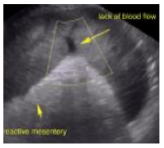
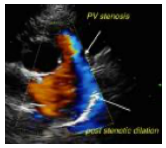
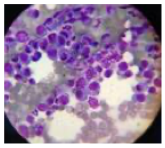
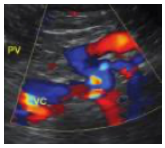
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

SonoPath.com
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PATIENT
Danny Kang

SPECIES
Canine

BREED
Cairn Terrier

SEX
Neutered Male

AGE
12 years

WEIGHT
21.4lbs

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

IMAGING PERFORMED BY
Ashley Fatzer

HOSPITAL NAME
Andover AH

REFERRING VET
Dr. Hummel

INVOICE
11360

DATE
8.8.22

PRESENTING CLINICAL SIGNS

History: presented 8/8 with fever, painful caudal abdomen on palpation, vomited this am, chronic hx of GI issues

Abnormal PE/Chem/CBC/UA Results: PE: painful caudal abdomen, 75% dehydrated Bloodwork n/a

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** and visible portion of the pelvic urethra are normal for the degree of luminal distension. The urine is anechoic with no evidence of debris. Cystic calculi and discrete masses are not observed. The region of the trigone is normal.

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

The **left kidney** is normal size (4.99 cm in length); 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 hydroureter. Renal vasculature is normal.

The **right kidney** is normal size (4.82 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild 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 mildly enlarged (0.63 cm at cranial pole) (0.78 cm at caudal pole) (2.05 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 borderline enlarged (0.52 cm at cranial pole) (0.65 cm at caudal pole) (1.69 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 (1.83 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 **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 to moderately fluid distended and hypomotile. The gastric wall is normal to mildly thickened (up to 0.66 cm) with apparent retention of the normal layering pattern. 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. There is no evidence of an obstructive pattern.

Pancreas
A portion of the **pancreas** is obscured by the gastric distention. In the visualized portions, no obvious pathology is observed.

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Suspected mild to moderate gastric ileus. The gastric wall changes are most consistent with inflammation with a lower possibility of emerging neoplasia.

*An obvious cause for the patient's clinical signs is not identified in this study. Considerations include primary gastrointestinal disease (infectious/parasitic disease, acute gastroenteritis, food allergy/intolerance), mild pancreatitis, underlying metabolic issue, other.

Secondary Findings

- Minor bilateral, age-related renal changes
- The mild bilateral adrenomegaly may be a normal variant for this patient or may represent early hyperplastic change.

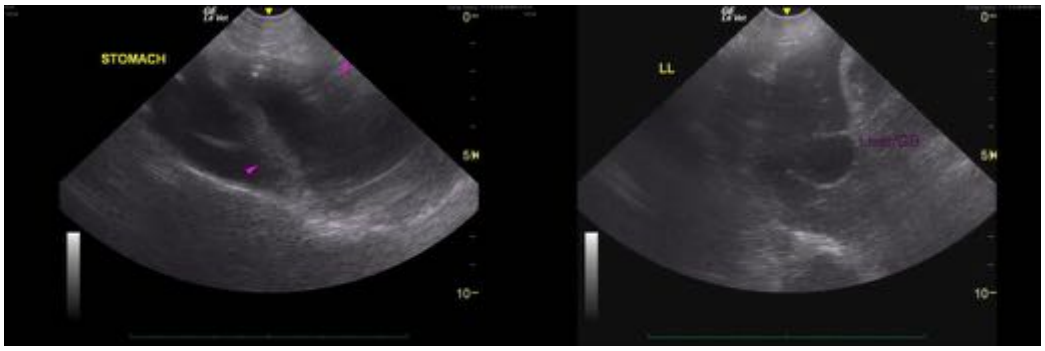
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Baseline lab work, including a CBC, chemistry panel, urinalysis and T4 is recommended, if not already performed.

Given the fever and history of vomiting, three-view thoracic radiographs are recommended to assess for occult aspiration pneumonia.

Regarding the GI signs, consider the following:

1. A fecal evaluation for ova and Giardia is recommended.
2. cPLI +/- a full GI panel including serum cobalamin and folate, TLI and PLI to further assess for acute pancreatitis and small intestinal disease.
3. Supportive care for acute gastroenteritis is recommended, including fluid therapy, antiemetics, gastric protectants and pain medication as needed. If the patient's clinical signs do not improve with supportive care, a more advanced GI work-up may be warranted.



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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