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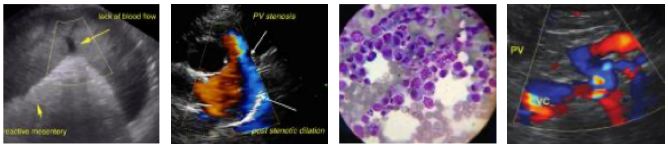
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Jayne Hencheck
56516A

SPECIES

Canine

BREED

Staff Bull Terrier

SEX

Intact Male

AGE

9 years, 10 mos

WEIGHT

16.6 kg

INTERPRETED BY

Andrea Nicastro, DVM, Diplomate ACVIM (*Small Animal Internal Medicine*)

IMAGING PERFORMED BY

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VET

Madison Vet Spec
Dr. Daggett

INVOICE

12189

DATE

2.9.23

PRESENTING CLINICAL SIGNS

History: Jayne presented to the MVS Emergency Service on Feb 09, 2023, at (10:45am), for evaluation of trouble walking. Jayne had an ear infection two weeks ago and was treated with Prednisone (finished on Saturday) and Mometavet. Two days ago, around 5am, patient went outside. The step to get out may have been icy but owners didn't witness him getting injured. He was very painful and reluctant to move. They took him to pcDVM and diagnosed neck pain after having trouble walking. They started Prednisone, Gabapentin, and Methocarbamol. Within 12 hours patient was having hematemesis and hematochezia. No improvement in how he was getting around and still very painful. They took him back to the pcDVM. They did IV fluids, Cerenia injection, stopped the Prednisone and Methocarb, and started Proviable. Overnight patient has had no improvement. He can walk about a yard or two before falling over and trembling in severe pain. He can sit up but starts to shake and fall right over again. No recent vomiting/diarrhea since hospital stay at pcDVM yesterday. No past medical problems other than the ear infection a couple weeks ago. Owner stated that when he was at the pcDVM the last two days he didn't have a fever. No c/s/v/d.

Abnormal PE/Chem/CBC/UA Results: T-103.3F SDMA 15 BUN 33 ALP 519 HCT 44.6 WBC 7.47l Neu 0.65k

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder lumen is moderately distended with anechoic urine. No masses, inflammatory changes or calculi are observed. The region of the trigone and visible portion of the proximal urethra are normal.

The prostate is enlarged (2.82 cm in width) with normal curvilinear peripheral contours. Parenchyma is heterogenous with several small, ill-defined cystic areas throughout the gland. The prostatic urethra is not overtly dilated.

The left kidney is normal in size (6.66 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney is normal in size (6.38 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is prominent at the cranial pole (0.90 cm) and normal in size at the caudal pole (0.56 cm). A 0.49 x 0.37 cm hypoechoic nodule is observed at the cranial aspect. Glandular echogenicity and detail at the caudal aspect are normal. The phrenicoabdominal vein and surrounding vasculature appear normal.

The right adrenal gland is in normal size (0.75 cm at cranial pole) (0.72 cm at caudal pole) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (1.27 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver
The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen. A 1.14 cm hyperechoic nodule is observed on the left side, at the caudal aspect. The remaining parenchyma is homogenous. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

The gall bladder is moderately distended. The wall is normal in thickness and hyperechoic. Luminal contents are anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal
The gastric lumen is fluid-distended and hypomotile. The gastric wall in the region of the fundus is normal in thickness with a normal layering pattern. In the region of the pyloric antrum, the wall is normal to slightly prominent in size (up to 0.59 cm) with retention of the normal layering pattern. The pyloric outflow tract appears patent. The proximal duodenal wall is thickened (up to 0.90 cm) and irregular. In a short (approximately 1.00 cm) of jejunum, the wall is thickened (up to 0.61 cm) with thickening of the mucosal and submucosal layers. The remaining small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. The small intestinal lumen is segmentally fluid-distended and hypomotile. The ileocecocolic junction and colonic wall are normal.

Pancreas
The right limb is visible with minimal deviation from the normal peripheral contours. The parenchyma is slightly hypoechoic relative to surrounding omental fat. No focal lesions are observed. The pancreatic duct is not overtly dilated. Surrounding mesentery is mildly hyperechoic.

Free Abdomen
The mesentery in the right cranial quadrant is mildly hyperechoic. Trace free fluid is observed. The medial iliac lymph nodes are visualized (left: 1.24 x 0.46 cm) (right: 2.09 x 0.64 cm). The nodes are normal in shape and echogenicity. A few prominent lymph nodes are also observed in the right cranial quadrant (the largest measuring 0.74 cm in length). A few prominent mesenteric lymph nodes are also visualized (the largest measuring 3.68 cm in length). The mesentery surrounding the nodes in the right cranial quadrant and at the mesenteric root is hyperechoic.

Other
The testicles are subjectively normal in size (left: 3.10 x 1.77 cm) (right: 3.37 x 1.36 cm) and symmetrical with homogenous parenchyma. No obvious pathology is observed.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The segmental duodenal and jejunal wall thickening may be due to inflammation, emerging neoplasia, or less likely, hypertrophy.
- The pancreatic changes are suggestive of mild acute or chronic active pancreatitis.
- There is evidence of peritonitis in the right cranial quadrant, likely secondary to pancreatic and/or duodenal pathology.
- Gastric ileus. Functional ileus is suspected, as there is no obvious evidence a pyloric outflow tract obstruction.

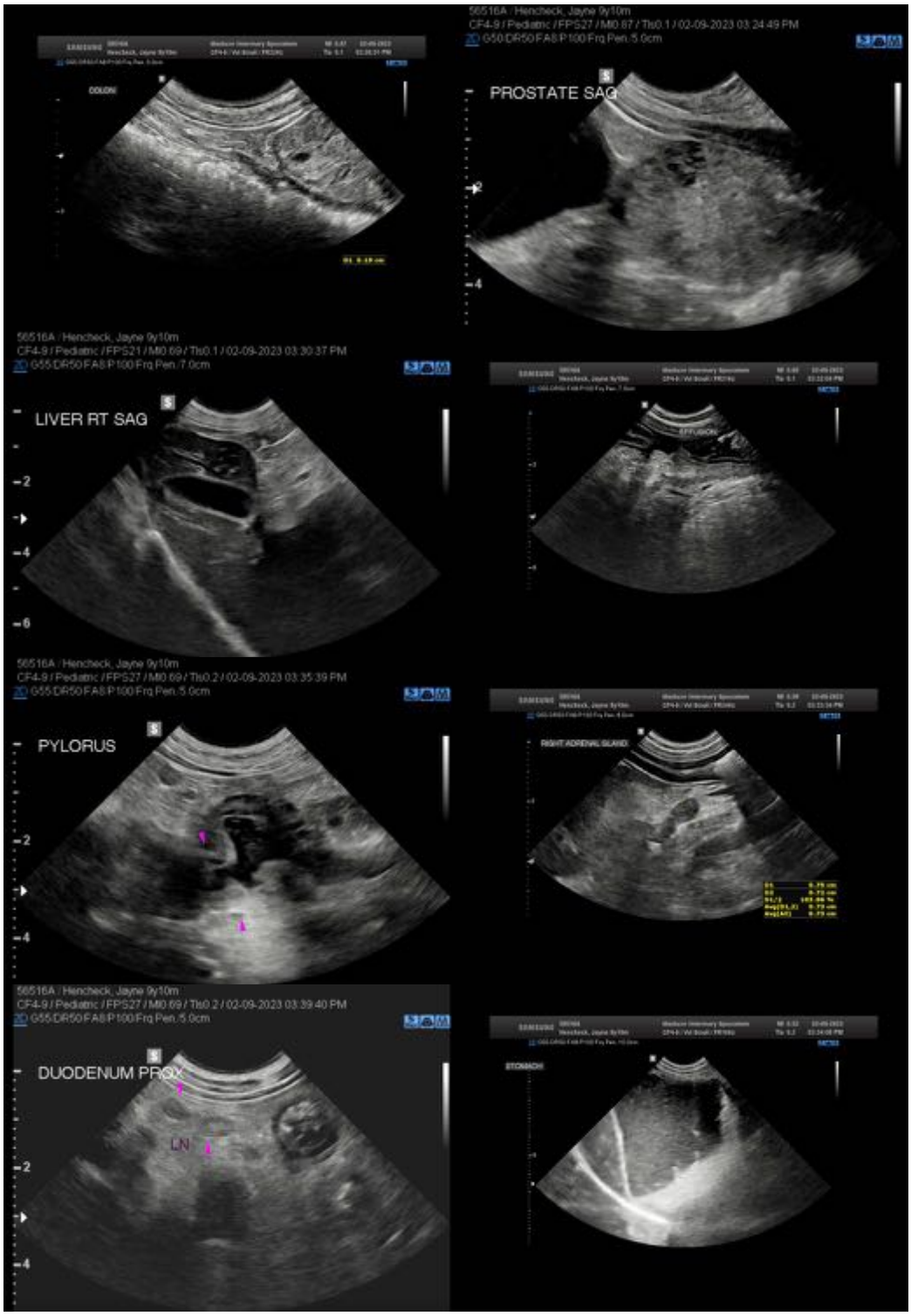
Secondary Findings

- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- The prostate changes are most consistent with cystic benign prostatic hyperplasia.
- Minor bilateral age-related renal changes. The left adrenal nodule may represent an area of benign nodular hyperplasia or an emerging tumor.
- The hyperechoic hepatic nodule trends toward the benign (i.e., regenerative nodule) with a lower possibility of emerging neoplasia.

  *Given the patient's clinical history, gastral duodenal ulceration is of concern, although an ulcer is not appreciated sonographically.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for occult esophageal disease.
- Consider an upper GI endoscopy to further evaluate for gastroduodenal ulceration. If pursued, care must be taken when passing the scope through the pyloric outflow tract. This is a common location for ulcers to occur and perforation with the scope is possible if a deep ulcer is present in this region. Alternatively, an abdominal exploratory with GI biopsies can be considered. However, with the approach, gastroduodenal ulcers may be difficult to appreciate unless a gastrotomy is performed. In the meantime, symptomatic care (i.e., proton pump inhibitor, sucralfate, pain medication, antiemetics) is recommended. If invasive diagnostics are not pursued at this time, serial sonographic monitoring of the abdomen is recommended to monitor the bowel changes and for increase in free fluid.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DUODENUM PROX
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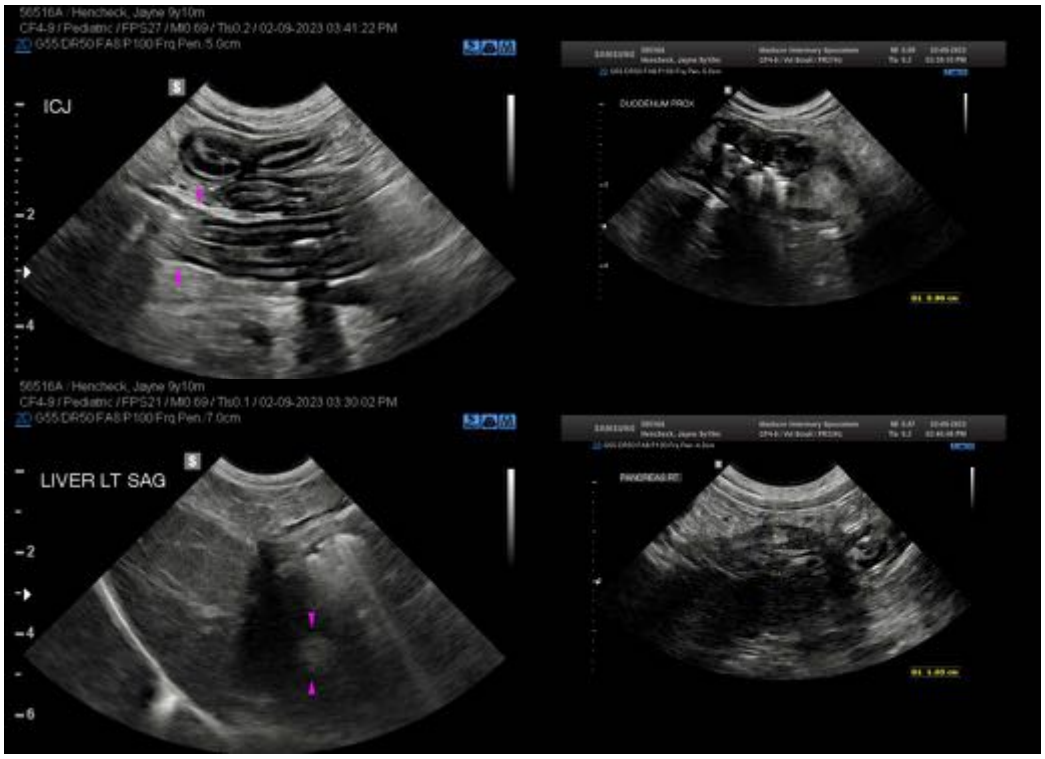
STOMACH



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.

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