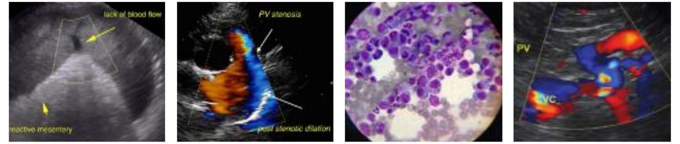

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1-800-838-4268 info@sonopath.com

PATIENT

Bennie Mawhinney

SPECIES

Canine

BREED

Bichon X

SEX

MN

AGE

11 years

WEIGHT

6.9 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Sara Barthelemy

HOSPITAL NAME
Britannia Kingsland Vet Clinic

REFERRING VET

Dr. Elaine Murphy

INVOICE

14791

DATE

9/1/22

PRESENTING CLINICAL SIGNS

Diarrhea with very periodic vomiting started a few weeks ago. Vomiting resolved. Diarrhea is liquidy with small amt blood. Treated with metronidazole and gastro diet but no response. History of elevated ALP (3000) and ALT (300). Has been on zenotonil.
Abnormal PE/Chem/CBC/UA Results: ALP 5000 and ALT 400. Elevated spec cpl and lipase. Fecal negative. Previously elevated triglycerides.

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 residual prostate was free of pathology.

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. Focal areas of non-obstructive mild medullary mineral were present in both kidneys. No evidence of pelvic dilation was present. The left kidney measured 4.2 cm in length. The right kidney measured 4.2 cm in length.

Adrenal Glands

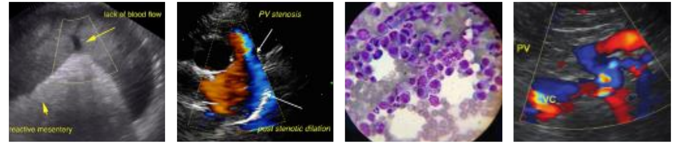
Both adrenal glands exhibited borderline to mild prominent size, given the patient breed and body weight. No evidence of adrenal tumors was noted. The adrenal glands exhibited a maintained symmetrical capsule contour and homogeneous adrenal parenchyma. The left adrenal gland measured 0.53 m width at the caudal pole and 0.52 cm width at the cranial pole. The right adrenal gland measured 0.61 cm width at the caudal pole and 0.67 cm width at the cranial pole.

Spleen

The spleen exhibited 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 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 presented enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder



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was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio with subjective mild luminal gas. The lumen of the stomach was empty with no signs of ileus, obstruction, or foreign material.

The small intestine presented intact wall layering with subjective propensity for mild segmental to generalized prominent duodenojejunal mucosa. The duodenum wall measured up to 0.59 cm width. The jejunum wall measured 0.33 cm width. No evidence of loss of intestinal wall layering or intestinal tumors was noted.

Normal visible colon wall layers were present with semi-formed to soft fecal matter, consistent with clinical history of diarrhea.

Pancreas

The pancreas exhibited mild prominent size with areas of minor capsule asymmetry with isoechoic nonhomogeneous to mildly mixed echogenic parenchyma compared to adjacent omentum.

Free Abdomen

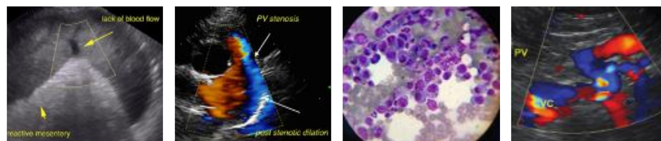
Intermittent mildly prominent to isoechoic mesenteric lymph nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). No free fluid was present. The omentum was of uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Benign hepatopathy - metabolic, reactive, vacuolar hepatopathy, inflammatory / immune-mediated disease, nonobstructive cholestasis, or other hepatopathy, no overt evidence of neoplasia which is considered unlikely
- Prominent to remodeled pancreas - patient variant, remodeling secondary to previous Inflammation or suspected low-grade to chronic pancreatitis
- Intact yet segmental to generalized prominent small intestinal walls - potentially indicative of Inflammatory enteropathy / IBD
- Normal colon containing semi-formed / soft fecal matter
- Mild chronic renal changes with mild focal medullary mineral
- Subjective borderline to mild prominent bilateral adrenal glands- Nonspecific, likely a patient variant given lack of reported clinical signs suggestive of Cushing's Syndrome

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Fresh fecal analysis to rule out parasitic ova/ Giardia, as well as a GI panel to assess Cobalamin/Folate levels, given the persistent diarrhea, is warranted. Dietary intolerance / food hypersensitivity, occult parasitism, dysbiosis, IBD, chronic pancreatitis, or less likely infiltrative intestinal neoplasia are possible.



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Empirically, a limited antigen or hydrolyzed diet trial with potential long term dietary therapy, prophylactic deworming (Panacur 50 mg/kg SID x 5 consecutive days with repeat protocol in 3 weeks even if fecal testing is negative), high colony count probiotic (Proviable or Visbiome), and as needed gastrointestinal support with assessment of clinical response may prove beneficial. An antibiotic trial could be considered if persistent GI signs with close monitoring as antibiotics may contribute to GI dysbiosis.
Intestinal biopsies may be required for a definitive diagnosis if persistent GI signs and pending additional therapy / diagnostics.

Adrenal workup could be considered if clinical signs suggestive of Cushing's Syndrome arise.

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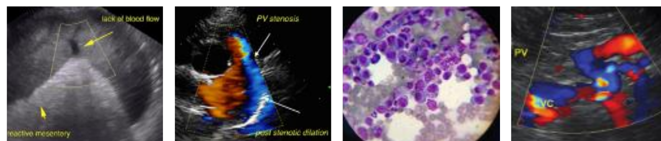

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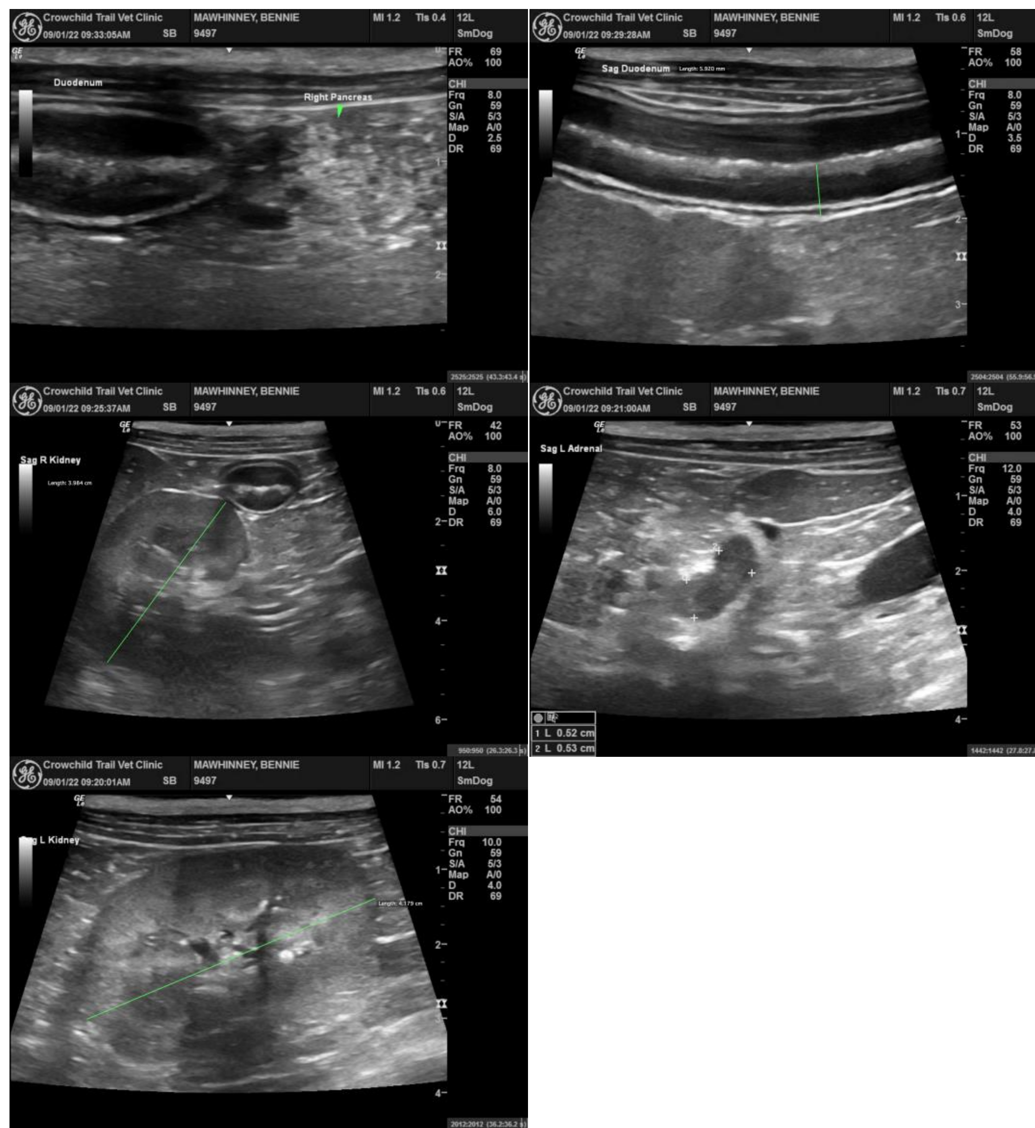

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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