SonoPath
Clinical Sonography & Telecytology
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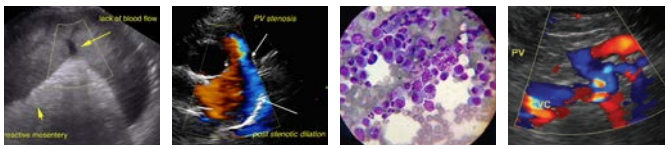

SonoPath.com™
1-800-838-4268 info@sonopath.com

PATIENT

Sandy Marantette

SPECIES

Canine

BREED

Chihuahua

SEX

Spayed Female

AGE

8

WEIGHT

3.1 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Callihan/

HOSPITAL NAME

Animal Emergency Care

REFERRING VET

Dr. Callihan

INVOICE

45500

DATE

2/26/23

PRESENTING CLINICAL SIGNS

Acute onset inappetence 2 nights ago, all owners can think of that she had was a single french fry, but that is something unusual for her. Has history of occasional GI upset that has never required medical care. Patient has very long soft palate and after midazolam we intubated her to maintain patent airway. Note: passed orogastric tube after seeing large amt fluid in stomach; most of scan is post-emptying She was admitted for IV fluids, Cerenia, analgesia overnight. She is BAR and doing better this morning, but no interest in food yet.

Abnormal PE/Chem/CBC/UA Results: Labwork was pretty unremarkable other than signs of hemoconcentration (elev Na, Cl, Hct), low normal TP (5.7; alb 3.7, glob 2.2); Urine marginally concentrated 1.035 with prot 30g/dL.

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.

The right kidney is normal in size (3.2 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.

The left kidney is normal in size (2.95 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.

Adrenal Glands

The right adrenal gland is normal in size (0.56 cm at the cranial pole and 0.40 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 (0.38 cm at the cranial pole and 0.43 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.

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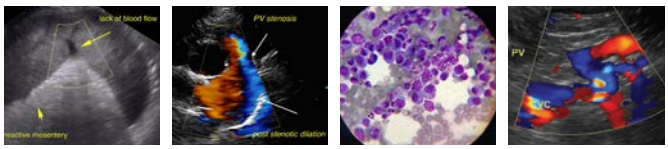

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Gallbladder is moderately distended with anechoic bile as well as mild suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

Gastrointestinal

Gastric mucosal hypertrophy with hyperechoic mucosa and some mucosal remodeling is noted, most prominently within the pylorus and after the reported nasogastric tube placement and lavage. There is no loss of mural detail. Layering is normal. There is marked luminal fluid accumulation noted until after the lavage, at which time it is decreased. No evidence of masses/nodules or foreign material present. The pylorus appears patent.

The visible small intestines are normal in wall thickness and layering. Bowel is diffusely mildly fluid distended without evidence of an obstructive pattern, plication and/or visible foreign material. Small intestinal hyperperistalsis is noted.

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.

PRIMARY FINDINGS

- **Bilateral medullary rim sign -** 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.

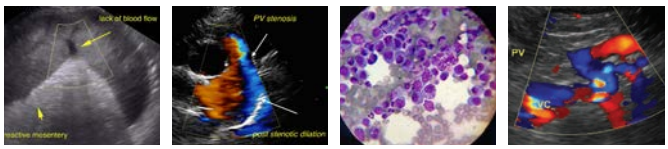
- **Gastroenteritis –** Consistent with irritation secondary to dietary indiscretion or intolerance, infection (bacterial, viral, other), parasitic or protozoal disease, toxin, other metabolic disease such as pancreatitis, other.

- **Gastritis –** Consistent with irritation secondary to dietary indiscretion or intolerance, infection (bacterial, viral, other), parasitic or protozoal disease, toxin, other metabolic disease such as pancreatitis, other. Microulceration cannot be ruled out.

SECONDARY FINDINGS

- Urinary bladder debris

- **Mild gallbladder debris -** Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. Echogenic bile is most commonly an incidental finding in dogs and should



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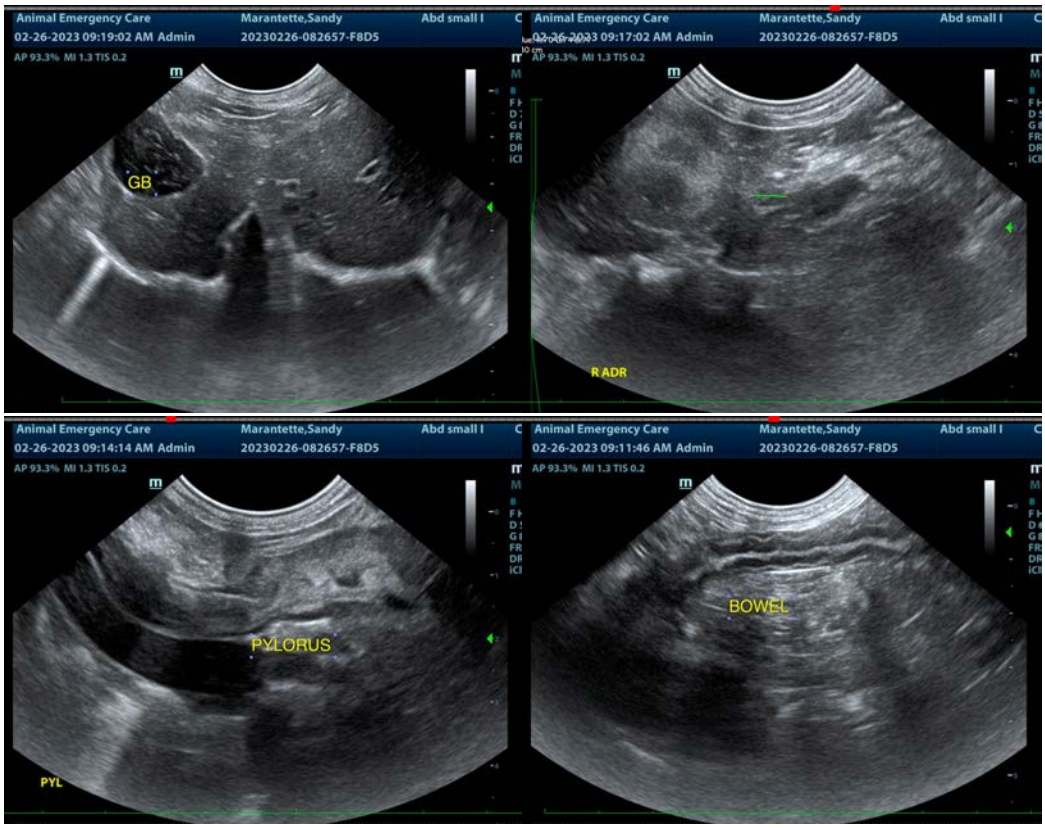
be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This study is most consistent with gastritis and possibly gastroenteritis, potentially as a result of dietary indiscretion versus mild or early infiltrative bowel disease. Given this patient's reported chronicity of more mild gastrointestinal signs, 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.

Additionally, given the reported proteinuria and low-normal total protein, a urine protein to creatinine ratio is recommended to further quantify the proteinuria. In the meantime, supportive/symptomatic medical management of gastritis is recommended with antiemetics, gastroprotectants, an appetite stimulant, if necessary, as well as potentially (once appetite returns) transition short term to a bland, easy to digest diet. Pending ongoing clinical signs, gastrointestinal panel results, etc., ultimately transition to a hydrolyzed protein diet may be considered, give this patient's reported mild chronicity based on trial-and-error response. Additionally, empirical deworming with a 5-day course of Panacur is recommended.

If clinical signs persist and/or gastric distention returns, recheck imaging may be warranted.



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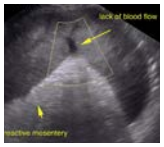
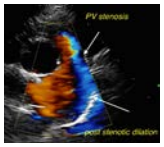
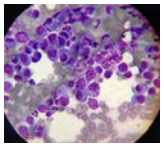
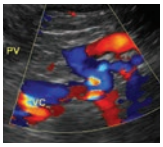

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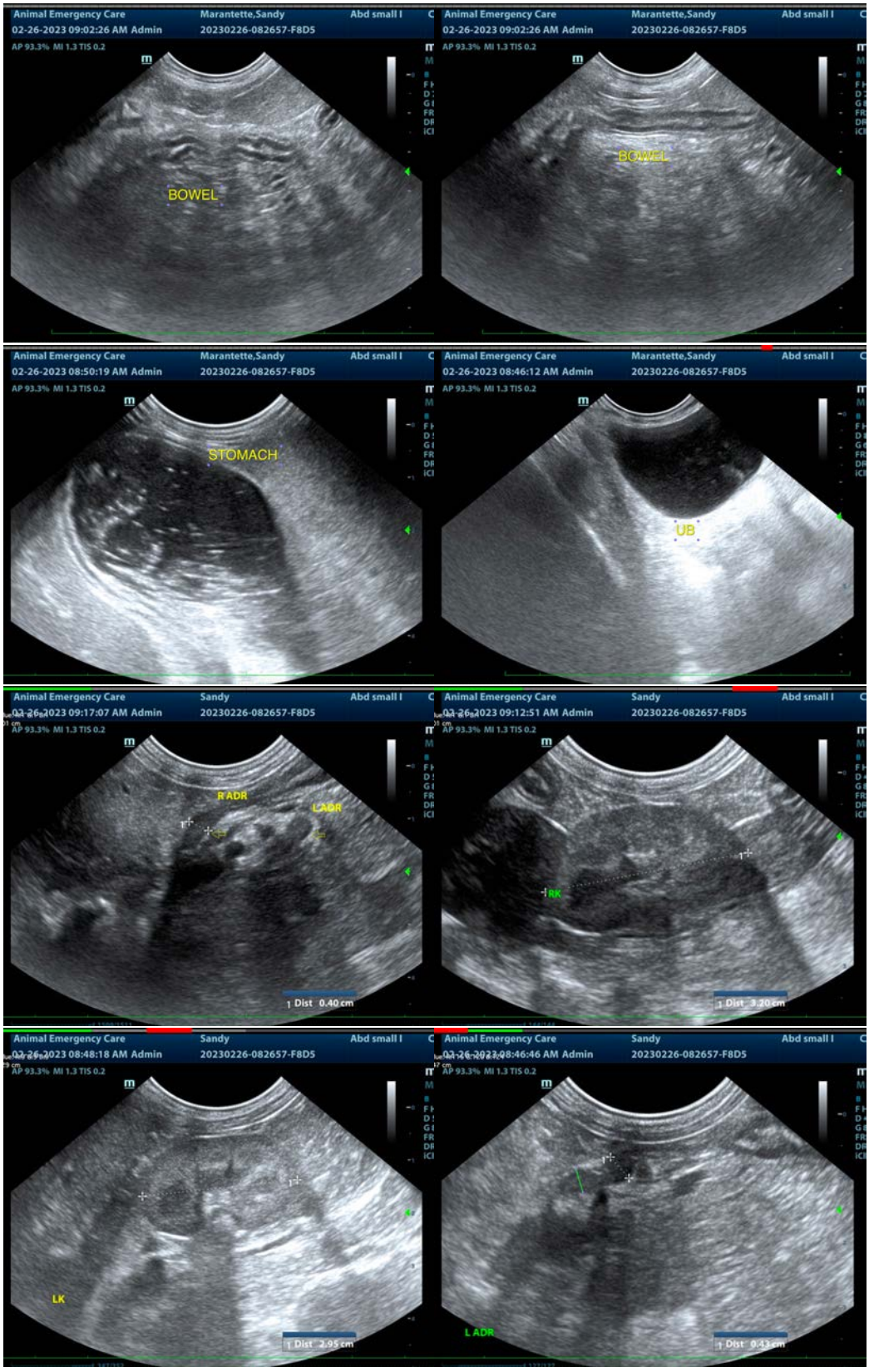

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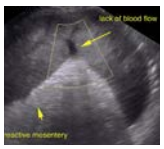
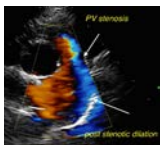
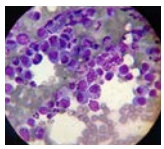
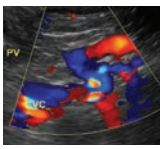

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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