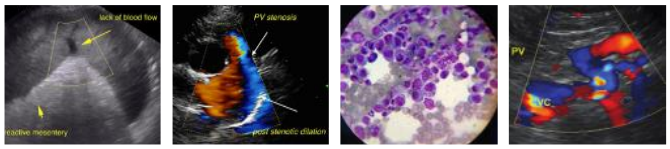
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Remy Franek

SPECIES

Canine

BREED

French Bulldog

SEX

Spayed Female

AGE

3 Years

WEIGHT

31 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Michelle Roche

HOSPITAL NAME

Fredon AH

REFERRING VET

Dr. Linda Grau

INVOICE

21224

DATE

2/21/23

PRESENTING CLINICAL SIGNS

History: On and off vomiting/diarrhea going back to end of January.

Abnormal PE/Chem/CBC/UA Results: CBC/Chem unremarkable, PE unremarkable

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is only mildly distended (empty). Visible contents are anechoic. Urinary bladder wall is unable to be fully assessed for pathology without further distension. No visible masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface. If there are urinary signs and/or concern for urinary bladder pathology, reassessment after complete filling is recommended.

Left kidney is normal is size (4.48 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 subtle hyperechoic band parallel to the corticomedullary border is present.

Right kidney is normal is size (5.14 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 subtle hyperechoic band parallel to the corticomedullary border is present.

Adrenal Glands

Left adrenal gland is unable to be well visualized in these images.

Right adrenal gland is normal in size (0.52 cm at caudal pole, the cranial pole is unable to be well visualized), 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.

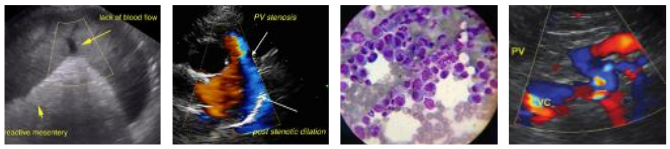
Liver

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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The visible small intestines are diffusely 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. *See end of GI section.

The visible colon is diffusely mildly thick, measuring up to 0.6 cm thick with intact layering visible.

Other

In the caudal mid abdomen, there is a focal bowel loop with an irregular corrugated thick wall, measuring between 0.7 cm and 0.8 cm thick. Intact layering is still present, and the lumen is empty without evidence of obstruction and/or visible foreign material present. The bowel loop is believed to potentially be colon based on the appearance of definitive colon elsewhere, however, it cannot be definitively traced to small or large bowel origin in these images.

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

- Diffusely thick colon with intact layering. This is consistent with an infiltrative, likely parasitic or benign inflammatory disease. Infiltrative neoplasia is possible but considered less likely. The focally thick irregular bowel loop described above may also represent colon with the same differential list, however, a focally involved segment of small bowel cannot be ruled out.
- Bilateral subtle medullary rim sign – A hyperechoic band parallel to the corticomedullary border is present.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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.

A fecal exam is recommended, as is a fecal enteropathogen PCR panel to Texas A&M GI Laboratory, for further evaluation of possible infectious disease.

In the meantime, empirical deworming with a 5-day course of Panacur is recommended, as is a probiotic, such as Visbiome or Proviable, and while awaiting the above recommended results, an empirical transition in diet based on trial and error response could be considered with options being a hydrolyzed protein diet, knowing some patients respond better to one brand vs the other, so sometimes several trials are necessary, or potentially a low fat or bland easy to digest diet, or potentially a fiber responsive colitis diet, again based on trial and error response.

Ultimately, if clinical signs persist, further evaluation and biopsies of the gastrointestinal tract may be warranted via either upper and lower GI endoscopy/colonoscopy or an exploratory laparotomy for full thickness biopsies.

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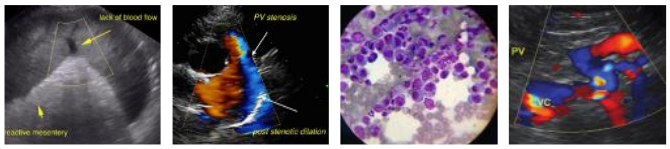

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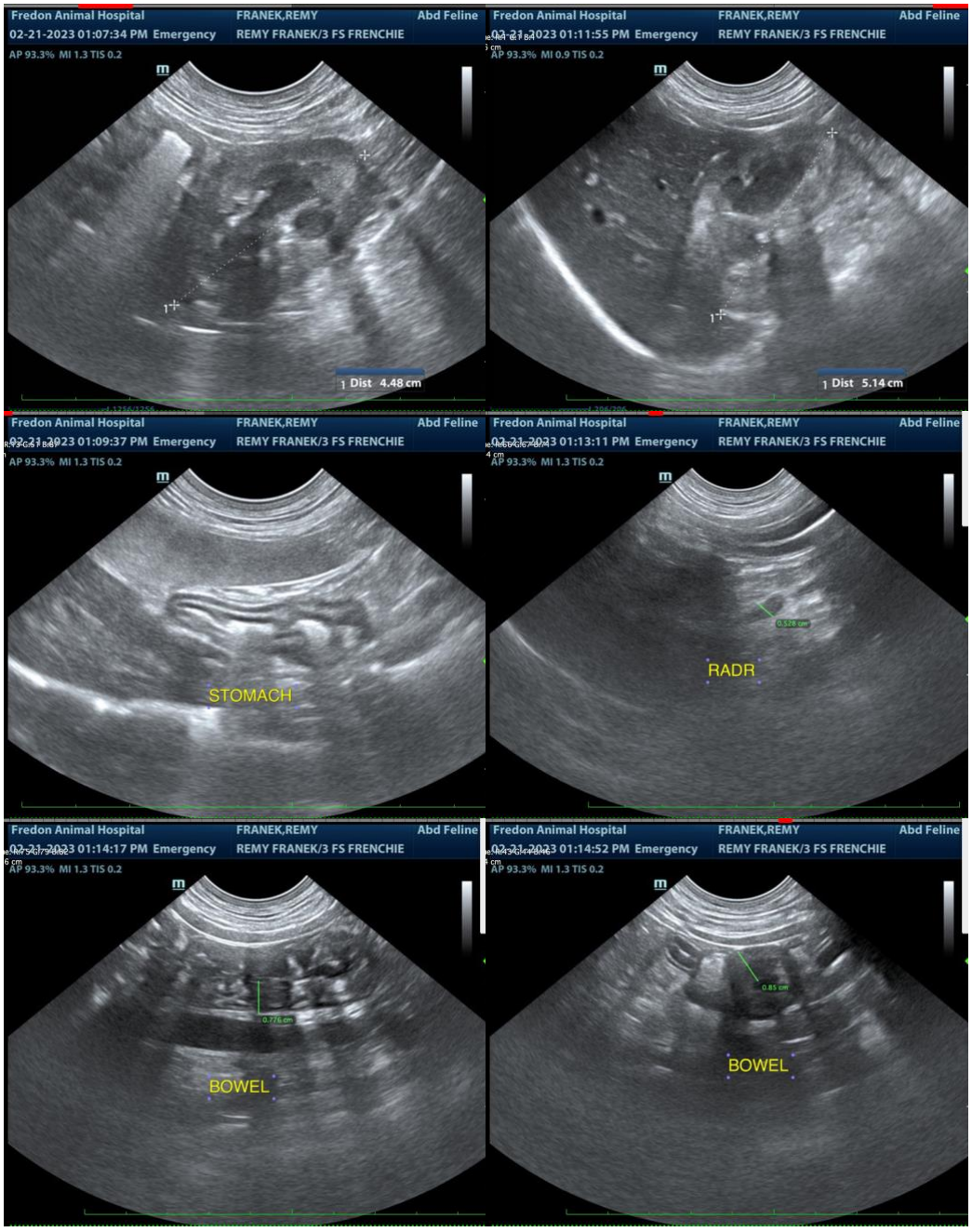

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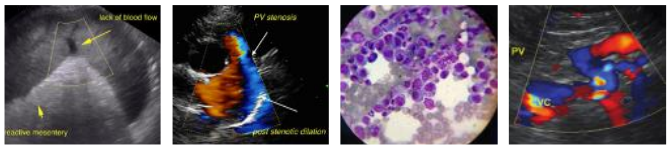

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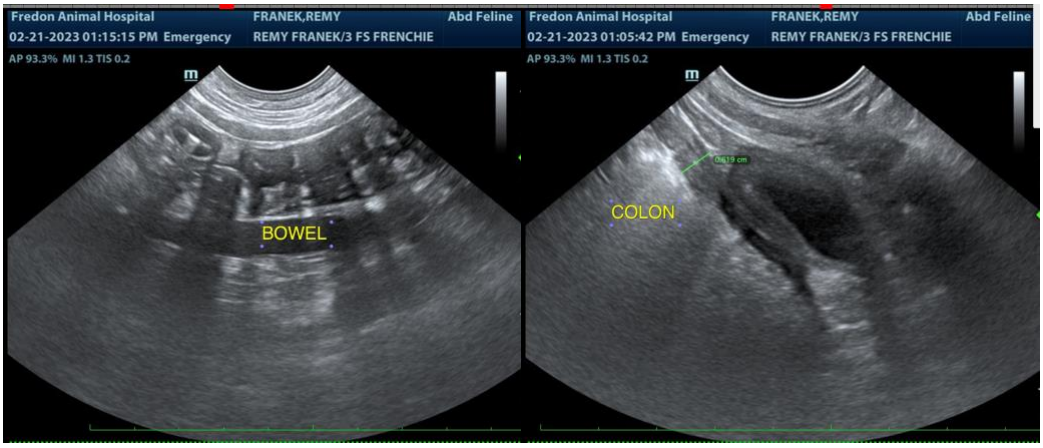

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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