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Clinical Sonography & Telecytology
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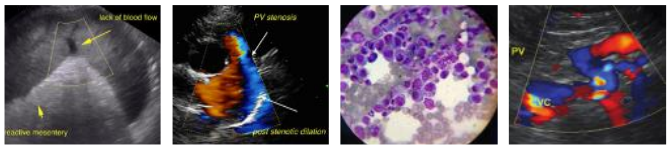


SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Doyle Douglas

SPECIES

Canine

BREED

Basset Hound

SEX

Neutered Male

AGE

9 Years 9 Months

WEIGHT

48 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Raul Casas- Dolz

HOSPITAL NAME

State Avenue VC

REFERRING VET

Dr. Raul Casas- Dolz

INVOICE

21052

DATE

2/6/23

PRESENTING CLINICAL SIGNS

History: 4-day Hx of V once a day; still good appetite; swollen R side of maxilla

Abnormal PE/Chem/CBC/UA Results: Swollen R maxilla; discharge from 108; discomfort with abd palpation

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.

Prostate is normal in size, echotexture and echogenicity for a neutered male.

Left kidney is normal in size (5.7 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 in size (6.2 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.

Adrenal Glands

The adrenal glands are unable to be well visualized in these images.

Spleen

Spleen is subjectively large 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. The spleen is folded upon itself, which is a positional non-pathologic variant.

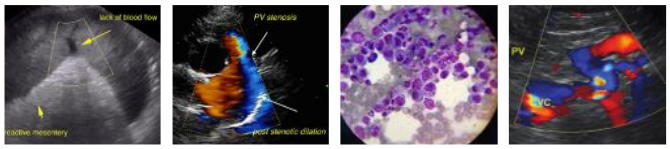
Liver

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 mildly overdistended with a moderate amount of non-dependent, mildly aggregated/inspissated sludge. Hypo to anechoic cystic areas are noted between the gallbladder sludge and luminal wall. The wall is otherwise smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is primarily empty with a small amount of ingesta/chyme in the pyloric antrum/pylorus 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.

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

- Emerging mucocele – 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. The non-dependent nature of this sludge combined with the cystic areas are suggestive, however, of possible emerging cystic mucosal hyperplasia or early gallbladder mucocele.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is not an obvious definitive cause for this patients vomiting in these images, unless the gallbladder disease is contributing to nausea. A general metabolic health screen is recommended for further evaluation of liver enzymes, bilirubin, etc., with a CBC chemistry panel, electrolytes and urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

Pending results, empirical medical management for gallbladder disease/emerging mucocele could be considered with antiemetics, hepatic nutraceuticals, including ursodiol, as well as a broad-spectrum antibiotic with monitoring for improvement. If improvement is noted, especially in liver enzymes, antibiotics should be continued until the enzymes either normalize or plateau. However, if enzymes are not elevated, and/or they are but there is no improvement, antibiotics should not be continued long term for the mucocele. Given this patients suspected dental disease/abscess, long term antibiotics for that may be on board regardless.

If the gallbladder is believed to be a cause of this patients vomiting due to liver enzyme changes, cranial abdominal pain, etc., close monitoring is recommended and if improvement is not noted, and/or clinical signs progress, ultimately, a surgical cholecystectomy may be warranted.

Other differentials for the vomiting, however, include bowel disease, which cannot be ruled out with a normal abdomen. Therefore, additionally, 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.

In the meantime, empirical deworming with a 5-day course of Panacur is also recommended, as well as management of the suspected tooth root abscess resulting in pain, swelling, etc.

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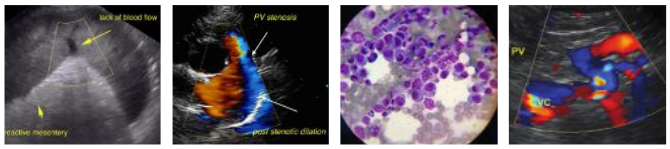

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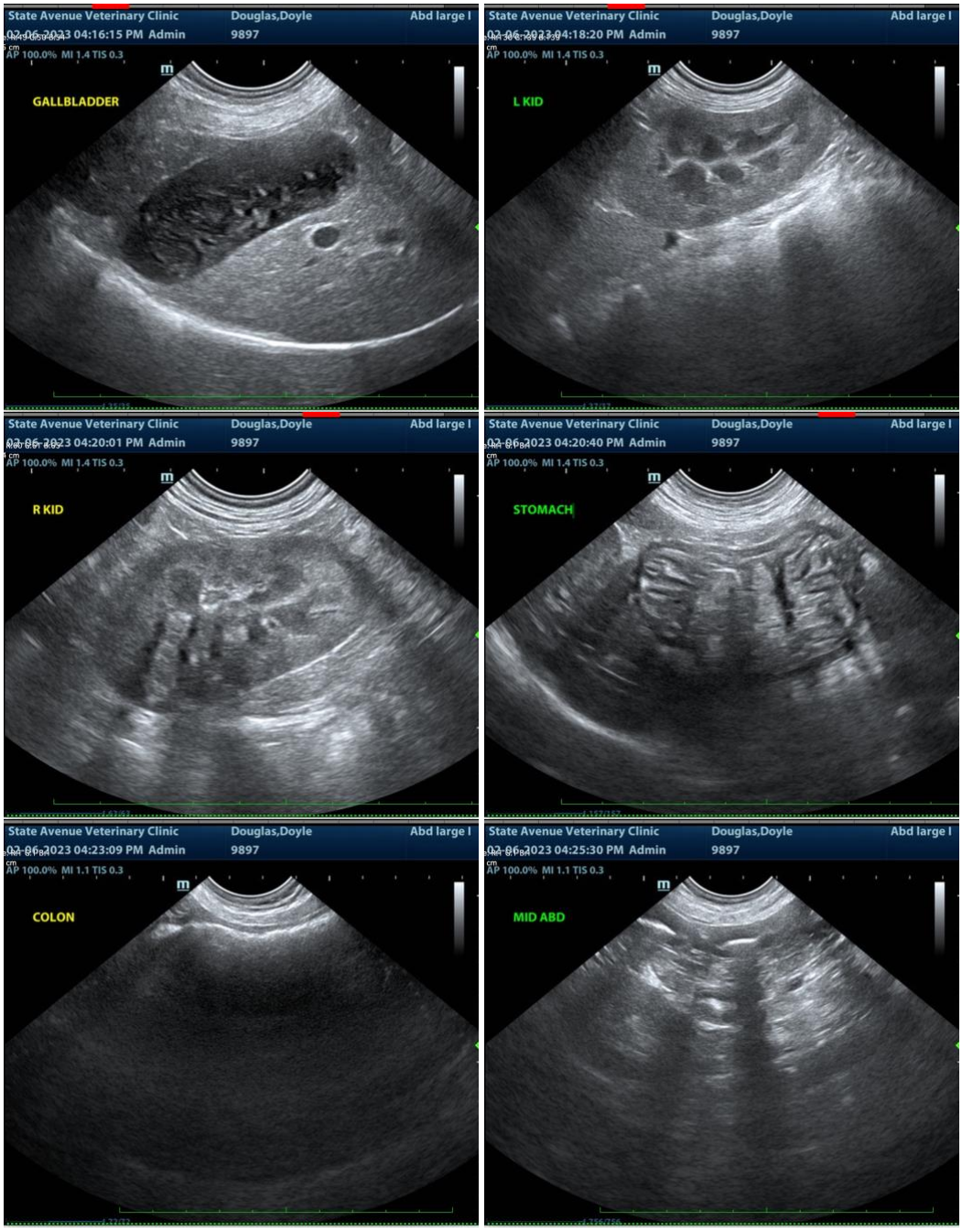

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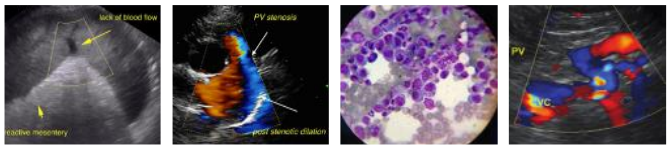

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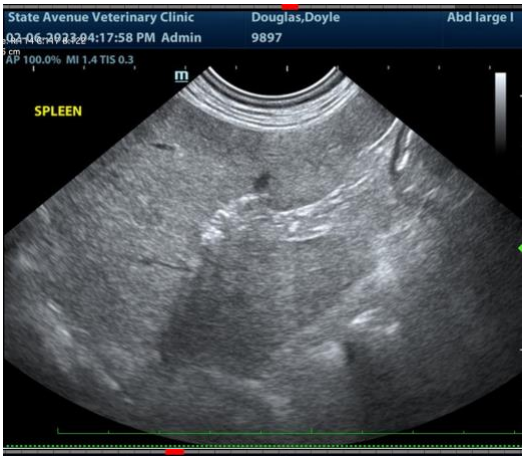

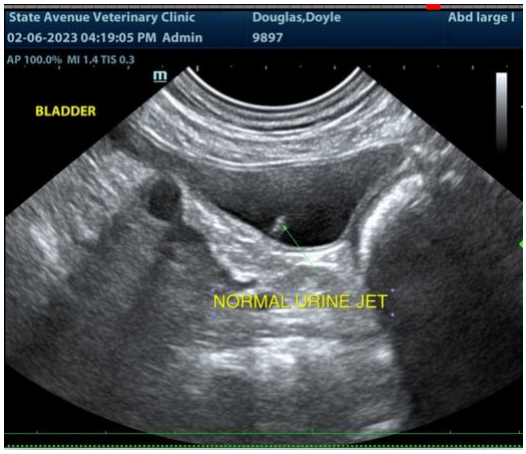

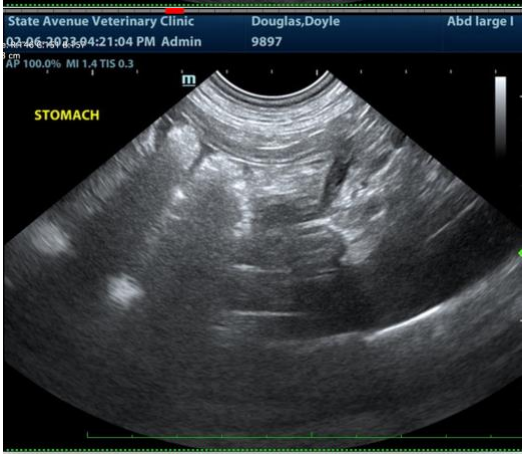

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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