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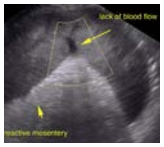
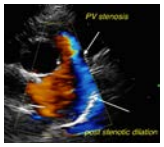
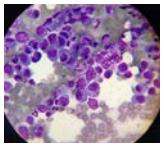
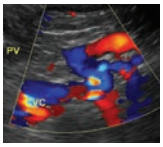

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1-800-838-4268 info@sonopath.com

PATIENT
Leo Kerr

SPECIES
Canine

BREED
Mixed

SEX
Neutered Male

AGE
6 Months

WEIGHT
36.2 Pounds

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Kelly Vazquez

HOSPITAL NAME
Cresskill AH

REFERRING VET
Dr. Rachleff

INVOICE
44487

DATE
1/25/23

PRESENTING CLINICAL SIGNS

Echo: grade 2/6 ejection murmur left cranial thorax. Abd: chronic vomiting and retching x 3 weeks. Abnormal PE/Chem/CBC/UA Results: Low normal proteins.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Prostate is normal in size, echotexture and echogenicity for a neutered male.

The right kidney is normal in size (4.88 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal in size (6.19 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

The right adrenal gland is normal in size (1.76 cm long x 0.45 cm at the cranial pole and 0.24 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (2.09 cm long x 0.59 cm at the cranial pole and 0.35 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

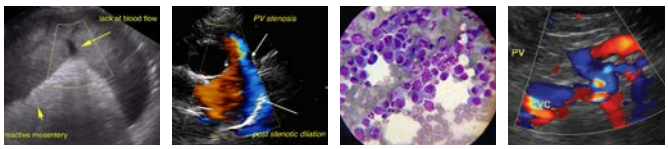
The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). Small intestinal motility appears adequate (1-3 contractions



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per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

*See other.

Pancreas

The pancreatic parenchyma is appropriately isoechoic to surrounding tissue. Visible capsule is smooth and normal in contour. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is no evidence of free peritoneal effusion noted in these images.

The mesenteric lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

In the mid abdomen, at the Ileocecocolic junction, there is a focal area of bowel imaged longitudinally that appears to be stacked bowel layers, consistent with a possible intussusception or possibly intermittent or sliding intussusception. Normal variant based on view can't be ruled out but is considered less likely.

ULTRASONOGRAPHIC FINDINGS

- **Reactive mesenteric lymph nodes –** infiltrative neoplastic disease cannot be ruled out but is considered less likely. This finding is likely a normal patient variant given the young age.

- **Possible partial or sliding intussusception may be present at the Ileocecocolic junction –** The appearance isn't classic for an absolute intussusception, but there is some suspicion in one view based on the appearance of the layers.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the lack of a definitive diagnosis of an intussusception, recommendations include further evaluation of the thorax (given the history of regurgitation and vomiting) with thoracic radiographs and echocardiogram, as are reportedly already planned, to look for evidence of a potential vascular anomaly potentially affecting the esophagus or other esophageal abnormalities.

In the meantime, given this patient's reportedly low normal proteins, a fecal exam is recommended if not recently evaluated, as is a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory. A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease.

In the meantime, supportive/symptomatic medical management of the gastrointestinal signs is recommended with antiemetics, gastroprotectants, empirical deworming with a 5-day course of Panacur, hydration/fluid therapy, etc.

If clinical signs persist and a diagnosis is not obtained from thoracic imaging and/or other diagnostics, recheck abdominal imaging including x-rays, potentially a barium swallow, ultrasound, or even an abdominal CT scan could be considered to reevaluate the possible partial intussusception or area of bowel in question prior to pursuing a more aggressive intervention such as surgery.

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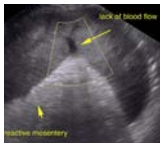
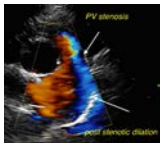
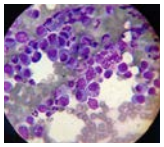
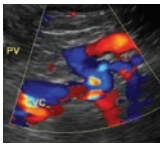

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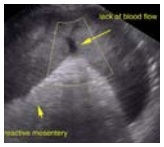
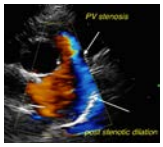
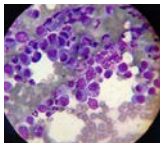
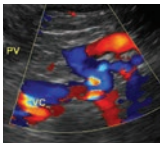

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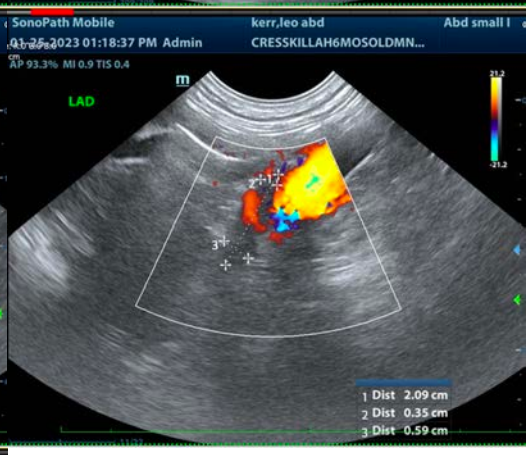

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM
Beth.Johnson@sonopath.com