



PATIENT

Pinto Scott

SPECIES

Canine

BREED

Cocker Spaniel

SEX

Neutered Male

AGE

6 ½ years

WEIGHT

36 ½ lbs

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

Harold Mike Beard

HOSPITAL NAME

West Prince AH

REFERRING VET

Dr. Harold Mike Beard

INVOICE

10550

DATE

3/16/22

PRESENTING CLINICAL SIGNS

History: Owner thinks that patient is constipated but he had a bowel movement this a.m. Stool was snotty and gloppy.

Abnormal PE/Chem/CBC/UA Results: Rectal exam revealed thickened rectal mucosa, some blood and mucous. CBC and Chemistry WNL.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is mildly distended with anechoic urine. The wall is of appropriate thickness for the level of repletion. The mucosal surface is slightly irregular. No cystic calculi are observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The prostate is not definitively visualized due to its pelvic location.

The left kidney presented normal size (5.14 cm in length); normal shape and architecture with 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 hydronephrosis. Renal vasculature is normal.

The right kidney is normal size (5.05 cm in length);, with a normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydronephrosis. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.46 cm at cranial pole) (0.57 cm at caudal pole); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is upper limits of normal size (1.38 cm at cranial pole) (0.72 cm at caudal pole) (2.03 cm in length); normal shape; 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 (1.17 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 contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed.



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The gall bladder is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. The cystic and common bile ducts are normal/not seen.

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Gastrointestinal

The gastric wall in the region of the fundus is borderline thickened (up to 0.46 cm), with a prominent muscularis layer. Within the gastric lumen, a 1.13 cm shadowing structure is visualized. The pyloric outflow tract appears patent. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. No obstructive or overt infiltrative disease is noted.

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Pancreas

The region of the pancreas is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional inflammation or effusion.

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Free Abdomen

The peritoneal cavity is normal. There is no evidence of inflammation or effusion. The abdominal lymph nodes are normal/not visible.

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ULTRASONOGRAPHIC FINDINGS

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Primary Findings

- The gastric wall thickening may be secondary to inflammation, hypertrophy or emerging neoplasia.
- The shadowing structure within the gastric lumen may represent foreign material and/or normal ingesta.

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*An obvious cause for the patient's large bowel diarrhea is not identified in this study. Differentials include infectious/parasitic disease, food allergy, inflammatory bowel disease, emerging neoplasia, underlying metabolic issue, other

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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- Fecal evaluation for ova and Giardia
- Prophylactic deworming with Fenbendazole at 50 mg/kg once a day for 5 days is recommended. Repeat above protocol in 3 weeks.
- Consider a GI panel (i.e., serum cobalamin, folate, TLI and PLI), to assess for concurrent small intestinal disease.

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- Consider a 6-week hypoallergenic diet trial.

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- Empirical treatment for histiocytic ulcerative colitis (i.e., fluroquinolone) can be considered. A positive response should occur within two weeks of initiating therapy if histiocytic ulcerative colitis is present. If responsive, 8-12 weeks of therapy is recommended.

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- If the above diagnostics are inconclusive, a lower +/- upper GI endoscopy with biopsies may be necessary to get a definitive diagnosis. If biopsies are pursued, fluorescence *in situ* hybridization, (FISH) should be performed on the tissue samples to assess for intramucosal *E. coli*.

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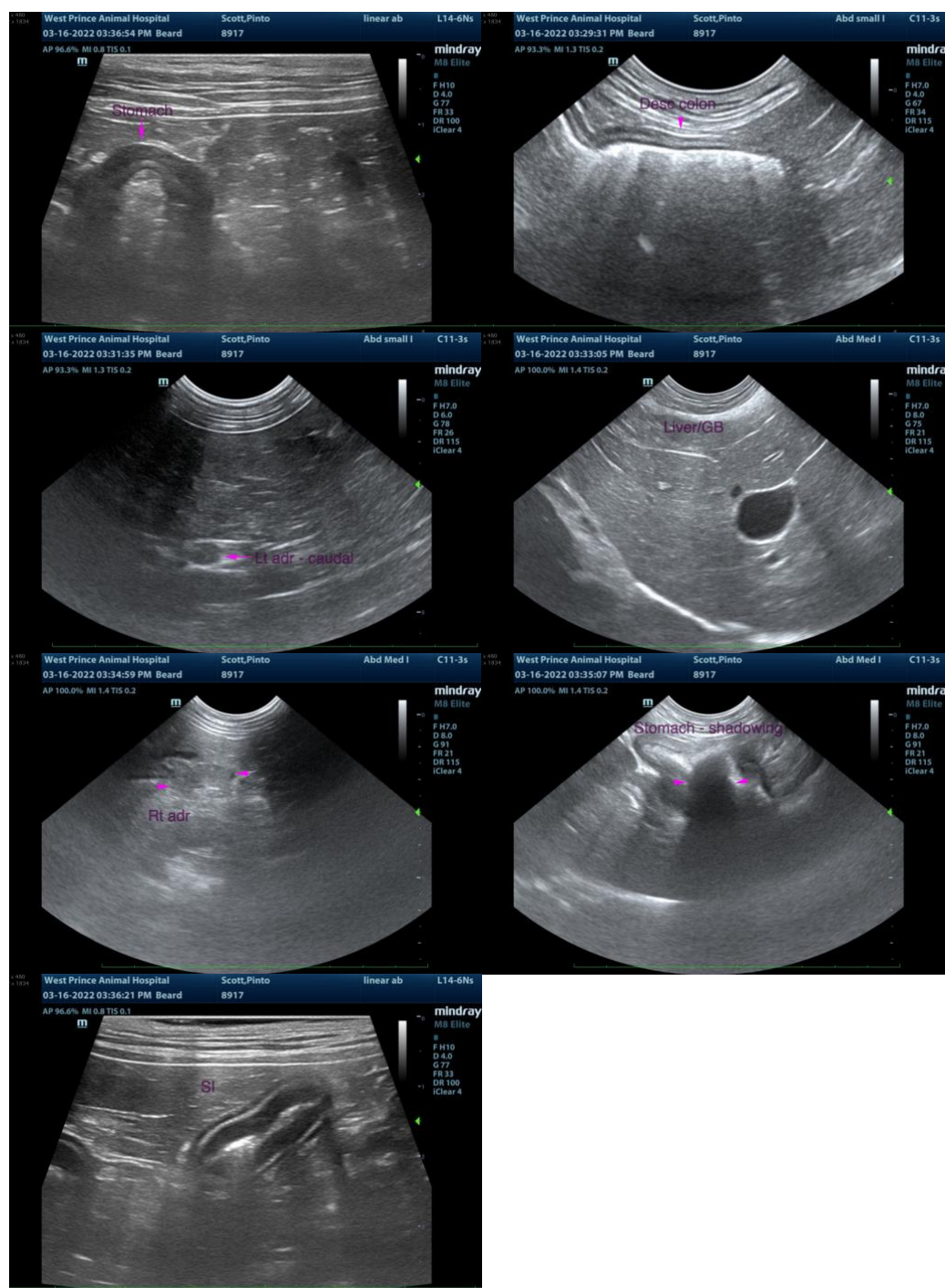
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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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info@SonoPath.com

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