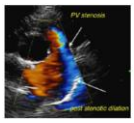
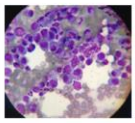
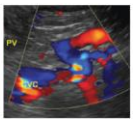




PATIENT

Candy Layne

SPECIES

Canine

BREED

Chihuahua

SEX

SF

AGE

11 years

WEIGHT

5.8 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Sarah Pender, CVT

HOSPITAL NAME

SVS Imaging QC

REFERRING VET

Dr. Narske

INVOICE

14643

DATE

8/18/22

PRESENTING CLINICAL SIGNS

Presented for vomiting, diarrhea, anorexia for couple days. Cerenia seemed to help the vomiting but still nauseous and drooling. Liquid almost clear diarrhea. On propectalin. Being hospitalized on IVF-LRS w/Metronidazole CRI, cerenia. Has not eaten anything since Sunday and that was very small amount. Drank a small amount of water Tuesday.
Abnormal PE/Chem/CBC/UA Results: Bloodwork WNL. Has mass inguinal area that has been there for years.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 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 area of the aortic trifurcation was free of pathology.

Areas of mild asymmetrical 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. No evidence of pelvic dilation was present. A cranial cortical cyst was noted in the left kidney. Nonobstructive medullary renolith was present in the right kidney measuring 0.74 cm in diameter. The left kidney measured 3.7 cm in length. The right kidney was mildly subnormal In size compared to the left, measuring 2.9 cm in length.

Adrenal Glands

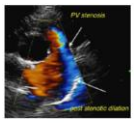
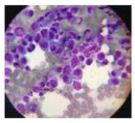
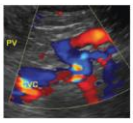
The bilateral adrenal glands were normal in size. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The left adrenal gland measured 1.5 cm length x 0.48 cm width at the caudal pole. The right adrenal gland measured 1.9 cm length x 0.68 cm width at the caudal pole. No overt evidence of adrenal neoplastic criteria was noted.

Spleen

The spleen was overall normal in size with maintained symmetrical capsule contour and homogeneous parenchyma. A solitary, mildly expansive, hypoechoic to nonhomogeneous cranial splenic nodule measuring 1.2 cm in diameter was present.

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 non-distended in size containing anechoic content with moderate, mildly congealed, hyperechoic, nonorganized luminal gallbladder debris. No evidence of gallbladder or peripheral gallbladder inflammatory criteria was noted. The cystic and common bile ducts were normal.

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Gastrointestinal

The stomach presented intact yet mild regional prominent wall layering. The stomach was moderately distended with retained anechoic fluid and nonshadowing chyme. No evidence of mechanical pyloric outflow obstruction or obstructive pyloric mural pathology was noted.

The intestinal walls demonstrated intact wall layering and maintained 1:3 muscularis / mucosa ratio. The mucosa exhibited mild decreased echogenicity with occasional mucosal speckling. A segmental to diffuse ileus pattern consisting of mild fluid accumulation in the intestinal lumen was present without evidence of mechanical small intestinal obstructive pattern, loss of intestinal wall layering, intestinal masses, or intestinal foreign material.

The colon walls presented intact yet prominent wall layering with mild thickened to echogenic submucosa. Semi-formed to soft feces, consistent with diarrhea, was present in the colon lumen with lumen dilation.

Pancreas

The left limb, right limb, and base of the pancreas presented hypoechoic to heterogeneous echogenicity compared to adjacent omental fat. Mild asymmetrical capsule margination was present with mild variable parenchymal swelling and mild peripancreatic reactivity / inflammation. No overt evidence of neoplasia.

Free Abdomen

Sonographic assessment of the inguinal mass revealed evidence of intestinal segments without evidence of intestinal obstructive pattern, as well as hyperechoic omentum, and scant free fluid within the inguinal mass. Generalized mildly hyperechoic omentum was noted. No evidence of significant intraabdominal lymphadenopathy or peritoneal free fluid was noted.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Gastroenterocolitis pattern with hypomotile stomach
- Mild active to chronic active pancreatitis pattern
- Nonspecific, mildly expansive cranial splenic nodule - multiple etiologies possible including hyperplasia, hematopoiesis, small hematoma, splenitis, less likely infarct, while potential for emerging neoplasia is possible
- Inguinal hernia

Secondary Findings

- Bilateral chronic renal changes with left kidney cortical cyst and nonobstructive right kidney renolith
- Mild hepatic parenchymal remodeling with moderate congealed yet nonorganized gallbladder debris (non-mucocele)

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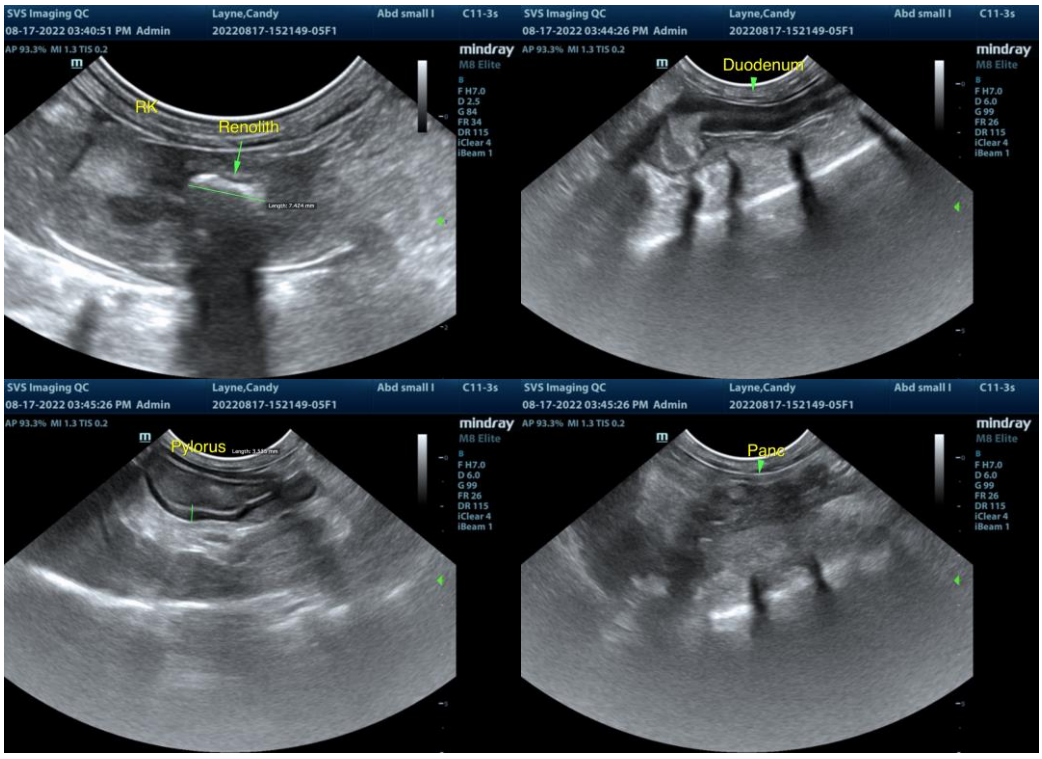
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The overall appearance of the gastrointestinal tract is suggestive of acute inflammatory criteria with some contribution to the patient's GI signs secondary to mild active to chronic active pancreatitis suspected. Dietary intolerance / food hypersensitivity, occult parasitism, gastroenteric insult, infectious gastroenteritis, IBD, or less likely yet possible occult infiltrative neoplasia are all potentials.

Further assessment may include fresh fecal analysis to rule out parasitic ova / giardia, Spec cPL for further assessment of the pancreas, +/- a full GI panel to include Cobalamin/Folate levels.

No overt evidence of obstructive small intestinal pattern within the inguinal hernia, although some degree of concurrent segmental enteritis within the inguinal hernia is suspected.

Sonographic monitoring of the cranial splenic nodule for evidence of progression +/- FNA cytology, assuming normal clotting status, could be considered. Empirically, aggressive therapy for acute gastroenterocolitis and pancreatitis with an assessment of clinical response and potential recheck sonogram if persistent / progressive GI signs are noted, would be reasonable.



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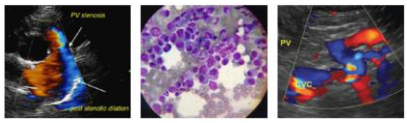

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Clinical Sonography & Telecytology

EDUCATIONAL TELECONSULTATION SERVICES™

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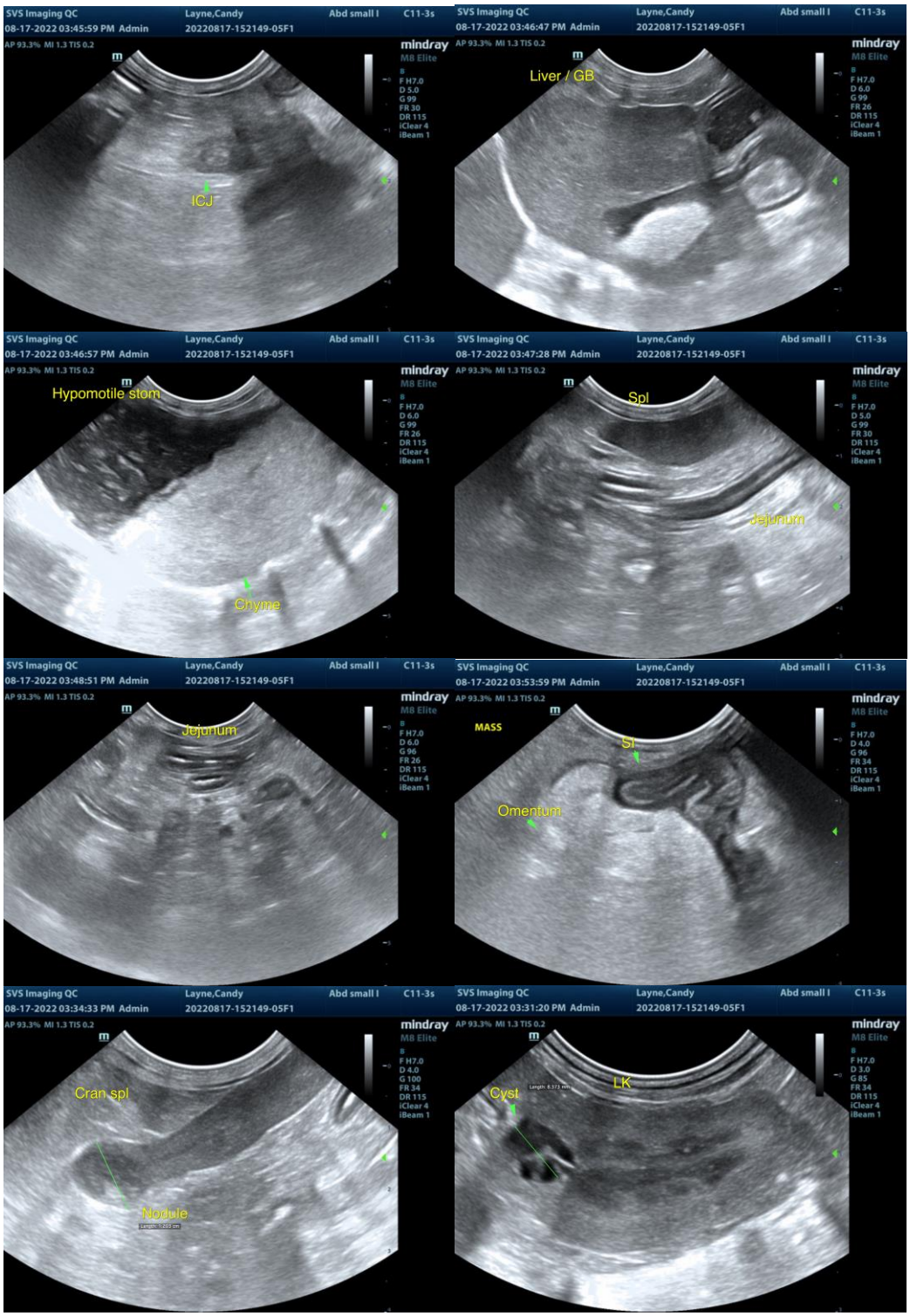

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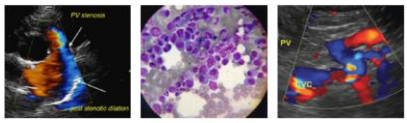

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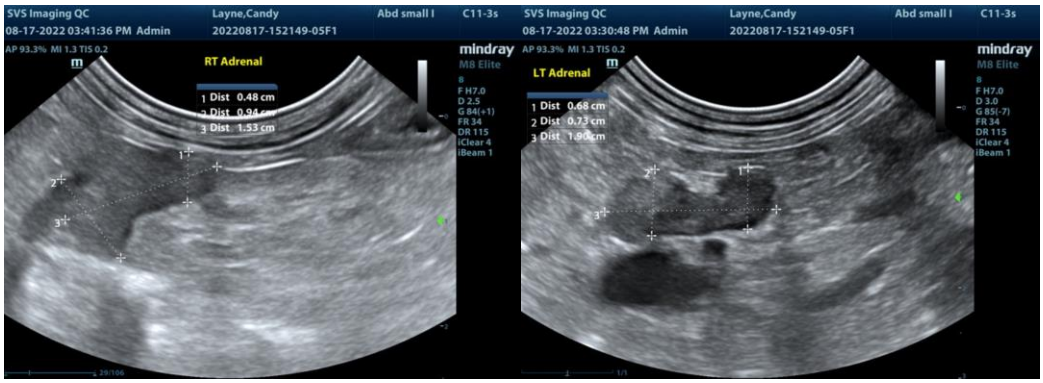

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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