SonoPath
Clinical Sonography & Telecytology
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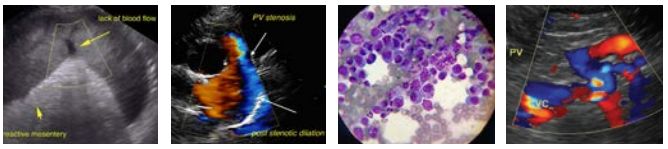

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1-800-838-4268 info@sonopath.com

PATIENT
Izzi Dreeszen

SPECIES
Canine

BREED
Yorkie

SEX
Spayed Female

AGE
6 Years

WEIGHT
5.8 Pounds

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

IMAGING PERFORMED BY
Rachel Runnells, RVT

HOSPITAL NAME
SVS Imaging KC

REFERRING VET
Dr. Sarah Meineka

INVOICE
24880

DATE
8/24/21

PRESENTING CLINICAL SIGNS

3-4 year long history of waxing and waning appetite, vomiting, and diarrhea. Currently presenting for anorexia, vomiting clear, and hematochezia/melena. Leaking diarrhea when pressure is put on abdomen.
Abnormal PE/Chem/CBC/UA Results: Bloodwork has been rechecked multiple times February 2021-August 2021. Climbing BUN (April 66, climbing to now 112 in August). Panhypoproteinemia resolved since beginning treatment for IBD. Now elevated Creatinine (1.6 up from 0.8 in Feb) and SDMA (25 in March, 14 in May, now 23) in addition to BUN elevation. Spec cPL currently 415, was 251 in March, 353 in May. Additional diagnostics in March: TLI >50 (range 5-35), cobalamin 462 (range 284-836), folate 17.8 (range 4.8-19). UA in March: spc grav 1.035, 100 mg/dL protein, pH 7.0, >1 hyaline casts/hpf UA August 21 (after rehydration with fluids): spc grav 1.022, protein 500 mg/dL, <1 nonhyaline casts/hpf. Fecal flotation negative but treated with 7 day course of fenbendazole and 21 day course of metronidazole in April. Receiving prednisone at 0.5 mg/kg/day and omeprazole BID and sucralfate BID.

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 were noted.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. Subtle mildly non-uniform increased cortex echogenicity and loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation present. Minor dystrophic medullary mineralization noted in both kidneys. The right kidney measured 3.7 cm. The left kidney measured 3.7 cm.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

The adrenal glands were uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.27 cm at the cranial pole and 0.28 cm at the caudal pole. The right adrenal gland measured 0.34 cm at the cranial pole and 0.33 cm at the caudal pole.

Spleen

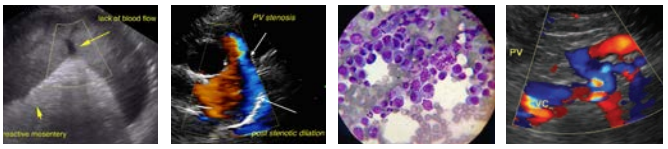
The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute 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 uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non distended in size with moderate non-dependent yet non-organized, echogenic debris. The common bile duct was normal.

Gastrointestinal

The stomach presented wall thickening secondary to echogenic mucosa hypertrophy, primarily in the area of the gastric antrum and pylorus. Intact wall layering was maintained and distinct. Mild gastric



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distension with primarily anechoic fluid was present. The gastric fundus and body were mildly gas distended. Gastric body wall measured 0.22 cm. Pylorus wall measured 0.41 cm.

The small intestine presented intact wall layering with subjective propensity for segmental prominent muscularis layer as well as generalized mildly prominent to echogenic submucosa. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material. Jejunum wall measured 0.25-0.30 cm. Duodenum wall measured 0.39 cm.

The colon walls presented intact yet prominent wall layering with mild thickened to echogenic submucosa. A minimal amount of subjective nonformed feces present.

Pancreas

The parenchyma of the pancreas was hyperechoic to adjacent omental fat with diffuse parenchyma remodeling. The capsule of the pancreas was mildly asymmetrical in contour without evidence of peripancreatic inflammation. These changes may suggest chronic inflammation, fibrosis, or saponification if previous history of pancreatitis. No overt signs of pancreatic neoplasia.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

Subtle subjective minor reactive peri intestinal mesentery noted.

ULTRASONOGRAPHIC FINDINGS

- Moderate chronic renal changes – consistent with chronic nephropathy as opposed to acute renal disease or insult.
- Moderate gallbladder debris (non-mucocele)
- Chronic enterocolonopathy – suggestive of chronic IBD/colitis
- Chronic pancreatitis
- Minor gastritis with minor retained pyloric fluid – no overt ulceration

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Overall appearance of the gastrointestinal and colon is suggestive of chronic inflammatory gastroenteropathy with suspicion for chronic IBD and mild colitis. The current use of Prednisone may potentially be masking enterocolic mural changes. Further renal staging to include urine C/S and protein: creatinine ratio on sterile urine sample may be considered. Recheck GI panel is recommended. In addition to current treatment protocol, limited antigen to hydrolyzed diet and high colony count probiotic such as Proviable or Visbiome +/- as-needed antibiotic therapy (Metronidazole or Tylosin) are recommended.

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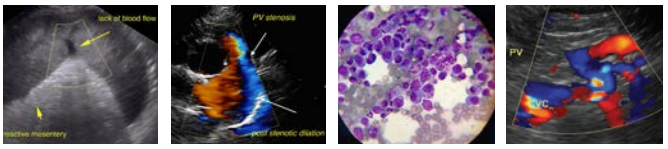

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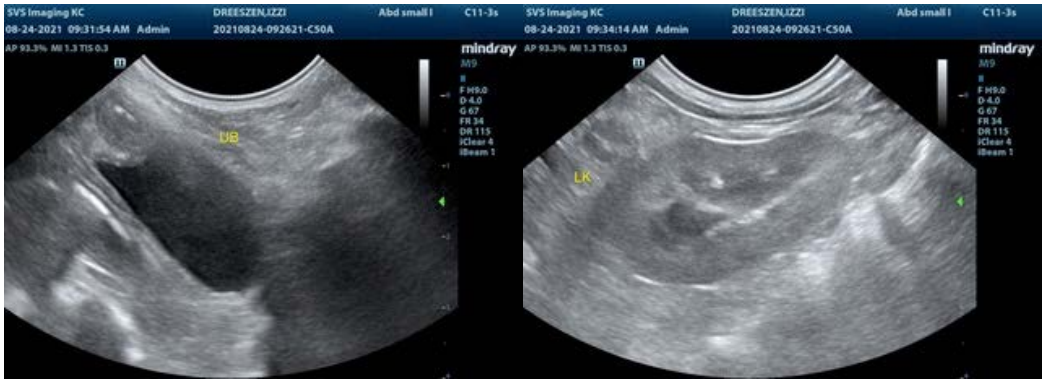

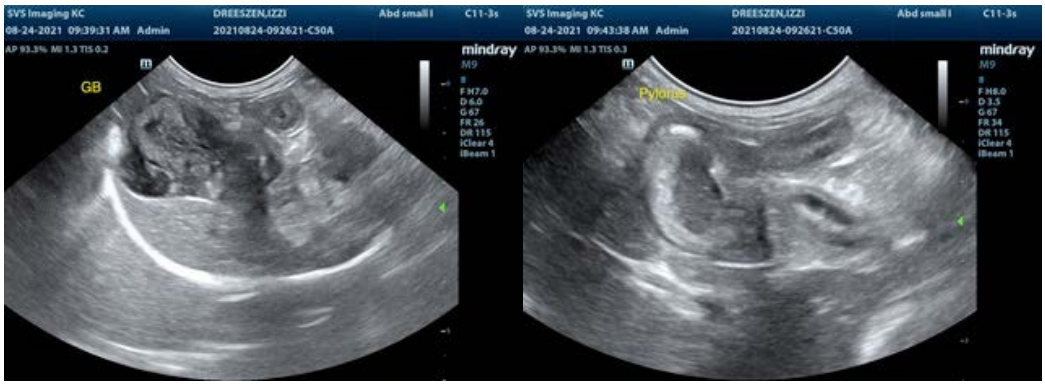

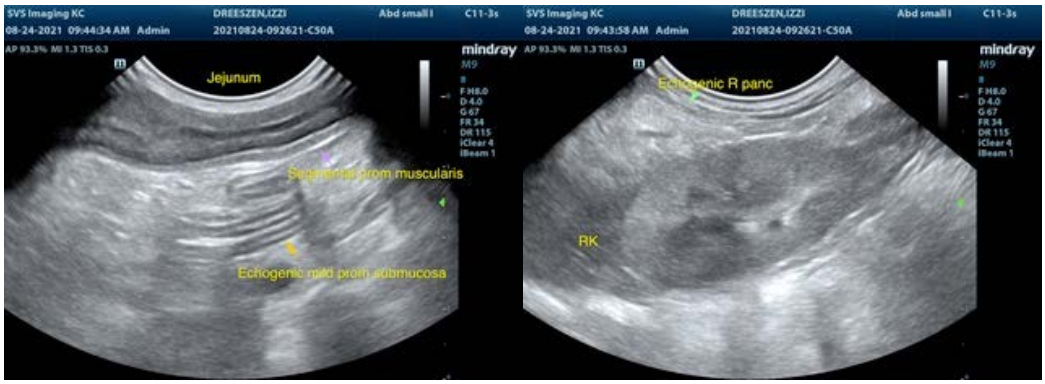

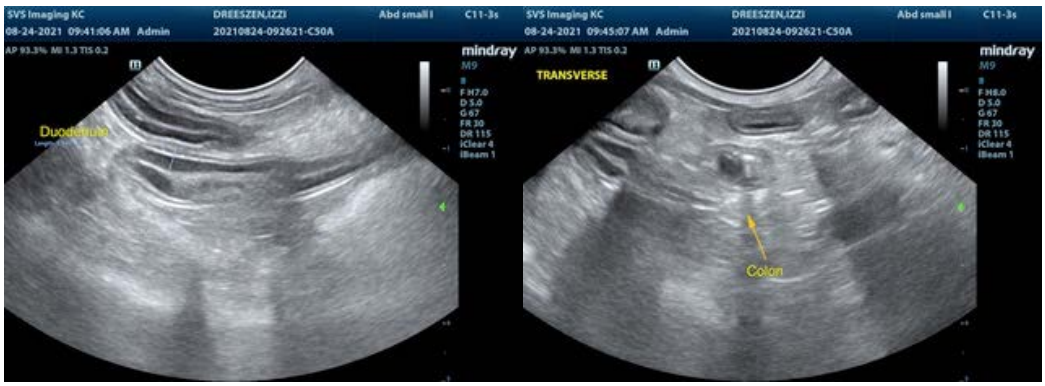

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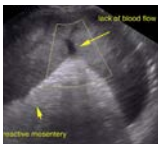
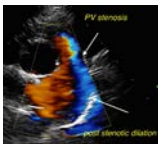
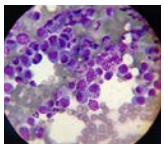
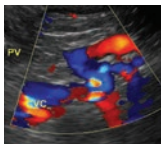

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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