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Clinical Sonography & Telecytology
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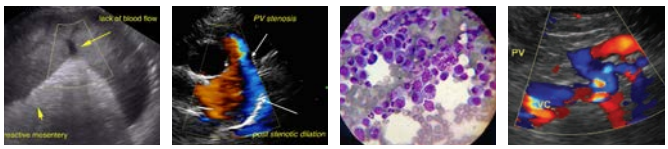

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Sweetie Shulz

SPECIES
Canine

BREED
DSH

SEX
Spayed Female

AGE
19

WEIGHT
3.29 kg

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

IMAGING PERFORMED BY
Dr. Alastair Westcott

HOSPITAL NAME
Dr. Alastair Westcott

REFERRING VET
Dr. Alastair Westcott

INVOICE
45549

DATE
2/27/23

PRESENTING CLINICAL SIGNS

Presented for investigation of a decreased appetite and a heart murmur in August of last year. Bloodwork at that time demonstrated a mild hypokalemia but was otherwise unremarkable. Was receiving solensia Q monthly. The abdominal ultrasound in August suggested potential, underlying IBD with the potential of low grade chronic to chronic-active pancreatitis, ages-related adrenal change and a torturous CBD which suggested ages-related change or mild, underlying cholangitis/cholangiohepatitis There was a overtly normal geriatric cardiac structure and function. Suggestive of a physiologic murmur. An elevated TLI suggested intestinal disease/ pancreatitis etc. Normal folate levels. A normal spec fpl makes pancreatitis less likely More recently, subsequent to a dental procedure, the client is noticing PU/PD.

Abnormal PE/Chem/CBC/UA Results: Ongoing weight loss, heart murmur An elevated TLI suggested intestinal disease/ pancreatitis etc. Normal folate levels. A normal spec fpl makes pancreatitis less likely Mild hypokalemia No significant proteinuria

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of - cm exhibited normal thickness and tone. Primarily anechoic urine was present in the lumen. Moderate non-depdnent particulate sediment was present without evidence of calculus formation. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural 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 loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measures 3.3 cm. The right kidney measures 3.4 cm.

Adrenal Glands

The left adrenal gland was normal in size with subtle non-homogeneous parenchyma. Potential for discreet pinpoint dystrophic left adrenal mineral, which is a normal age related finding in a cat. The right adrenal gland exhibited subtle prominent size with mild capsule asymmetry, mild non-homogeneous contour, and subtle heterogeneous non-mineralized parenchyma measuring 1.0 cm length x 0.54 cm at the caudal pole.

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The spleen measured 0.61 cm in width at the level of the hilus. 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. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver

The liver was subjectively normal in size, 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. Minor echogenic debris present. Minor proximal non-obstructive common bile duct dilation noted.

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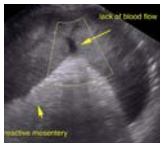
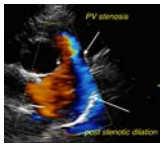
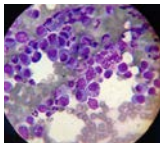
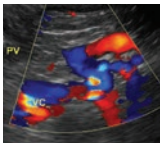

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Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. Gastric body wall measured 0.24 cm. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material.

The small intestine presented generalized intact wall layering with segmental propensity for mildly prominent jejunal muscularis layer, without evidence of significant mural hypertrophy, loss of intestinal wall layering, or intestinal masses. Duodenum wall measured 0.21 cm. Jejunum wall measured up to 0.29 cm. Ileocolic wall measured 0.26 cm. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material.

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

Pancreas

The pancreas was normal in size and overall contour with subtle non-homogeneous hypoechoic left limb parenchyma compared to adjacent non-reactive peripancreatic omentum.

Free Abdomen

No omental masses, lymphadenopathy, or evidence of significant lymphadenopathy.

PRIMARY FINDINGS

- Persistent intact yet mild segmental prominent intestinal wall layering
- Mildly non-homogeneous to hypoechoic left pancreas
- Static mildly irregular right adrenal gland
- Minor non-obstructive proximal common bile duct dilation – static.
- Previously noted persistent urinary bladder sediment.

SECONDARY FINDINGS

- Static chronic renal changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Similar sonographic presentation compared to the previous study without overt evidence of significant pathology, although some degree of mild progressive mural hypertrophy possible with potential for measurement variation. No overt evidence of neoplastic criteria.

The urinary bladder sediment may suggest cellular / crystalline debris or mucus. Cystocentesis for UA +/- C/S if evidence of inflammatory cells is recommended.

Continued monitoring of potassium levels given the mildly prominent to irregular right adrenal gland with periodic assessment of BP suggested. Although there is potential for patient variant, given the patient's chronic weight loss, low-grade chronic inflammatory enteropathy is suspected. Intestinal biopsies would be required for definitive diagnosis. Alternatively, empirical therapy for likely mild chronic IBD with assessment of caloric plane and continued monitoring of weight loss would be reasonable. Chronic low-grade triad disease could be an alternative differential diagnosis, although no evidence of significant pancreatitis or hepatobiliary disease.

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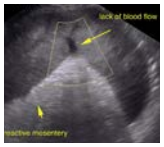
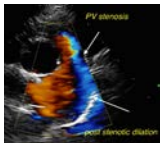
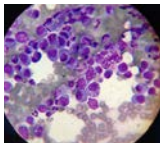
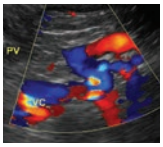

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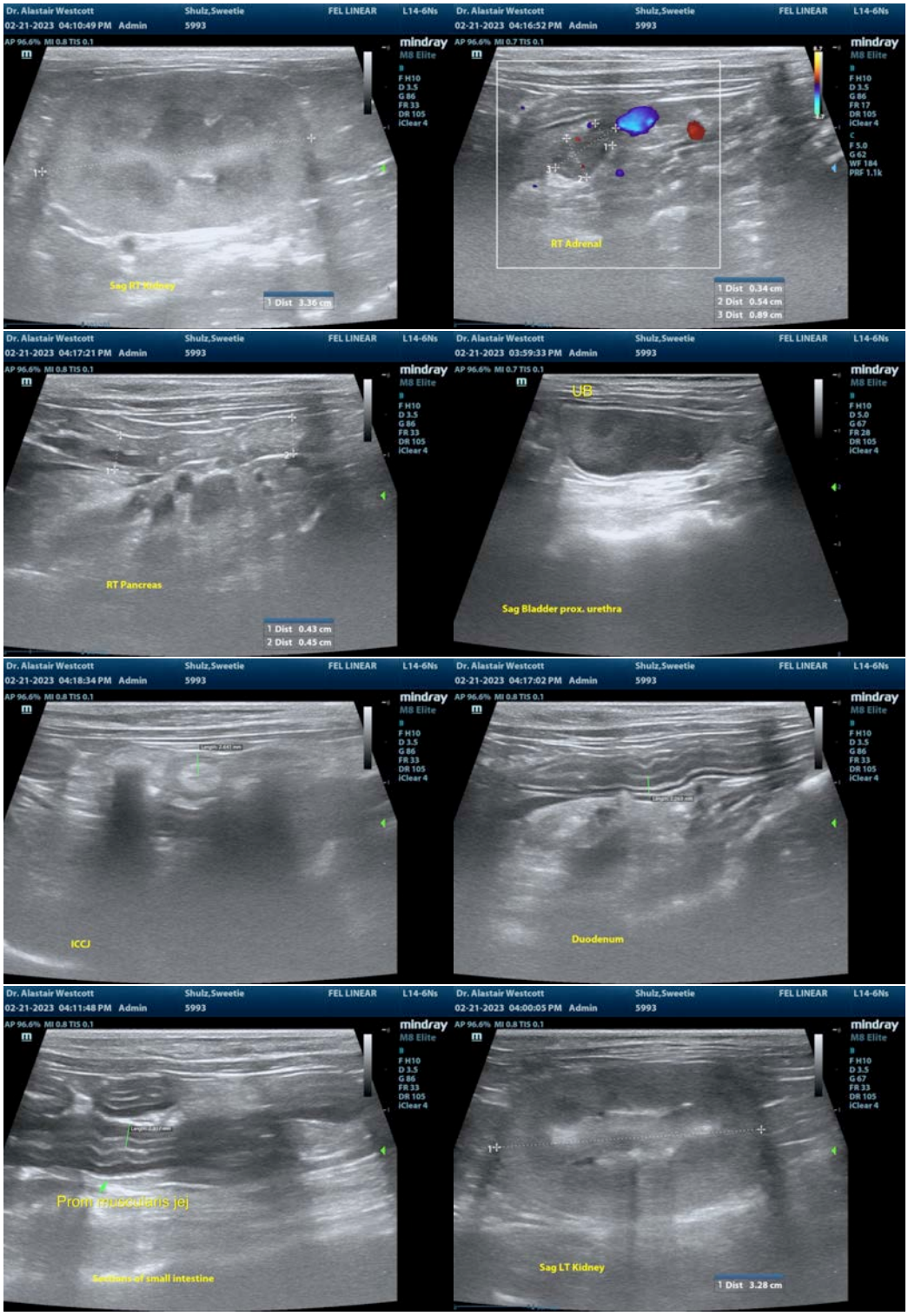

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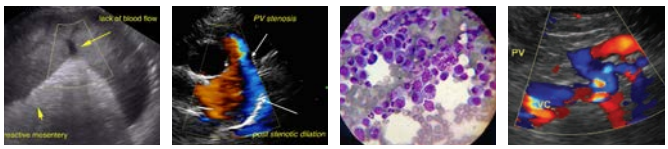

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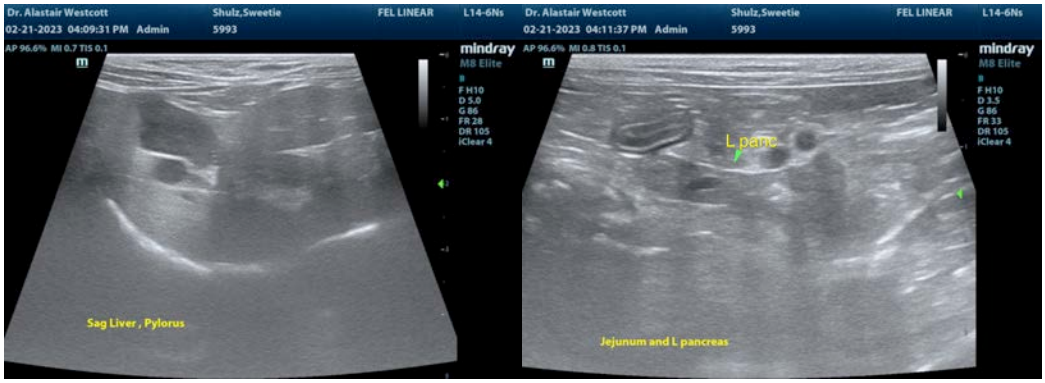

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

info@SonoPath.com