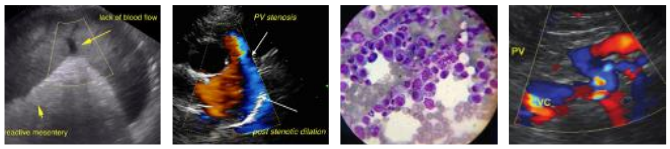
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Blu Rinker

SPECIES

Canine

BREED

Pit/Lab Mix

SEX

Spayed Mix

AGE

6 Years

WEIGHT

69 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Amy Mayhew, LVT

HOSPITAL NAME

SVS Imaging MI

REFERRING VET

Union Lake VH

INVOICE

17584

DATE

10/3/22

PRESENTING CLINICAL SIGNS

History: PU/PD long time- months and getting worse (will drink so fast she will V) HX Suspected IBD + had a positive response to food trial and Tylan powder initially

Abnormal PE/Chem/CBC/UA Results: Superchem/CBC:Hct WNL=48.7% CBC WNL ALP=243 (23-212) Additional chemistries WNL tCa=10.3 (7.9-12) Alb=3.2 (2.3-4.0) Electrolytes WNL Cortisol pending Spec Cpli WNL<75 2 view abd rads- mixed opacity stomach- food suspected but also r/o other-like fibers, Spondylosis LS , SI little clumped caudal right abd. Stool + in colon

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately 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.

Left kidney is normal is size (5.84 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.

Right kidney is normal is size (6.33 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

Left adrenal gland is normal in size (0.6 cm at cranial pole and 0.61 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.74 cm at cranial pole and 0.75 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

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 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.

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 empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

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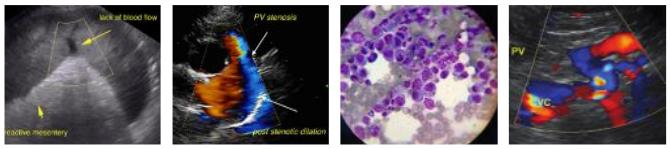

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The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The observed pancreas appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is no evidence of peritoneal effusion. There is no apparent lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

- This is a relatively unremarkable/normal abdomen

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given this patients history of gastrointestinal signs, combined with new polyuria/polydipsia, a baseline cortisol, followed by an ACTH stimulation test, as is reportedly already pending is recommended.

Additionally, 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.

Urinalysis and, if indicated based on urinalysis results, urine culture are recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

If cortisol and urinalysis testing do not help diagnose a cause for the polyuria/polydipsia, additional diagnostics could include a first A.M. urine specific gravity to begin with to see if urine concentration is possible, as most animals drink less overnight. If concentration occurs, then the polyuria/polydipsia is most likely behavioral/psychogenic, anxiety, etc. If, however, primary polyuria is suspected, then additional diagnostics could include a urine culture, T4, bile acids, leptospirosis testing and/or an empirical course of antibiotics. If after that, a diagnosis is still not obtained, a more advanced work up, including things like a closely monitored water deprivation test, desmopressin trial, etc. may be necessary.

In the meantime, empirical deworming with a 5-day course of Panacur and transition to a hydrolyzed protein diet is recommended.

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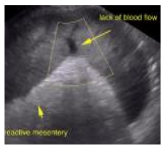
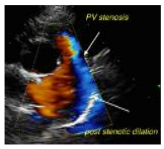
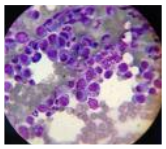
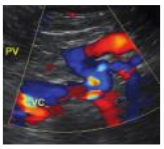

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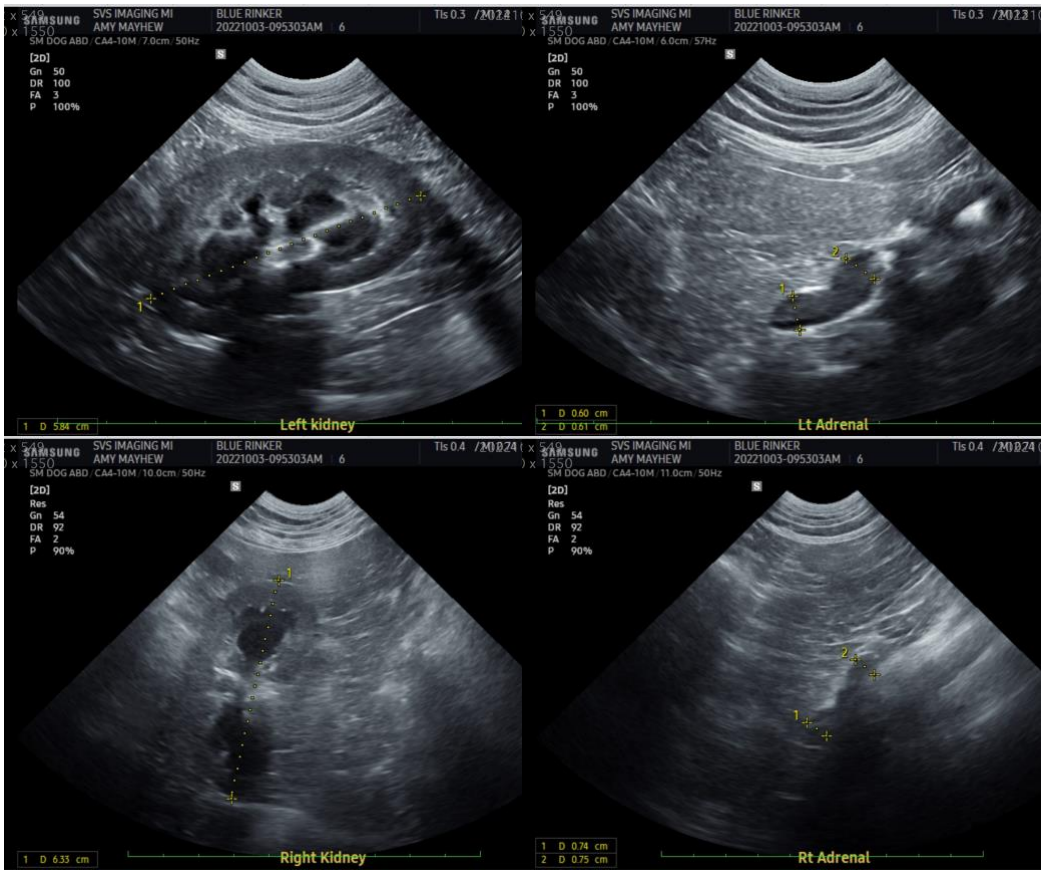

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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