

**DATE PRESENTING CLINICAL SIGNS**

2/28/23 Increased GI noise, change in stools. Weight gain (10lbs), thyroid normal.

PATIENT Current Medications: Cerenia, Omeprazole.

Lab Results: WNL.

Abby Benesch Date of Previous IntraPet Ultrasound: No previous.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

SPECIES Imaging Performed By: Andi Parkinson, BS, RDMS.

Canine

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**BREED** *Urinary System*

Labrador

The urinary bladder is adequately distended with anechoic contents. No distinct masses, inflammatory changes, or distinct cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness. However, the wall is occasionally mildly irregular in appearance, including along the dorsal wall near the apex, where a 0.50 cm long x 0.30 cm deep, echogenic, non-shadowing density is noted.

SEX

Spayed Female

The right kidney is normal in size (7.36 cm), shape and echogenicity. It has smooth peripheral margination.

AGE

4/1/11

There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

WEIGHT

69.5 Pounds

The left kidney is normal in size (6.78 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.

INTERPRETED BY

Beth Johnson, DVM
DACVIM

Adrenal Glands

The right adrenal gland is normal in size (0.62 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. The cranial pole is difficult to fully visualize in these images, but there is no evident pathology visible.

HOSPITAL NAME

Timonium AH

The left adrenal gland is normal in size (2.8 cm long x 0.50 cm at the cranial pole and 0.96 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

REFERRING VET

Dr. McMichael

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.

INVOICE

45583

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.

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 very echogenic reverberation artifact from intraluminal gas. There is no evidence of obstruction, foreign

material or infiltrative disease; however, complete visualization of far wall is partially inhibited by gas. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). 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 (< 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.

Full evaluation of the cranial abdomen is partially limited by the large amount of gas in the stomach, and while no pathology is suspected, subtle pathology could be missed.

ULTRASONOGRAPHIC FINDINGS

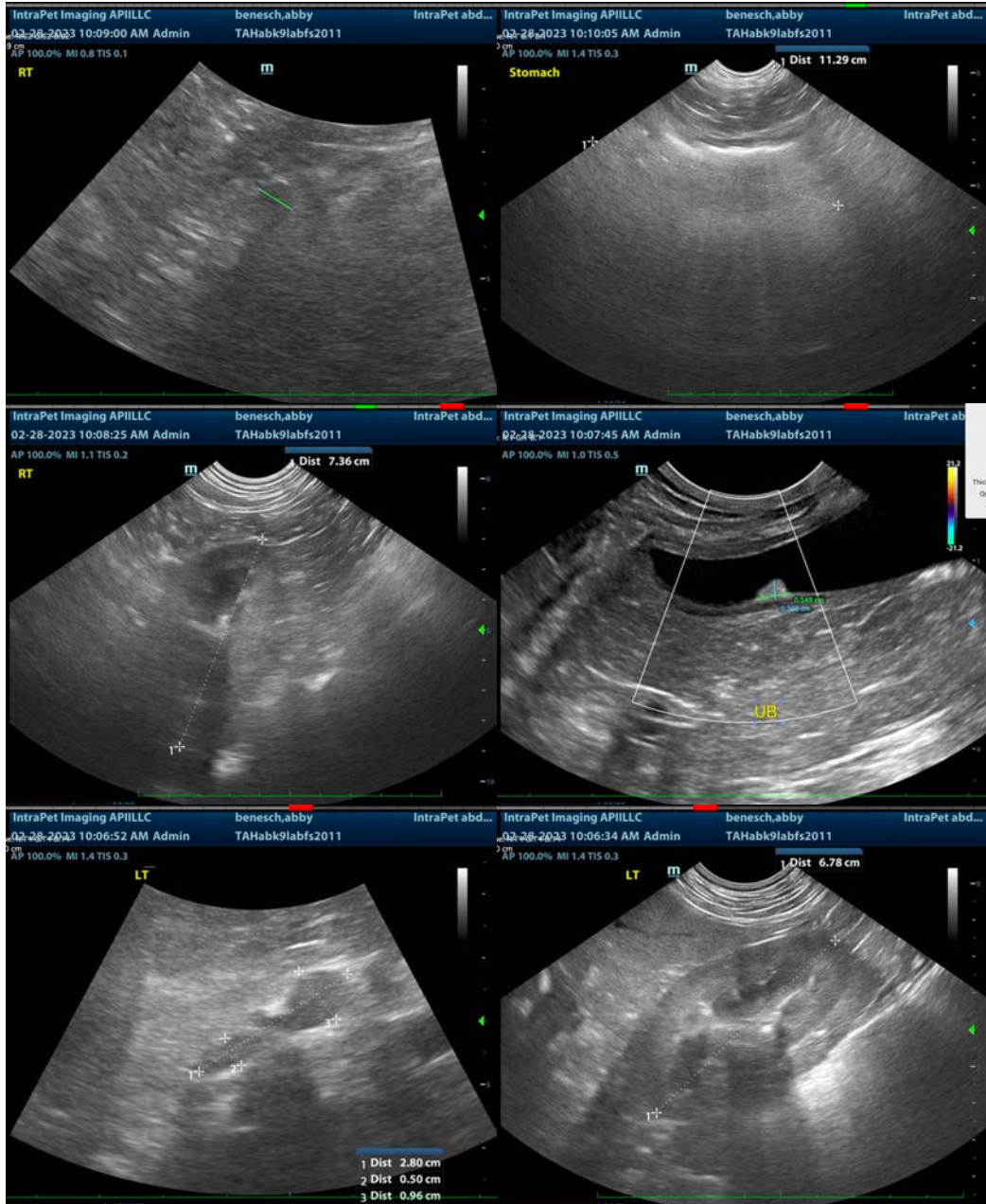
- Non-shadowing echogenic density along the dorsal urinary bladder wall, as well as a diffusely mildly irregular wall – Findings may represent adhered debris, mucus, small blood clots, etc., or potentially emerging benign polypoid cystitis. Infiltrative neoplasia can't be ruled out but is considered exceedingly less likely.
- Gas distended stomach – consistent with this patient's reported history of borborygmus.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not recently evaluated, a 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 ratio is recommended.

Further evaluation of gastrointestinal health and biome is recommended, beginning with a fecal test, a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory, and a fecal enteropathogen PCR panel to Texas A&M GI Laboratory.

In the meantime, empirical transition in diets using trial and error response to assess success could be considered, beginning with a bland, easy to digest or biome friendly diet, or potentially a hydrolyzed protein diet, etc. Additionally, a probiotic such as Visbiome or Provable could be considered, as could a course of Simethicone.





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