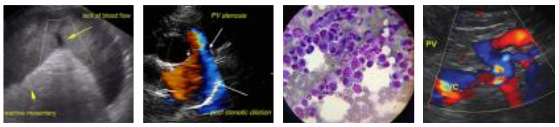

PATIENT

Petey Arnston

SPECIES

Canine

BREED

Chihuahua Mix

SEX

MN

AGE

12 years

WEIGHT

10.9 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Jenna Walsh, CVT

HOSPITAL NAME

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Dr. Parker

INVOICE

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PRESENTING CLINICAL SIGNS

1. Neuro: Potential seizure activity starting few weeks ago. Not started on any medication yet. Hx of suspect idiopathic vestibular disease (8/2021). Tooth root abscess --> buphthalmia noted around that time. IVD signs significantly improved prior to COHAT to address tooth. OS still slightly prominent. 2. GI: Progressive hyporexia and becoming a picky eater. Recent weight loss and hx of intermittent vomiting. Primary Question/Differential to Be Answered in This Exam Attempting to r/o pancreatitis or primary GI changes as etiology for appetite changes vs. other Will also be utilizing sedation to evaluate P's teeth/oral cavity.
Abnormal PE/Chem/CBC/UA Results: Last labs performed 5/9/2022 Mildly elevated BUN x years with no progression. USG 1.023 with potential proteinuria (2+ on stick) Mild neutrophilia at 12089 /µL (2060-10600) and mild monocytosis at 1256 /µL (0-840) PrecisionPSL elevated at 369 U/L (24-140) *NPS on fecal, Accuplex neg x 4, T4 WNL.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 5.0 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.

The residual prostate was symmetrically normal in size with uniform parenchyma and slight coarse echotexture measuring 1.0 cm in diameter.

The area of the aortic trifurcation was free of pathology.

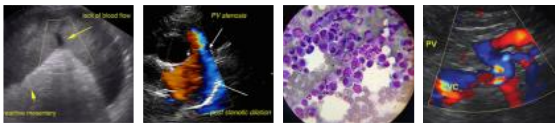
Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 3.5 cm in length. The right kidney measured 3.9 cm in length.

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 1.8 cm length x 0.61cm width in the caudal pole. The right adrenal gland measured 1.8 cm length x 0.58 width in the caudal pole.

Spleen

The spleen exhibited mild folding which is not considered pathological and likely a patient variant or possibly owing to sedation. The spleen presented a 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



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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/ Gallbladder

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 normal in size with mild, primarily dependent to mild nondependent, nonmineralized debris primarily in the area of the caudal lumen and gallbladder neck. Between the nondependent debris and inner luminal wall were areas of hypoechoic suspected mucus. No evidence of gallbladder or peripheral gallbladder inflammation was noted. The cystic duct and common bile ducts were normal without evidence of dilation.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction, or foreign material. The gastric body wall width measured 0.29 cm.

The small intestine presented intact to subjective prominent wall layering owing to subjective propensity for mildly prominent duodenojejunal mucosa. Intermittent nonspecific jejunal mucosal speckling was present.

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

Pancreas

The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

Free Abdomen

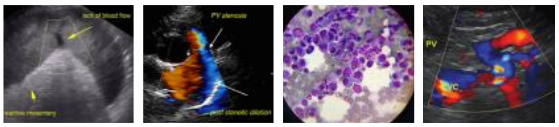
No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Intact yet subjective mild prominent small bowel walls
- Heterogeneous pancreas - potential for low-grade to chronic pancreatitis vs. patient / age-related variant
- Bilateral mild chronic renal changes
- Mild gallbladder debris and suspected mucus (non-mucocele)

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The small intestinal presentation may indicate a normal patient variant, although the possibility of an underlying inflammatory process i.e., IBD could be possible. No evidence of gastrointestinal



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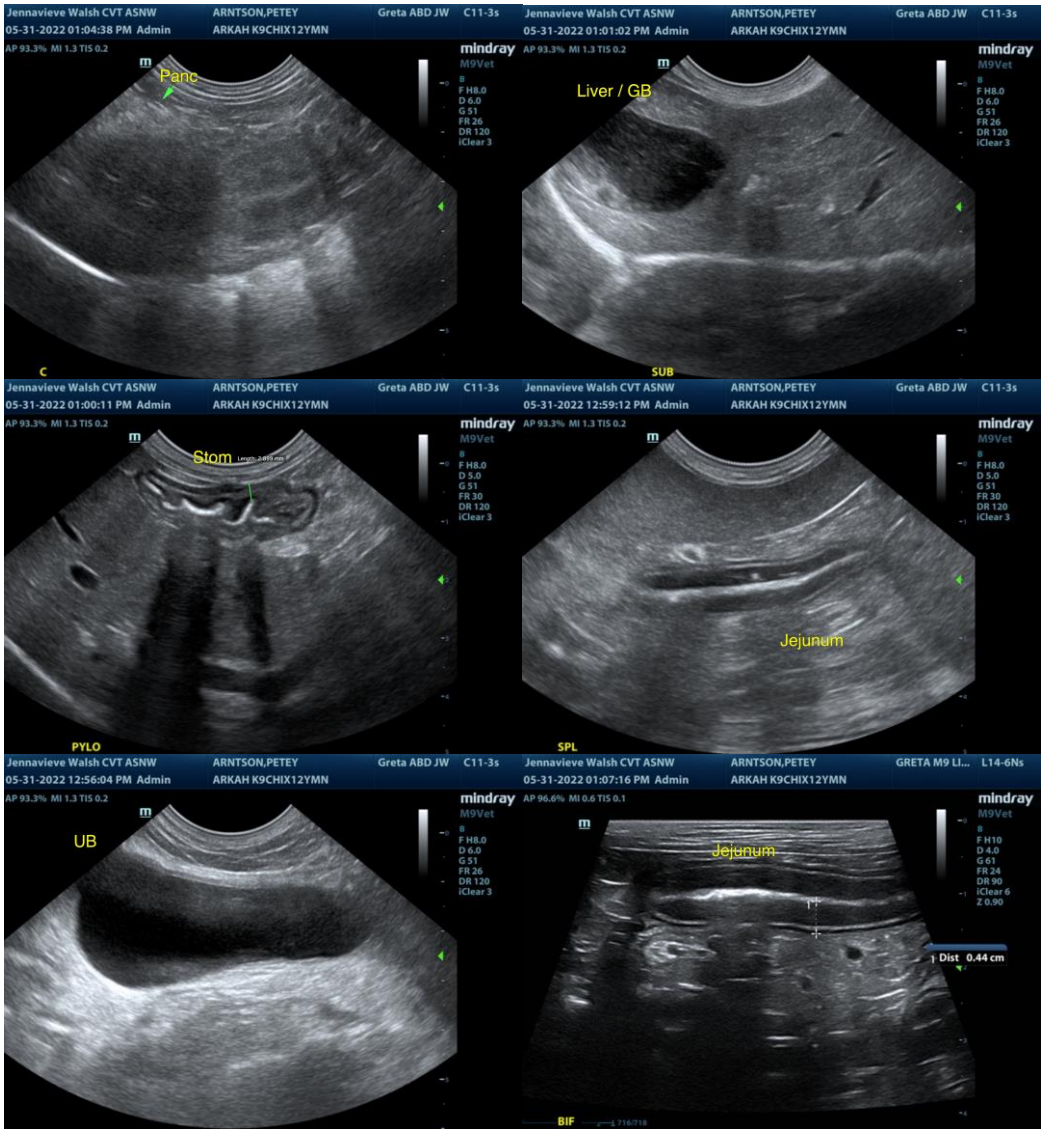
neoplastic criteria was noted. Potential for a combination of underlying Inflammatory enterophathy and low-grade to chronic pancreatitis may be considered a primary differential diagnosis.

Further assessment may include a GI panel to include PLI/TLI/Cobalamin/Folate. Three view chest radiographs are suggested to rule out occult thoracic or esophageal pathology as a contributing factor. Empirical continued gastrointestinal support and assessment of caloric plane would be reasonable. Further renal staging to include urine C/S and protein: creatinine ratio on sterile urine sample may be considered.



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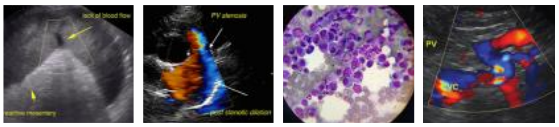

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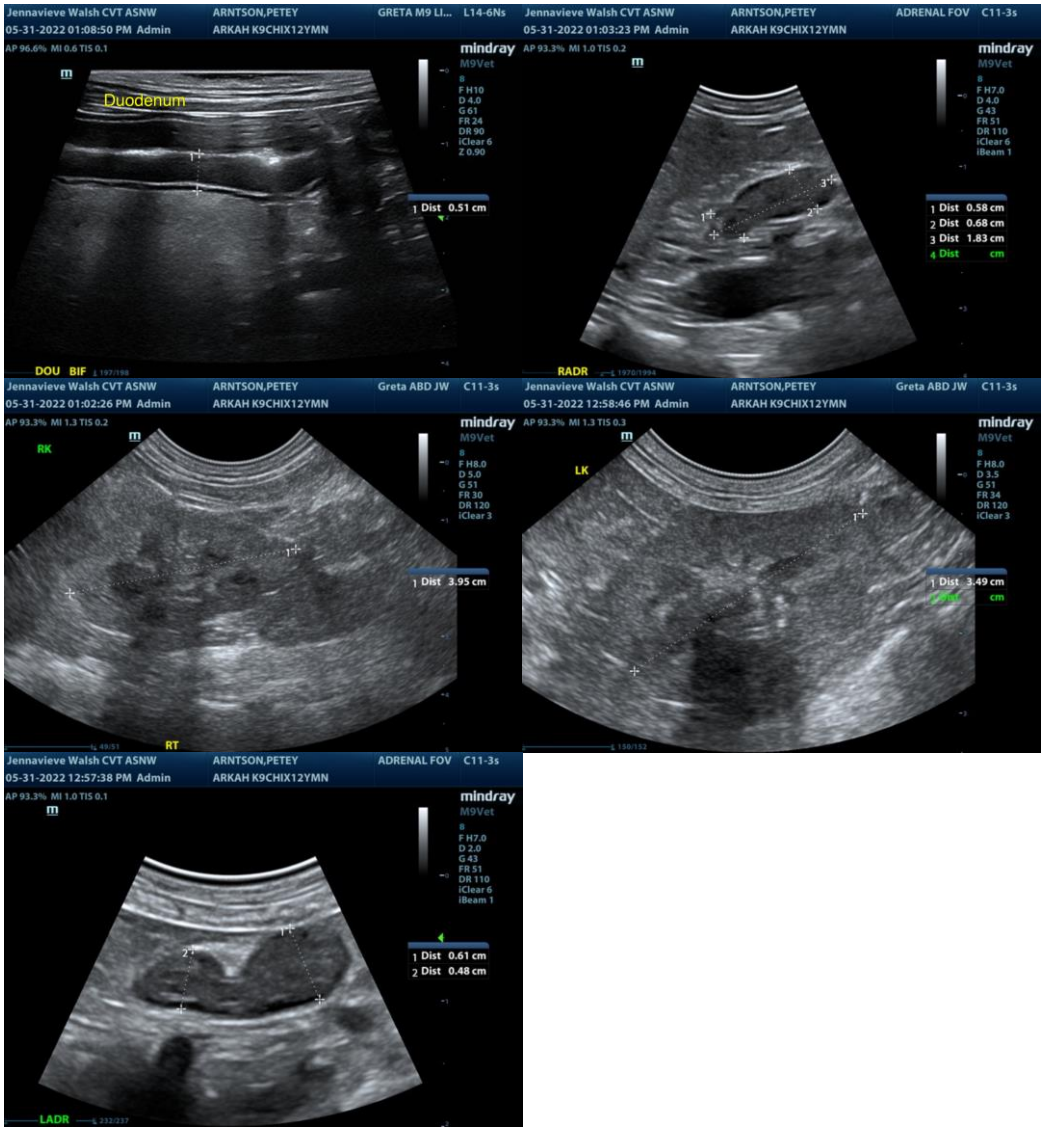

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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