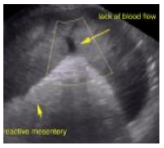
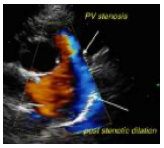
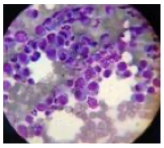
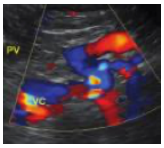
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

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

**PATIENT**

Ivy Maynes

**SPECIES**

Canine

**BREED**

Poodle X

**SEX**

Female Spayed

**AGE**

4 years

**WEIGHT**

12 kg

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Dr Sarah Barthelemy

**HOSPITAL NAME**

Bridgeland VC

**REFERRING VET**

Dr Elock

**INVOICE**

12635

**DATE**

4.3.23

## PRESENTING CLINICAL SIGNS

History: Periodic episodes of inappetence. Labs normal.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone is normal.

The left kidney is normal in size (4.03 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.

The right kidney is normal in size (4.31 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.

### *Adrenal Glands*

The left adrenal gland is normal in size (0.42 cm at cranial pole) (0.51 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 appear normal.

The right adrenal gland is in normal size (0.42 cm at cranial pole) (0.42 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 appear normal.

### *Spleen*

The spleen is normal in size (0.75 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 appears 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. The portal vein to caudal vena cava ratio is approximately 1: 1.

The gall bladder lumen is moderately distended. The wall is thin and smooth. A small amount of suspended echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

### *Gastrointestinal*

The gastric lumen is not distended. 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, there is questionable thickening of the wall (up to 0.52 cm) with a prominent muscularis layer. The pyloric outflow tract appears patent. The small intestinal lumen is not dilated. The small intestinal wall is normal in thickness. There is slight disruption in the normal 1:3 muscularis: mucosal ratio in some segments. The colonic wall is normal. There is no evidence of an obstructive pattern.

### *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.

### *Free Abdomen*
The peritoneal cavity is normal. There is no evidence of inflammation or effusion. A 0.70 cm hypoechoic sublumbar lymph node is visualized.

## ULTRASONOGRAPHIC FINDINGS

### Primary Findings

- The small intestinal wall changes are suggestive of inflammatory bowel disease. The questionable thickening of the pyloric antral wall could be consistent with pyloric hypertrophy, inflammation, normal variation, emerging neoplasia (less likely), other.

### Secondary Findings

- The prominent sublumbar lymph node could be consistent with reactive lymphadenopathy, lymphoid hyperplasia, or emerging neoplasia.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

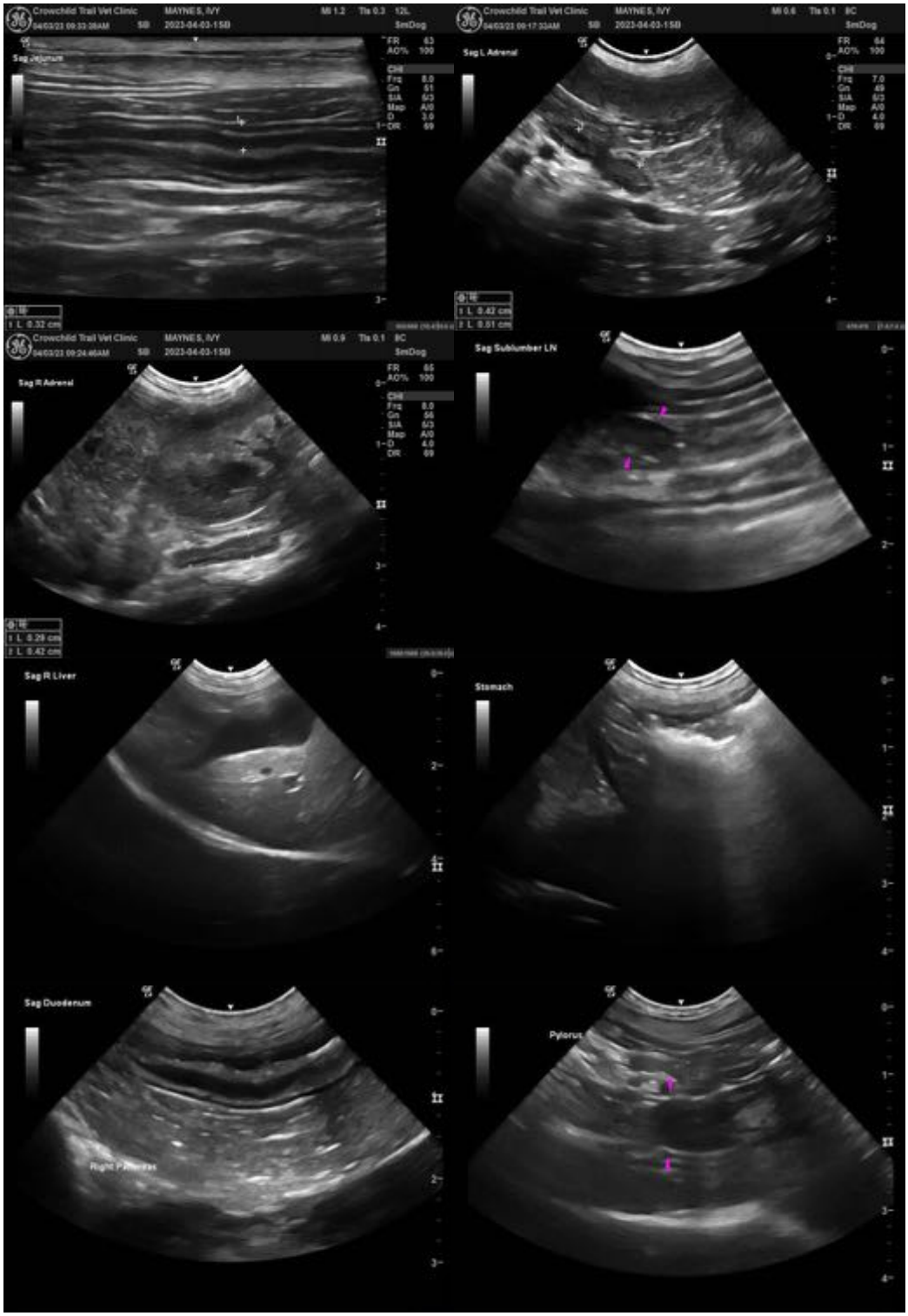
- Given the patient's vague clinical signs, consider the following:

    1. Orthopedic and neurologic evaluation to assess for nonmetabolic causes of inappetence
    2. Consider whole-body radiographs to assess for pathology in the chest and bony lesions.
    3. A comprehensive tick panel may also be warranted.

- To further assess for underlying GI, pancreatic and underlying metabolic disease, consider the following:

    1. Fecal evaluation for ova and Giardia
    2. GI panel including serum cobalamin and folate, TLI, PLI and resting cortisol level (send to Texas A&M).
    3. +/- GI biopsies (i.e., endoscopic, or surgical)

- Given the prominent sublumbar lymph node, consider a rectal examination along with evaluation of the skin on the hind end to assess for underlying pathology that may be draining to this lymph node.


Crowchild Trail Vet Clinic
MAYNES, IVY
Sag Jejunum
Sag L Adrenal
Sag R Adrenal
Sag Sublumber LN
Sag R Liver
Stomach
Sag Duodenum
Pylorus

**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.

**Andrea Nicastro**, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com