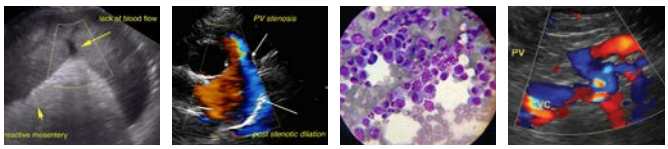
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Jameson Foley

SPECIES
Canine

BREED
Bulldog X

SEX
Neutered Male

AGE
10 Years

WEIGHT
68.4 Pounds

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
A. Murphy, CVT

HOSPITAL NAME
Wauwatosa Vet

REFERRING VET
Dr. Kate Self

INVOICE
43927

DATE
1/4/23

PRESENTING CLINICAL SIGNS

Presented 2 days ago for vomiting and no signs of pancreatitis. Labs normal. administered Famotidine and Cerenia in clinic and sent home Cerenia. Still continuing to vomit on meds. Has a history of seizures and skin issues. No known IBD. recurrent UTI's with Rods present. Current medications include: levetiracetam, potassium bromide, phenobarbital, and tylosin.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended with primarily anechoic contents and a large amount of echogenic non-shadowing debris. Apical urinary bladder wall is diffusely thick (1.4 cm). Mucosa is hyperechoic and irregular. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface.

The area of the prostate is examined without evident pathology.

The right kidney is normal in size (6.31 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 (6.89 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 caudal pole of the right adrenal gland is normal and measures 1.0 cm in size. The cranial pole is not well visualized in these images.

The left adrenal gland is normal in size (0.92 cm at the cranial pole and 0.85 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.

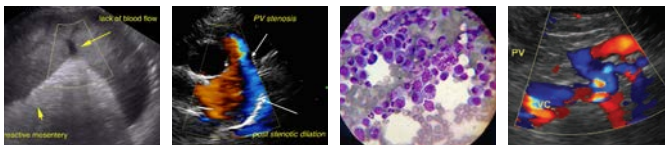
Liver

Liver is subjectively enlarged (swollen contour) without disruption of architecture. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen and falciform fat. 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 visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta.



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There is 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. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is 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.

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.

There is no apparent lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- **Chronic Cystitis -** Urinary bladder wall changes are most consistent with chronic cystitis. Infiltrative neoplasia cannot be ruled out but is considered less likely give the location and diffuse nature of the changes.

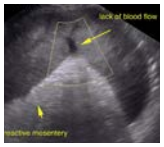
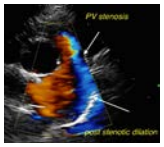
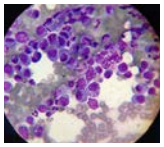
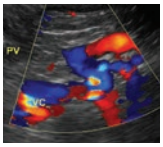
- **Hyperechoic hepatomegaly -** This appearance is non-specific and most consistent with a benign steroid (endocrine) or vacuolar hepatopathy or reactive or idiopathic hepatopathy. Inflammatory and/or infiltrative disease (such as round cell neoplasia) are also possible, but considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The most significant finding in this study is the urinary bladder pathology. Recommendations include a urine culture if not recently evaluated, and given the chronicity of the urinary tract infections, treatment as a complicated urinary tract infection is recommended based on culture and sensitivity results, with a long course of antibiotics (i.e. 4+ weeks). This treatment recommendation include a follow up culture a week to 10 days after starting antibiotics to ensure no secondary pathogens are present, as well as a final culture a week to 10 days after finishing antibiotics to be sure infection has fully cleared.

There is not an ultrasonographically visible explanation for the vomiting. Recommendations in addition to managing the suspected urinary tract infection include supportive/symptomatic medical management of acute gastritis, gastroenteritis with antiemetics, gastroprotectants +/- appetite stimulants, if necessary, etc. If vomiting persists beyond management of the urinary tract infection and supportive therapy, recheck imaging, ideally fasted, if possible, is recommended. Pending results, additional workup for underlying gastrointestinal disease may be recommended in the form of a baseline cortisol. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

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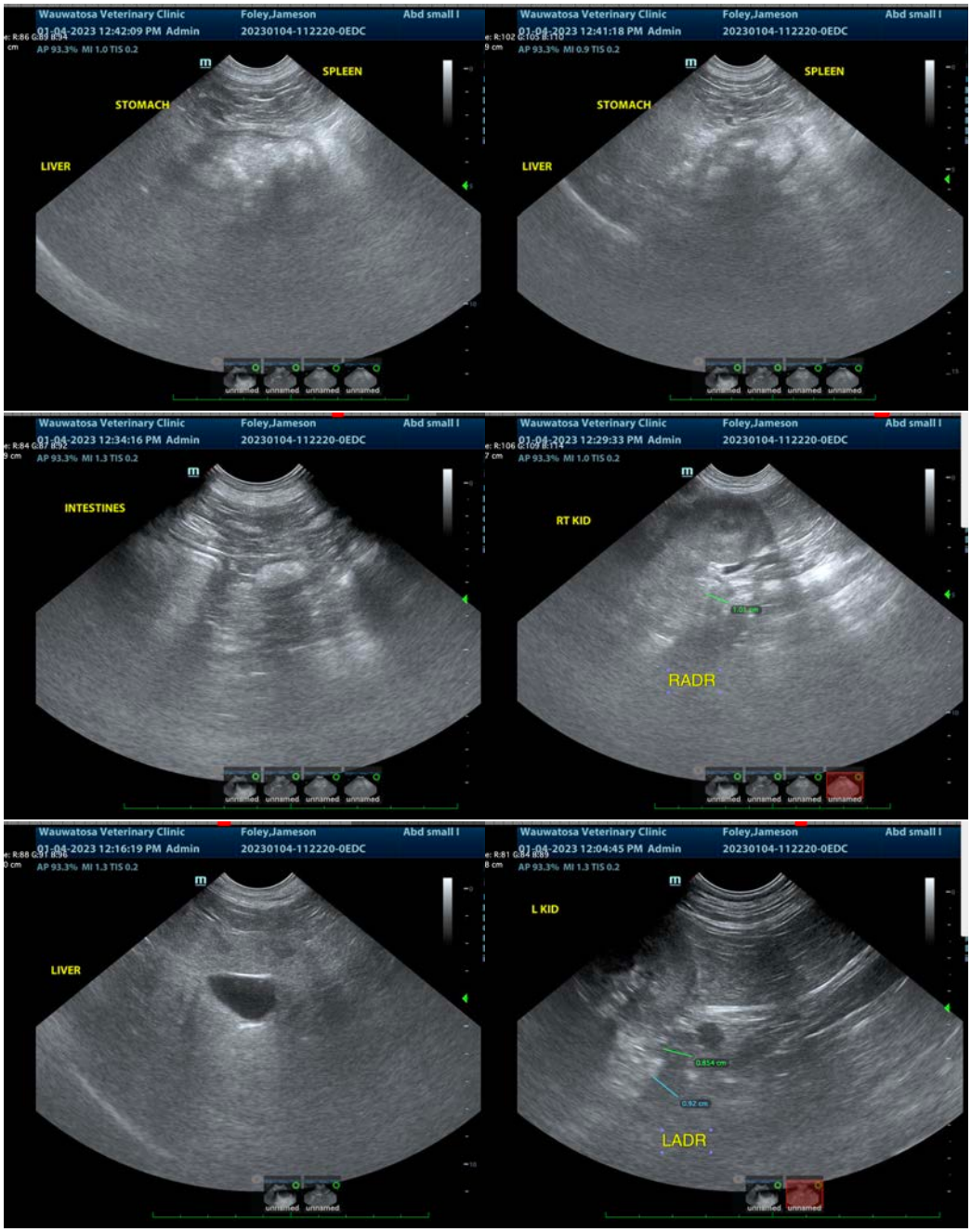
Additionally, in the meantime, empirical deworming with a 5-day course of Panacur could be considered.



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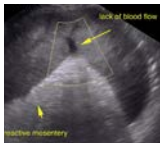
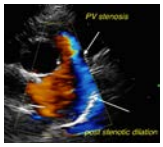
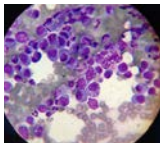
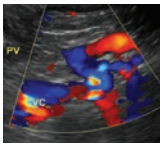

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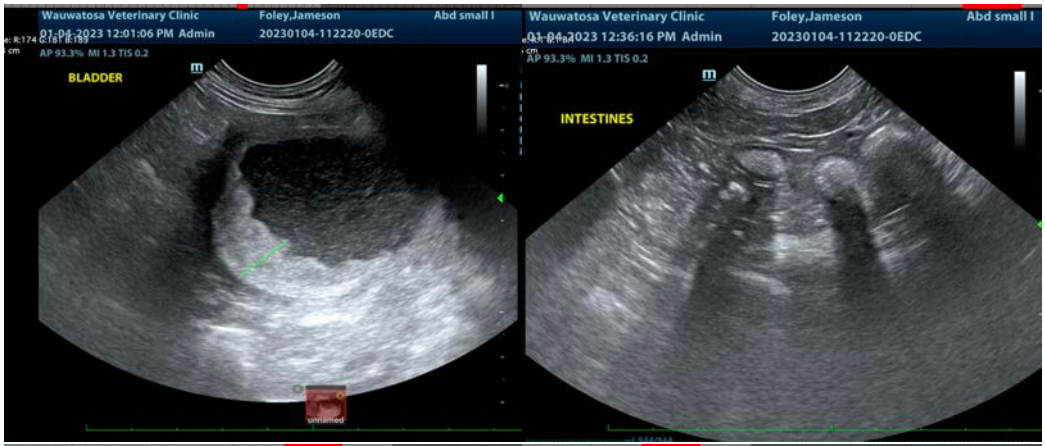

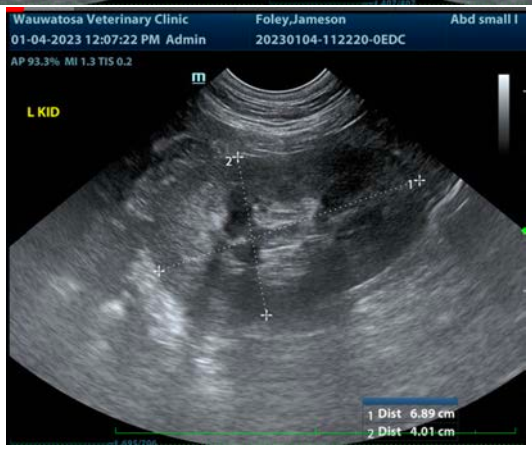

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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