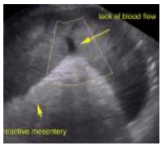
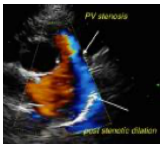
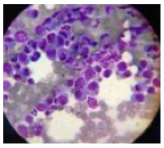
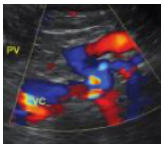
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

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

PATIENT

Tsunami Monk

SPECIES

Canine

BREED

Shepherd X

SEX

Spayed Female

AGE

14 years

WEIGHT

26.6 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Erin Wicks

HOSPITAL NAME

Shores AEC

REFERRING VET

Dr. Slenbaker

INVOICE

11405

DATE

8.15.22

PRESENTING CLINICAL SIGNS

History: Presented at our hospital. Ingested 3-4 boxes of Optavia bars (supplement/atkins) Thurs night including wrappers. Dh starting Fri AM 2-3x not bloody, vomit 8x including wrapper Fri. Went to rdvm Fri and had outpatient treatment—sq's, Pepcid, omeprazole, penicillin, cerenia, rads and bw were done. Rads showed gas and kibble in her stomach per o. Difficulty walking starting yesterday, syringe feeding Gatorade.
Previous Health Concerns: arthritis, 5 yrs ago bloat sx; hx of getting into trash and other toxins such as rodenticide, Dasaquin
Current Medications: sucralfate, metronidazole, famotidine, previcox, gabapentin
Appetite/When did they eat last: last ate Thurs

Abnormal PE/Chem/CBC/UA Results: Abdominal: tender cranially; no overt masses palpable
Results of Diagnostics: RDVM- rads- wrappers/ ingesta but no obvious obstruction(relayed by owner- no rads available)
BW- RDVM- AST 93(H) ALT 166(H) BUN 56 (H) Na 155(H) PrecPSL- 345(H)
CBC WBC 20.3(H) HCT 64(H) T4 <(0.50) (L) euthyroid vs true hypothyroidism

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** is minimally distended. The wall is of appropriate thickness for the level of repletion. Luminal contents are mostly anechoic. No cystic calculi are observed. A Foley catheter is seen within the lumen.

The **left kidney** is normal size (7.01 cm in length); with a slightly irregular shape. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. One to two small cortical cysts are seen. There is a questionable cortical infarct at the craniomedial aspect. There is no evidence of pyelectasia, nephroliths, or hydroureter. Renal vasculature is normal.

The **right kidney** is normal size (6.89 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The **left adrenal gland** is normal size (0.38 cm at cranial pole) (0.46 cm at caudal pole) (1.67 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.

The **right adrenal gland** is normal size (1.06 cm at cranial pole) (0.67 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 (2.29 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. 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. Luminal contents are anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The **gastric lumen** is mildly distended with soft, shadowing material. The gastric wall is diffusely thickened (up to 1.15 cm) and slightly irregular, with retention of the normal layering pattern. 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 and appropriate mural detail. The colonic wall is normal. There is no obvious evidence of an obstructive pattern.

Pancreas

The right limb of the **pancreas** is visible with normal curvilinear peripheral contours. The parenchyma is largely isoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Free Abdomen

There is no evidence of free fluid. The abdominal **lymph nodes** are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The gastric wall changes are most consistent with gastritis. However, hypertrophy or emerging neoplasia cannot be completely excluded. The soft, shadowing material in the gastric lumen is suggestive of foreign material (i.e., wrappers). The material appears nonobstructive at this time.

Secondary Findings

- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

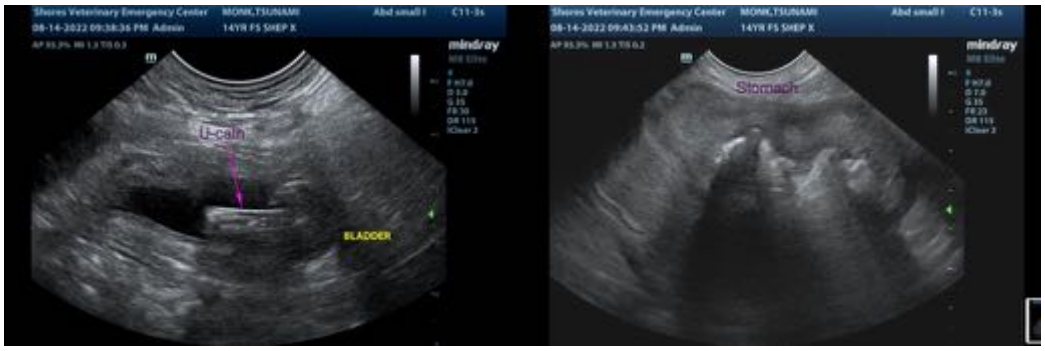
- Bilateral, degenerative renal changes with a questionable left cortical infarct

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

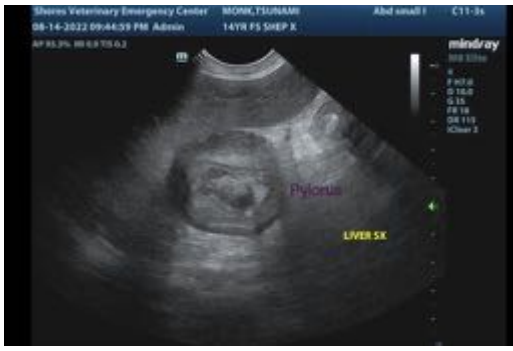
Continued supportive care for gastroenteritis is recommended, along with serial monitoring of the patient's bloodwork to assess for changes in metabolic function.

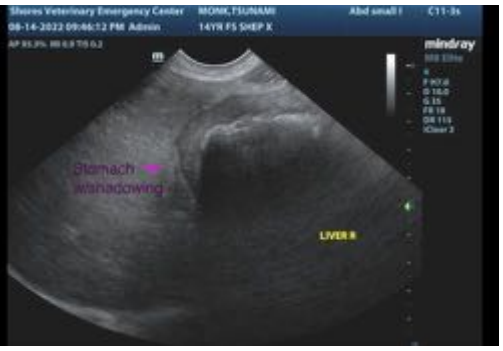
Also consider three-view thoracic radiographs to assess for occult aspiration pneumonia.

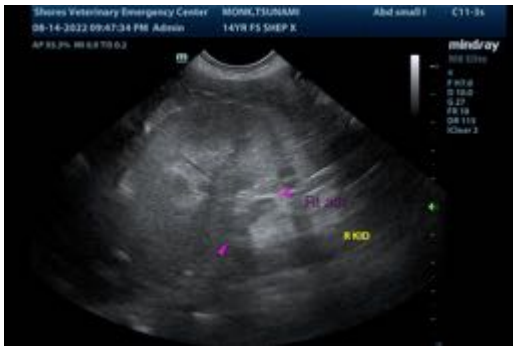
If clinical signs do not improve within 48-72 hours of aggressive supportive care, a more advance GI work-up may be warranted.

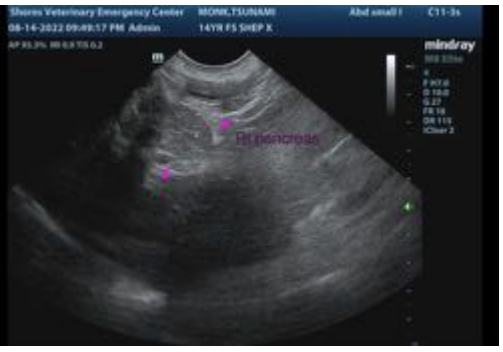

U-caln
BLADDER

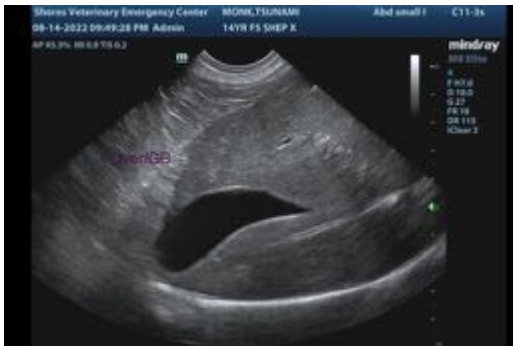
Stomach

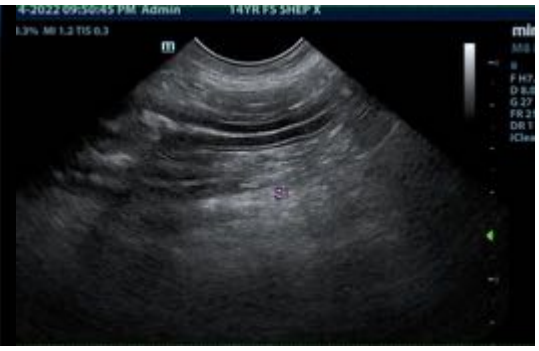

Pylorus
LIVER SX


Stomach
wshadowing
LIVER R


Rl adr
R KID


Rl pancreas


GvenGB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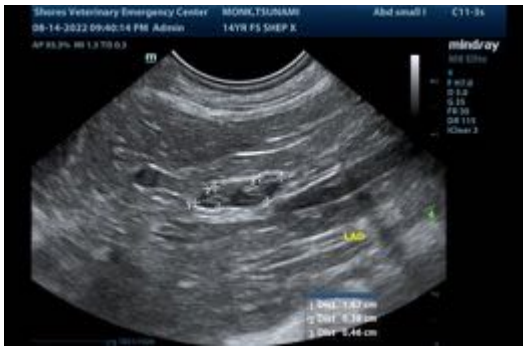

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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