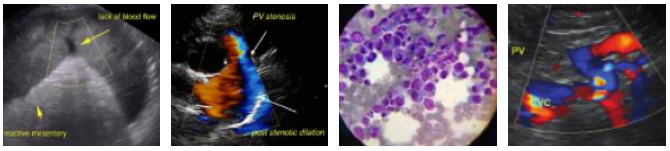
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Hershel Brandenberg

SPECIES
Canine

BREED
Australian Shepherd/Hound mix

SEX
Male, neutered

AGE
1 Yr.

WEIGHT
38 lbs.

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

IMAGING PERFORMED BY
Amy Mayhew

HOSPITAL NAME
SVS Imaging Michigan

REFERRING VET
Dr. Cullen

INVOICE
15110

DATE
7/17/23

PRESENTING CLINICAL SIGNS

History: Has been vomiting the last week. Was acting sick a month ago every day and off. Vomiting about once a day for the last week. Usually about 5 hours eating. Keeping water down but not drinking a lot. Has been doing a bland diet, and eating well. A month ago wasn't eating the kibble very well, letting it sit for hours. Before that was eating very well. Has been having diarrhea on and off over the last month. Will go from solid to soft stools. Has been on and off lethargic, usually in the morning. Has stopped new treats/chews. Used to be to eat new treats, ect and not have any issues with them. No meds. Is on trio for the last year.
Abnormal PE/Chem/CBC/UA Results: Normal physical exam except for ptyalism (does get car sick though). Lab work had eosinophilia, hypokalemia, low cholesterol and negative routine fecal examination.

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 and the proximal urethra, visible to a depth of 2 cm, are normal.

The prostate is normal in size (1.09 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal size (5.46 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 hydroureter.

The right kidney is normal size (5.56 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 hydroureter.

Adrenal Glands

The left adrenal gland is normal size (0.51 cm at cranial pole) (0.53 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.

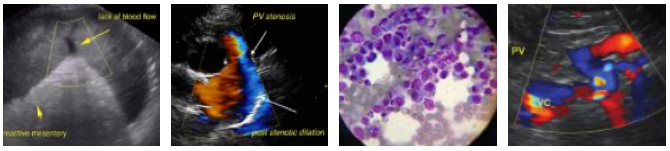
The right adrenal gland is normal size (0.64 cm at cranial pole) (0.51 cm at caudal pole); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (1.55 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



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regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed. The gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric wall is normal thickness with a normal layering pattern. The gastric lumen contains ingesta and ill-defined hypoechoic areas. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal with a normal layering pattern. Mucosal striations/fogging is observed in the duodenum. The ileocecocolic junction and colonic wall are normal. The colonic lumen contains diarrheic stool. No obstructive disease is noted.

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

1-2 medial iliac lymph nodes are visible. They are normal in shape and echogenicity. A 1.15 cm lymph node is also observed just caudal to the stomach. A 4.75 x 1.13 cm mesenteric lymph node is also seen. The mesentery surrounding the cranial abdominal lymph node is mildly hyperechoic. There is no obvious evidence of free fluid.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

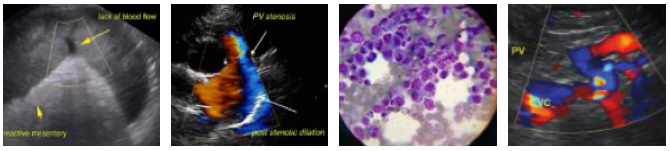
- The hypoechoic areas within the gastric lumen may represent fluid pockets, foreign material, normal ingesta, tissue, other.
- The mucosal striations/fogging in the duodenum could be consistent with lymphangiectasia/inflammatory disease.

Secondary Findings:

- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONSs

- Regarding the gastric luminal changes, consider a recheck ultrasound (following 24-36 hours of fasting) with use of power Doppler on hypoechoic areas. If the abnormalities are still present, consider an upper GI endoscopy with biopsies along with a Texas GI panel (serum cobalamin, folate, TLI, PLI and resting cortisol level).
- Also consider initiation of a low-fat hypoallergenic or hydrolyzed protein diet as well as a probiotic.



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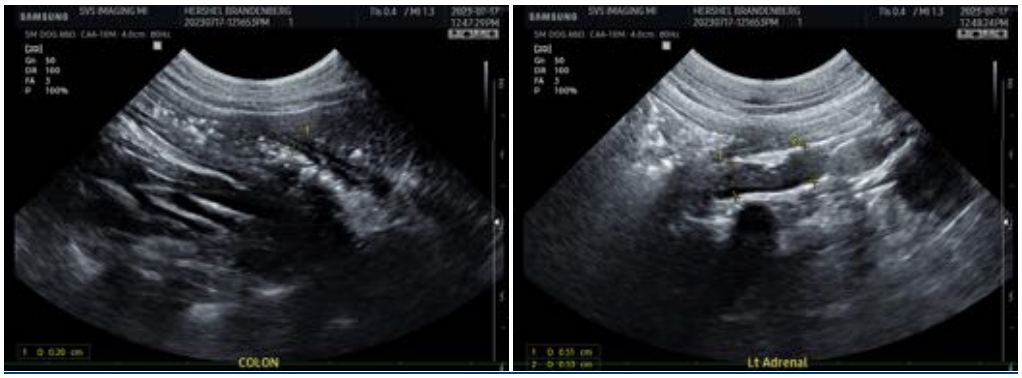
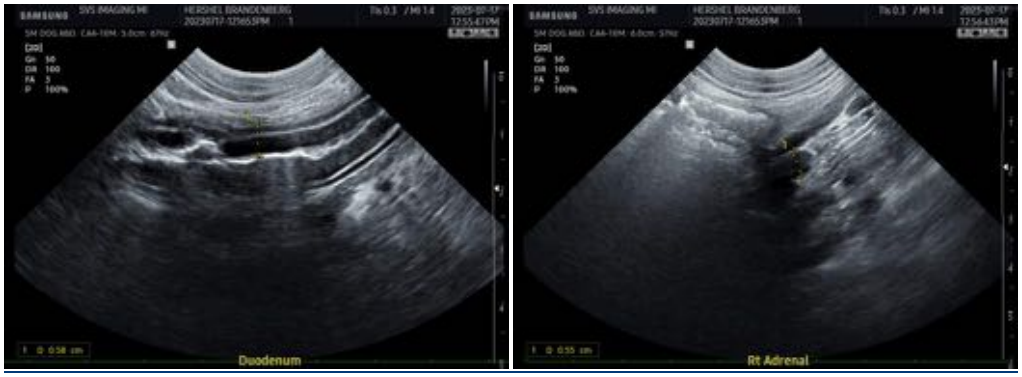
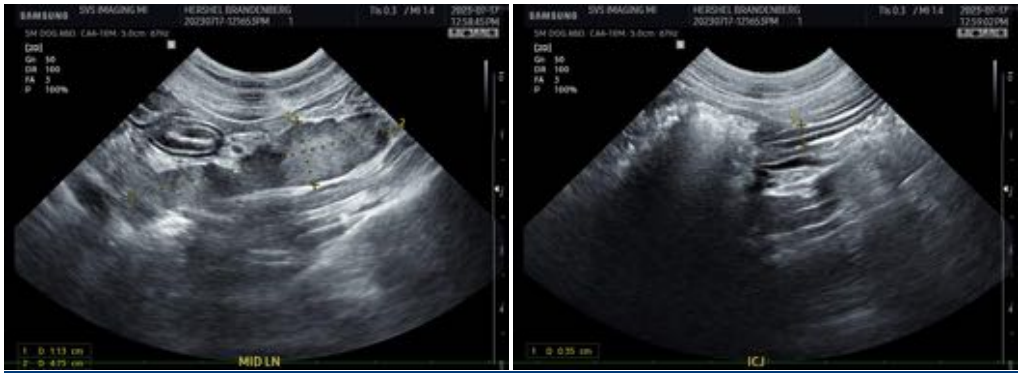
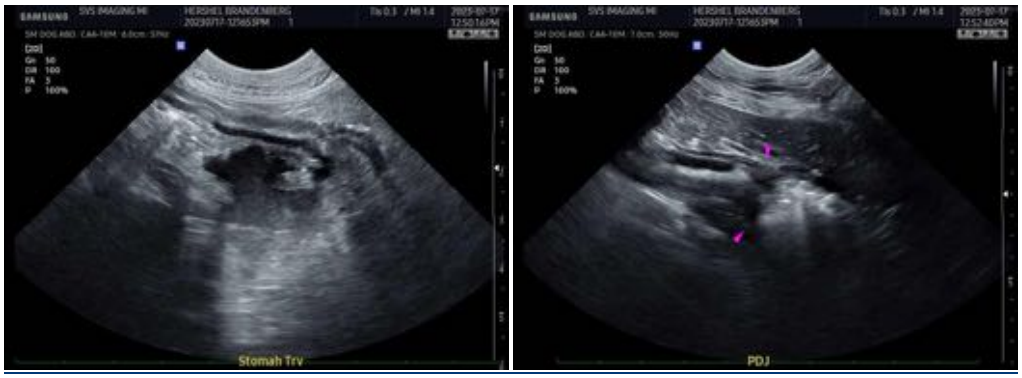
- Thoracic radiographs should be performed prior to anesthesia to evaluate for occult esophageal disease.









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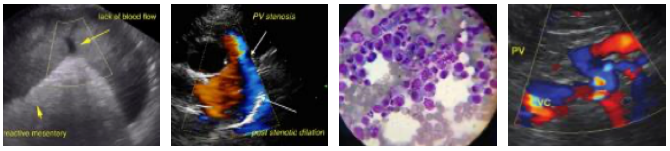

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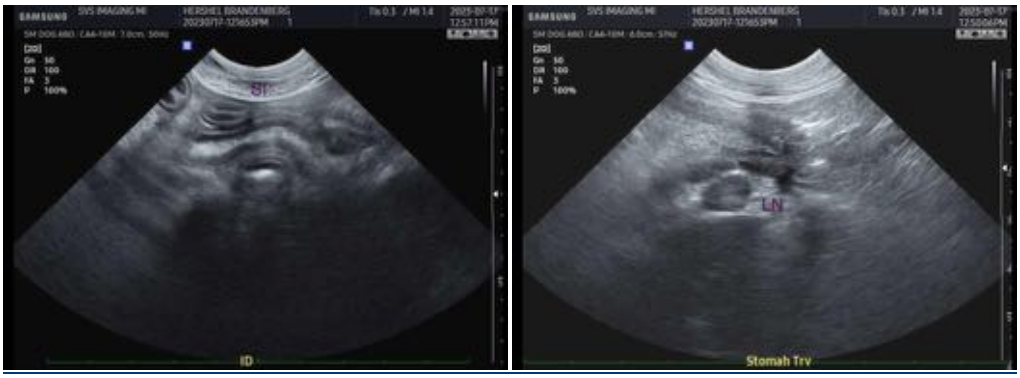

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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