



PATIENT

Doogie Waffle

SPECIES

Canine

BREED

Mini Poodle

SEX

Neutered Male

AGE

10 Years

WEIGHT

6.8 Pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Adrienne Waffle

HOSPITAL NAME

Torch Lake VC

REFERRING VET

Adrienne Waffle

INVOICE

17931

DATE

11/1/22

PRESENTING CLINICAL SIGNS

History: Hx of pancreatitis. Extremely painful in abdomen. Previous US done 12/22/21

Abnormal PE/Chem/CBC/UA Results: TPR WNL

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with occasional echogenic non-shadowing debris, most consistent with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can also present with echogenic debris. No masses or cystoliths are observed. The 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.

Left kidney is normal is size (3.43 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, or infarcts observed. A hyperechoic band parallel to the corticomedullary border is present. Non-obstructive linear multifocal hyperechoic diverticular foci with acoustic shadowing are noted.

Right kidney is normal is size (3.43 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. A hyperechoic band parallel to the corticomedullary border is present. Non-obstructive linear multifocal hyperechoic diverticular foci with acoustic shadowing are noted.

Adrenal Glands

Left adrenal gland is normal in size (0.4 cm at cranial pole and 0.39 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.4 cm at cranial pole and 0.42 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



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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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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.

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

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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.

AGE

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Free Abdomen

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings

WEIGHT

6.8 Pounds

- Medullary rim sign bilaterally - This finding is of unknown clinical significance and can be a normal variant, often idiopathic. Medullary rim sign can be present with renal disease including FIP, lymphoma, hypercalcemic nephropathy, Leptospirosis, tubular disease, other and should be interpreted in combination with other more specific indications of kidney disease such as isosthenuria, proteinuria, azotemia, etc. This is a common incidental finding in patients with diabetes mellitus. Nonobstructive dystrophic mineralization noted bilaterally.

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Secondary Findings

- Urinary bladder debris

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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This patients reported laboratory changes of mild hyperglobulinemia and monocytosis are suggestive of chronic inflammation. There is no visible ultrasonographic evidence in these images at this time of a chronic inflammatory source and/or a pain source. While pancreatitis cannot be definitively ruled out based on a normal ultrasound, pancreatitis causing the severe pain reported would be unlikely with a normal ultrasound. Having said that, further recommendations include 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, given the evidence of chronic inflammation in the lab work and the ALT, testing for Leptospirosis is warranted if not recently evaluated.

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Additionally, given the reported kidney changes, 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. In the meantime, further evaluation for pain sources outside the abdomen, such as orthopedic and/or neurologic, cervical, spinal is recommended.

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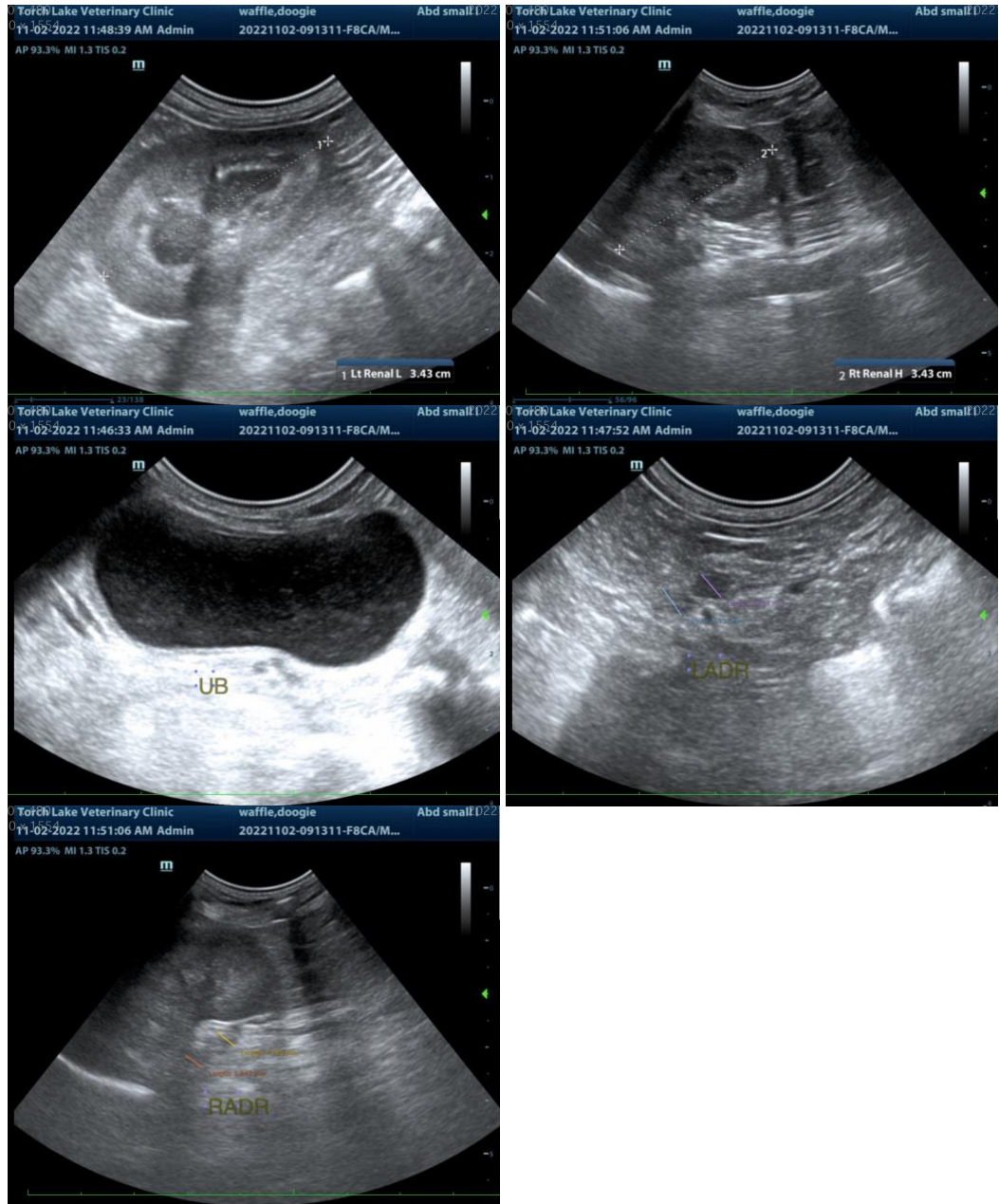
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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



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