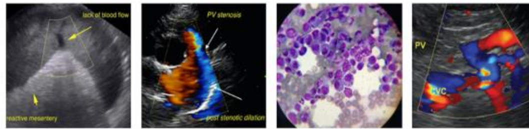


PATIENT
Annie Kristiansen

SPECIES
Canine

BREED
Silky Terrier

SEX
FS

AGE
2008

WEIGHT
11.5

INTERPRETED BY
R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY
Rebekah Jakum, CVT ARDMS/RVT

HOSPITAL NAME
New Britain VC

REFERRING VET
Dr. Bandekar

INVOICE
11821ag

DATE
10/10/2022

PRESENTING CLINICAL SIGNS

Intermittent vomiting.

Abnormal PE/Chem/CBC/UA Results: ALB 3.2 GLOB 3.5 ALP 250 Na:K 32 PSL 137 CBC wnl T4 0.7

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 4.5 cm in length. The right kidney measured – cm in length.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

The bilateral adrenal glands were normal in size. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The left adrenal gland measured 0.39 cm width in the cranial pole and 0.67 cm width in the caudal pole. The right adrenal gland measured 0.57 cm width in the caudal pole.

Spleen

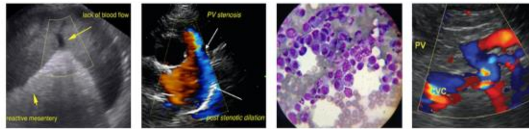
The spleen exhibited primarily finely textured parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Mild generalized parenchyma heterogeneity was present without evidence of nodular changes. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. The parenchymal heterogeneity is likely consistent with benign changes such as extramedullary hematopoiesis or age-related remodeling with minor potential for inflammatory or neoplastic disease.

Liver

The liver exhibited generalized enlargement with normal structure, and contour. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to benign parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content with mild non-dependent echogenic debris. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented mild wall thickening secondary to echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. The gastric body wall measured 0.43 cm width. Mild gastric distension with mild retained primarily anechoic fluid was present. No evidence of retained ingesta or pyloric outflow obstruction was noted.



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The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. Minor intermittent to segmental duodenojejunal non-specific mucosal specking was present. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material. The duodenum wall measured 0.42 cm width. The jejunum wall measured 0.37 cm width.

Normal visible colon wall layers were present with apparent formed feces in lumen.

Pancreas

The pancreas base and right pancreatic limb exhibited subtle prominent size with mild capsule asymmetry and mildly hyperechoic non-uniform parenchyma compared to the adjacent omental fat.

Free Abdomen

No peritoneal effusion was present.

Intermittent focally enlarged hepatic lymph nodes were present adjacent to the portal vein. These lymph nodes exhibited minor asymmetrical contour and mild uniform hypoechoic parenchyma. Some lymph nodes exhibited a borderline abnormal width: length ratio. Evidence of perilymphatic inflammation was evident. An example of lymph node size was 2.1 cm x 1.1 cm.

ULTRASONOGRAPHIC FINDINGS

- Gastroenteritis pattern, potential for inflammatory bowel
- Hepatomegaly exhibiting minor parenchymal remodeling-subjectively benign
- Mild gallbladder debris (non-mucocele)
- Suspect chronic pancreatitis
- Non-specific subjectively benign/reactive hepatic lymphadenopathy
- Mild chronic renal changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Potential for chronic pancreatitis as a contributing factor to the intermittent vomiting may be suspected if evidence of cranial abdominal/subxiphoid discomfort on palpation is present. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. Assuming normal clotting status and using a 25g needle, a hepatic FNA for screening cytology could be considered for further assessment although the overall sonographic appearance of the liver may suggest metabolic/reactive/vacuolar hepatopathy pattern.

Hepatosupportive medications such as Denamarin or Vitamin E as well as Ursodiol due to its antioxidant and immunomodulatory effects within the liver would be warranted if progressive ALP elevation or evidence of cholestasis.

Empirically a canned novel protein diet trial, as needed gastric protectant protocol as well as prophylactic deworming (Panacur 50 mg/kg SID x 5 consecutive days with repeat protocol in 3 weeks even if fecal testing is negative may prove beneficial. Sonographic reassessment of the GI tract is suggested if evidence of persistent/progressive vomiting despite dietary/conservative support.

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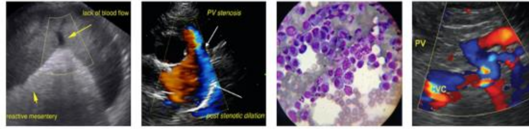

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Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

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RIGHT ADRENAL

ABDOMEN
Panc base / R panc

ABDOMEN
Hepatic LNs

RIGHT KIDNEY

LIVER
Duo

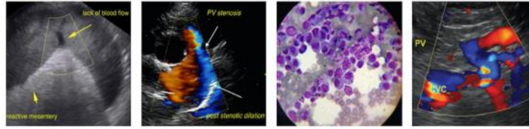
LIVER
GB

STOMACH

LIVER

SPLEEN
Mild mucosal speckling
Jej

LEFT KIDNEY



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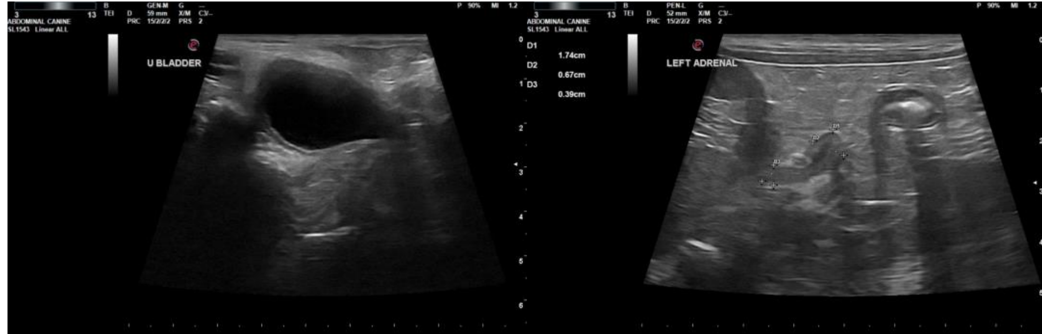

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine/Feline Practice)
mac.daniel@sonopath.com