gas and mildly soft stools in the colon. Absence of sonographic signs does not rule out a diagnosis of a chronic enteropathy, for example, inflammatory bowel disease, dysbiosis, maldigestive disease, etc.
- **Liver:** A *mild* reactive hepatopathy may be present due to an underlying systemic illness. However, the coarse/granular echotexture and slightly prominent walls of the portal veins may represent mild hepatic inflammation. Hepatitis, which may be primary (immune-mediated) or secondary in origin cannot be excluded. Examples of secondary causes include, toxins, including medications and natural supplements, infectious agents, such as, parasites, viruses, or bacteria, such as leptospirosis and vector borne diseases. Cholangitis/cholangiohepatitis should not be excluded despite the absence of hyperechogenicity.
- **Gallbladder**: Gallbladder *sludge* is most likely clinically insignificant, however, gastroesophageal reflux disease (GERD), can occur in some patients. Obtaining a history regarding signs of GERD from the client is suggested. Treatment with an anti-acid or a proton pump inhibitor may be required.
- **Kidneys:** Very mild mineralization, which may be associated with very early age-related changes, however, diet may also be implicated. Pyelonephritis cannot be excluded despite the absence of classical sonographic signs.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

*A baseline (random) cortisol to exclude hypoadrenocorticism.

Evaluation for back pain and joint pain

Urinalysis, if not already performed, +/- urine culture, +/- urine protein: creatinine ratio

spec cPL to confirm pancreatitis. If positive, consider fasting triglycerides

SNAP 4Dx (or equivalent test)

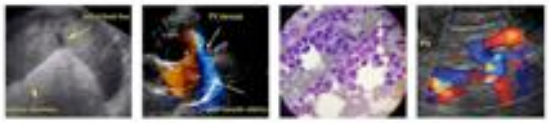
Leptospira spp. PCR (if has not received antibiotics in last 2 months)

Obtaining a history regarding signs of GERD from the client is suggested. Treatment with an anti-acid or a proton pump inhibitor may be required.

If signs of GERD, 10-14 day trial with famotidine or omeprazole (0.7-1 mg/kg PO q12h)

Review of current diet including fat and calcium content. Exclude possible infectious source (e.g., raw meat diet, i.e. *Campylobacter* spp, *Clostridium* spp., Salmonella, etc.).

Trial with analgesic gabapentin, with slow uptitration to avoid sedation, etc.



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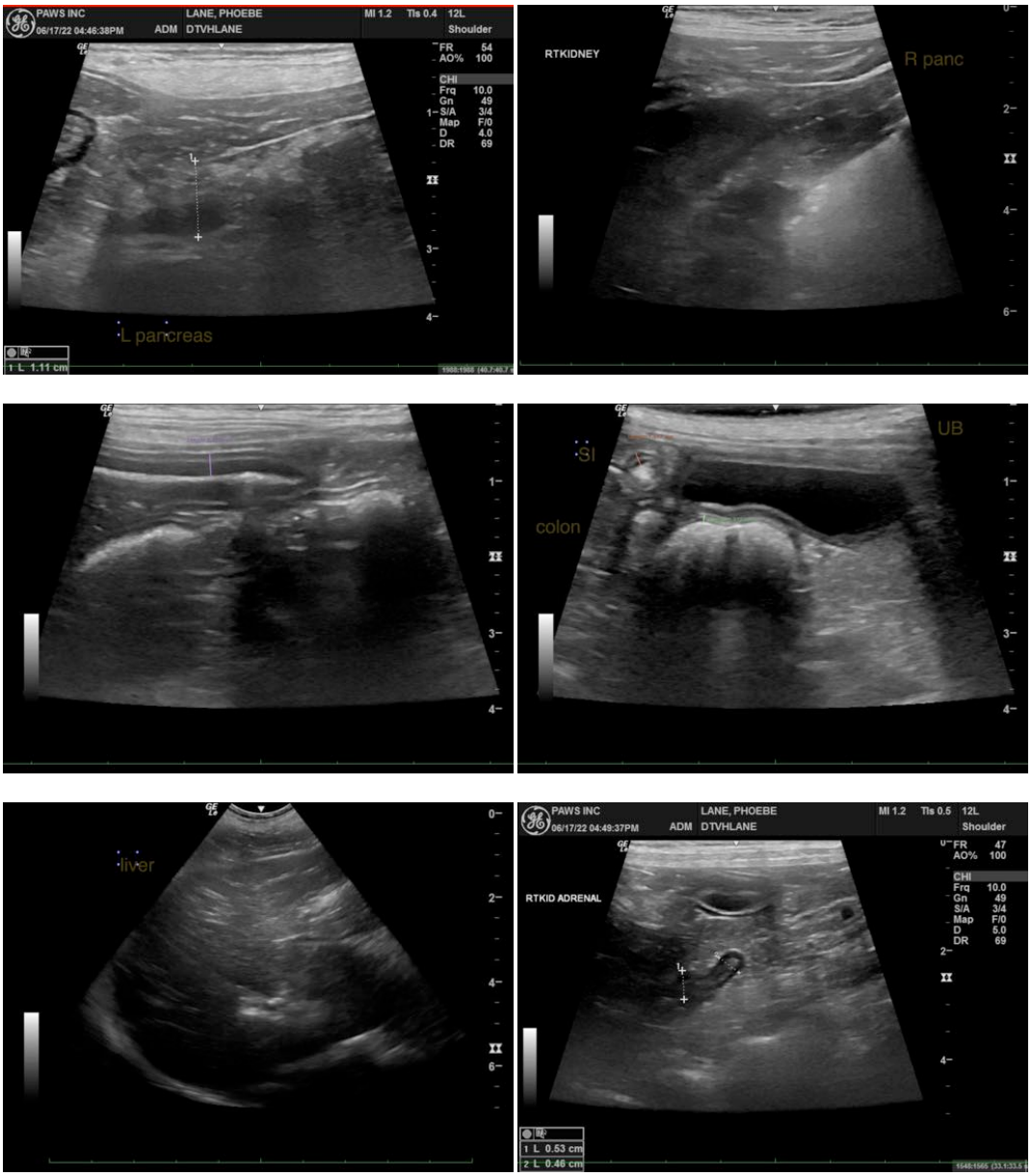
If there is little improvement in Phoebe's clinical status with the above recommendations, one should consider cholangitis/cholangiohepatitis, as well as a secondary ascending bacterial infection. Although indiscriminate use of antibiotics is not normally recommended, one could begin treatment with a broad-spectrum antibiotic and assess her clinical response.

Small frequent meals with low fat diet (less than 20 grams fat/1000 kcal of food) if pancreatitis

Once feeling better, deworm.



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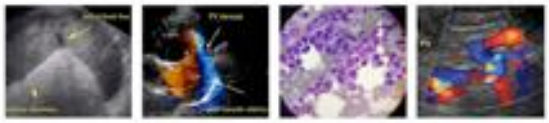

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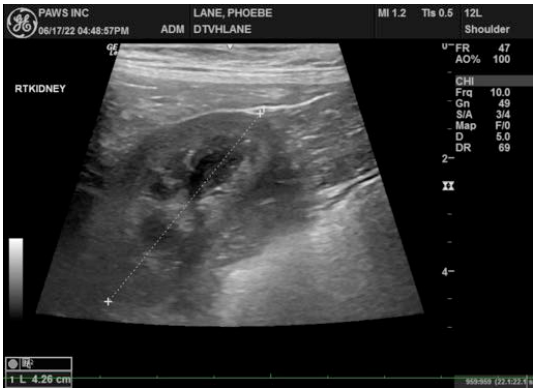
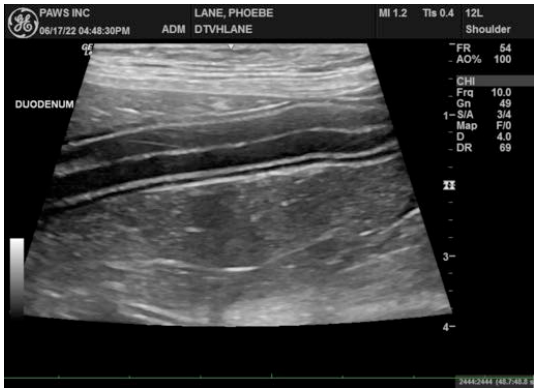
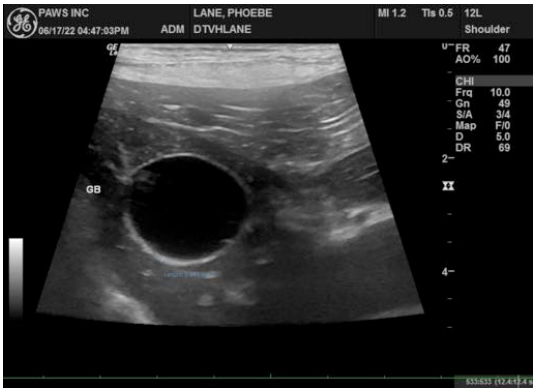
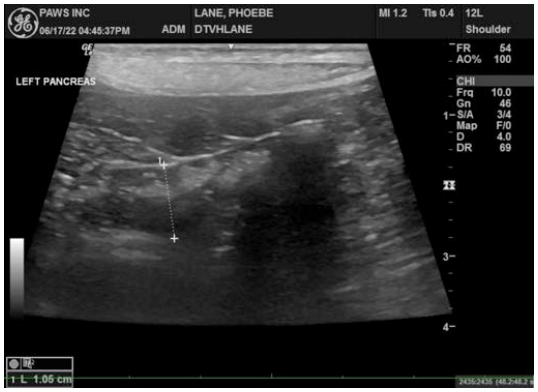
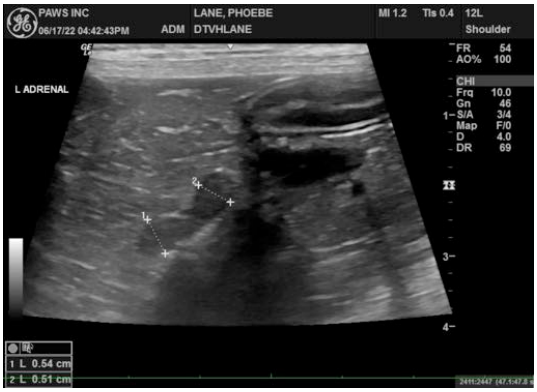








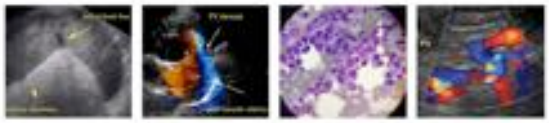


The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Lisa Carioto, DVM, DVSc, Diplomate ACVIM

Lisa.Carioto@sonopath.com



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