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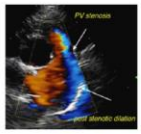
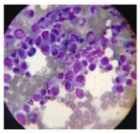
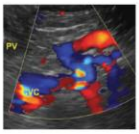

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PATIENT

Tiki Weitzel 1315B

SPECIES

Canine

BREED

Cocker Spaniel

SEX

F/S

AGE

13y 7m

WEIGHT

11.1 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Tom McNeill

HOSPITAL NAME
SVS Imaging CT

REFERRING VET
Madison Veterinary Specialists-Dr. Maller

INVOICE

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10/7/22

PRESENTING CLINICAL SIGNS

Vomited once 5 days ago Became anorexic and very lethargic 2 days ago Ate a small amount of hamburger this morning Had one instance of diarrhea this morning Increased water consumption and urination History of GI upset (vomiting, diarrhea), bilateral TECA, bilateral TPLO, and anal sacculectomy Current medications: Prednisone, Vitamin B12, Tylan powder, Dasequin
Abnormal PE/Chem/CBC/UA Results: rDVM bloodwork: CBC normal, HCT 38%, ALP and ALT > 2000, GGT 4, Tbili 0.3

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 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 was 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 moderate loss of corticomedullary symmetry and definition expected for the age of the patient. Intermittent cortical cysts were noted along with pinpoint medullary mineral. Scant pyelectasia, suspected to be secondary to IV fluid therapy, was also noted. The left kidney measured 6.4 cm in length. The right kidney measured 6.9 cm in length.

Adrenal Glands

Mild prominent bilateral adrenal gland size, based on caudal pole width measurement in light of body size, was present in the adrenal glands with uniformly hypoechoic parenchyma. The left adrenal gland measured 0.65 cm width at the caudal pole and 0.67 cm width at the cranial pole. The right adrenal gland measured 0.99 cm width at the caudal pole and 0.78 cm width at the cranial pole.

Spleen

The spleen exhibited potential mild enlargement with folding. Generalized parenchyma heterogeneity was present with focal, hypoechoic to hyperechoic nondisruptive nodules. An example of a hypoechoic splenic nodule measured 0.71 cm in diameter. Lymphoid hyperplasia, hematopoiesis, infection / splenitis, and myelolipomas, are possible. Neoplastic criteria cannot be definitively excluded.

Liver/ Gallbladder

The liver was moderately enlarged with areas of mild asymmetrical capsule contour. Generalized heterogeneous mixed echogenic parenchyma exhibiting parenchymal remodeling was present. No masses or nodules were noted. The gallbladder was non-distended in size containing mild, nondependent, mildly hyperechoic gallbladder debris. Non-thickened yet mildly hyperechoic gallbladder walls were present. No evidence of gallbladder or peripheral gallbladder inflammation was noted. Subjective mild common bile duct dilation, which did not appear to extend to the level of the duodenal papilla, was noted. The common bile duct measured 0.4 cm in diameter.

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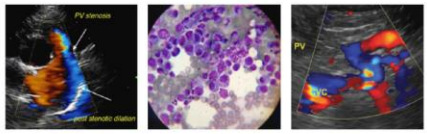

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Gastrointestinal

The stomach presented wall thickening secondary to echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. The stomach was empty without evidence of retained ingesta, fluid, or foreign material.

The small intestine presented intact yet generalized mild prominent wall layering owing to propensity for mildly prominent mucosa. No evidence of mechanical / metabolic ileus was noted. The duodenum wall measured 0.38 cm width. The jejunum wall measured 0.35 cm width.

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

Pancreas

The pancreas was mildly prominent in size and contour with heterogeneous to mildly hypoechoic parenchyma compared to adjacent omentum. Minor capsule asymmetry was noted. No signs of active inflammation or neoplasia.

Free Abdomen

Intermittent mesenteric and medial iliac lymph nodes were present. The lymph nodes exhibited mild nonhomogeneous parenchyma without evidence of peripheral inflammation and maintained a normal width: length ratio (<0.5). An example of a medial iliac lymph node measured 2.4 cm x 0.8 cm. Small pockets of intermittent scant peritoneal free fluid were noted. Mild perilymphatic and peri intestinal hyperechoic mesentery was noted.

ULTRASONOGRAPHIC FINDINGS

- Hepatomegaly exhibiting heterogeneous to irregular parenchyma - chronic vacuolar hepatopathy / vacuolar hepatitis, inflammatory / immune-mediated disease, hyperplasia, hematopoiesis, fibrosis, or other hepatopathy are possible, potential for neoplastic criteria cannot be excluded
- Mild gallbladder debris with subjective mild nonobstructive common bile duct dilation - possible cholangitis (non-mucocele)
- Subjective mild generalized inflammatory gastroenterocolonopathy pattern
- Mild splenic folding with intermittent nondisruptive variably echogenic nodules
- Prominent to heterogeneous pancreas - age/patient variant with benign remodeling, potential for chronic to chronic active pancreatitis
- Bilateral chronic renal changes with cortical cysts, minor medullary mineral, and scant pyelectasia
- Bilateral mildly prominent adrenal glands - nonspecific, no evidence of adrenal neoplastic criteria

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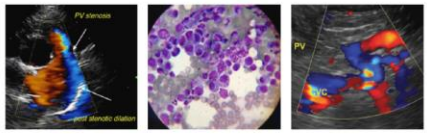

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- Intermittent nonspecific yet subjective benign / reactive mesenteric lymph nodes and scant free fluid - lymph nodes not overtly consistent with neoplastic criteria

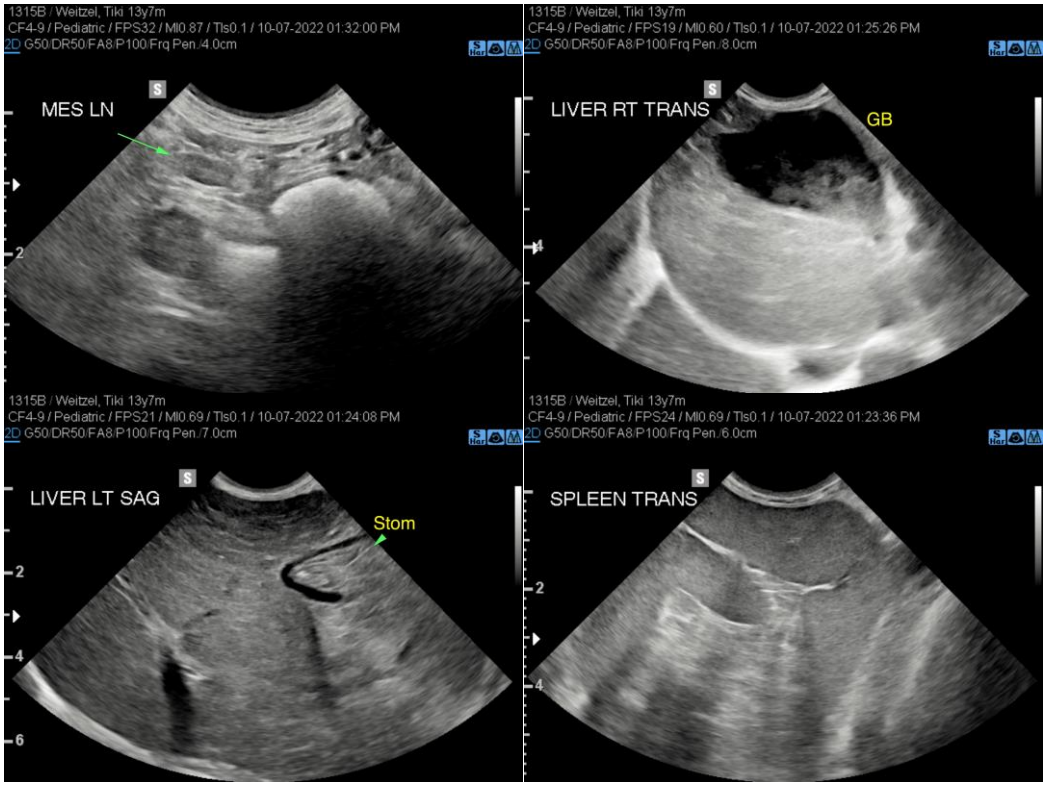
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Potential for chronic to chronic active pancreatitis would be suspected if evidence of cranial abdominal or subxiphoid discomfort on palpation, correlation with a Spec cPL could be considered.

Assuming normal clotting status, screening hepatic FNA cytology is warranted for further assessment. Potentially, Prednisone therapy may be masking intraabdominal pathology, yet may also be contributing to the elevated hepatic enzymes.

Potential for inflammatory bowel disease, given the patient history of GI signs, is possible.

Further renal staging to include urine C/S and protein: creatinine ratio on sterile urine sample may be considered.



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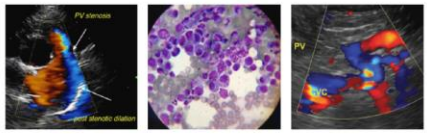

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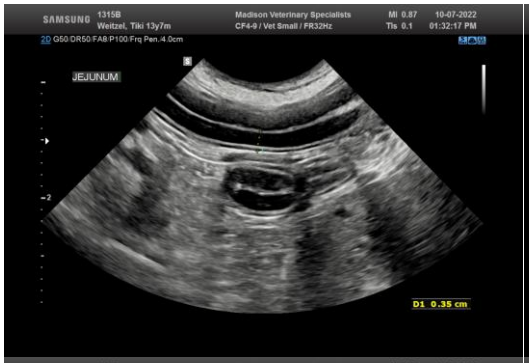

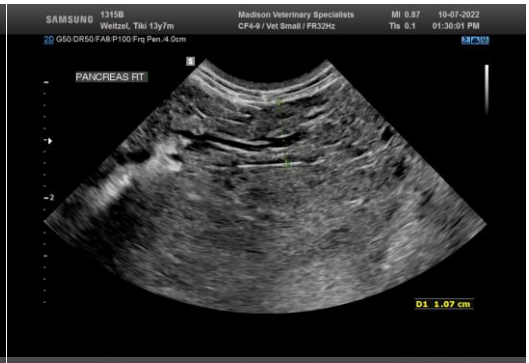

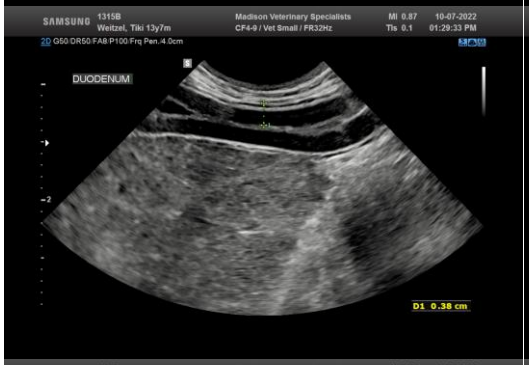

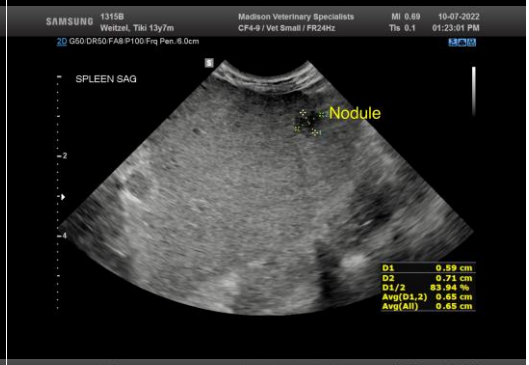

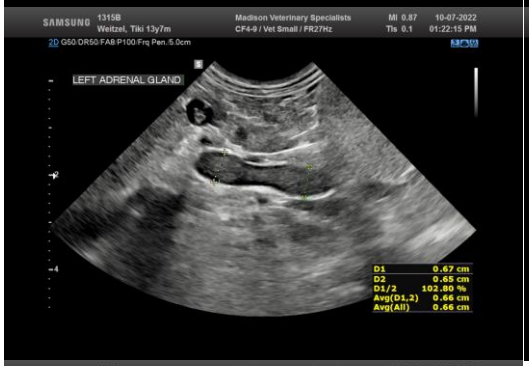

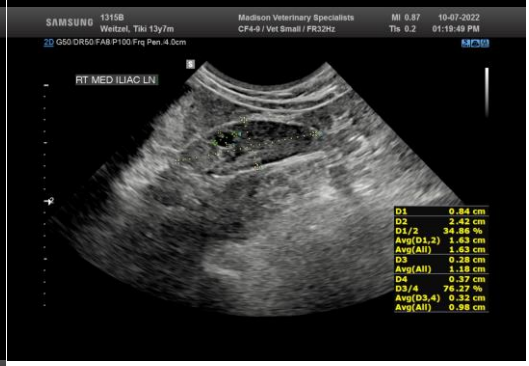

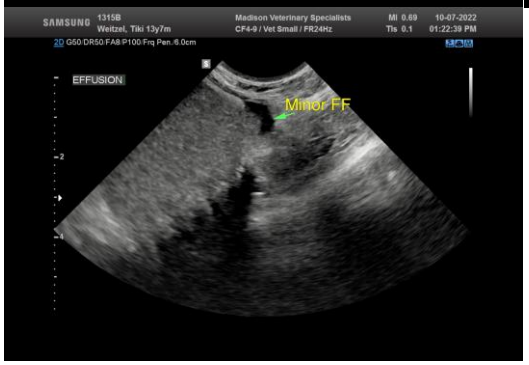

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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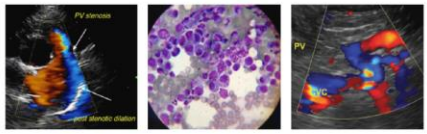

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Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

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