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Clinical Sonography & Telecytology
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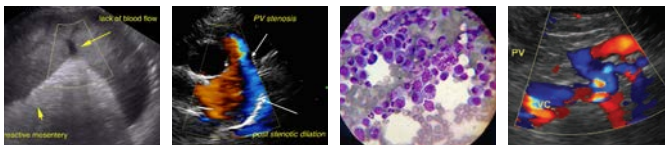

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1-800-838-4268 info@sonopath.com

**PATIENT**
Violet Keeney

**SPECIES**
Canine

**BREED**
Mixed

**SEX**
Female

**AGE**
4 Months

**WEIGHT**
18.4

**INTERPRETED BY**
Beth Johnson, DVM DACVIM

**IMAGING PERFORMED BY**
Dr. Sarah Green

**HOSPITAL NAME**
Healing Spirit

**REFERRING VET**
Dr. Sarah Green

**INVOICE**
44968

**DATE**
2/9/23

## PRESENTING CLINICAL SIGNS

4 days post exploratory laparotomy with gastrotomy. Large rag with embedded plastic shards removed from the colon prior to surgery. No additional foreign material found in the stomach or palpated in the intestines. Pylorus was patent. Duodenum was markedly dilated, large segments of small bowel were mild to moderately hyperemic but appeared vital. Appeared to improve following surgery, had been eating, but was hyporexic. Anorexic and hiding today.

Abnormal PE/Chem/CBC/UA Results: QAR-T, afebrile, abdomen mildly distended, non-painful on palpation. FNA of effusion showed pink, hazy fluid, TS=1.8 g/dL. Cytology pending

## 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.

The right kidney is normal in size (5.1 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.

The left kidney is normal in size (4.7 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.

### *Adrenal Glands*

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

### *Spleen*

The spleen is not well visualized in these images.

### *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 stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

There is some normal empty small bowel noted, but the majority of all the intestines are markedly overdistended with echogenic fluid. Some of the dilated intestine is definitely colon, but there is subjectively too much dilated bowel to be only colon. Additionally, in the mid abdomen there is an intussusception.

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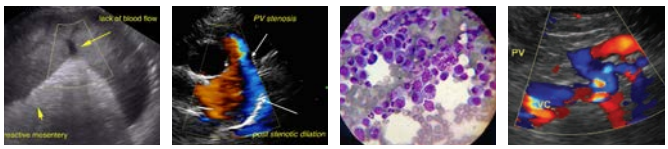

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### *Pancreas*

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 a large amount of echogenic appearing free fluid throughout the abdomen.

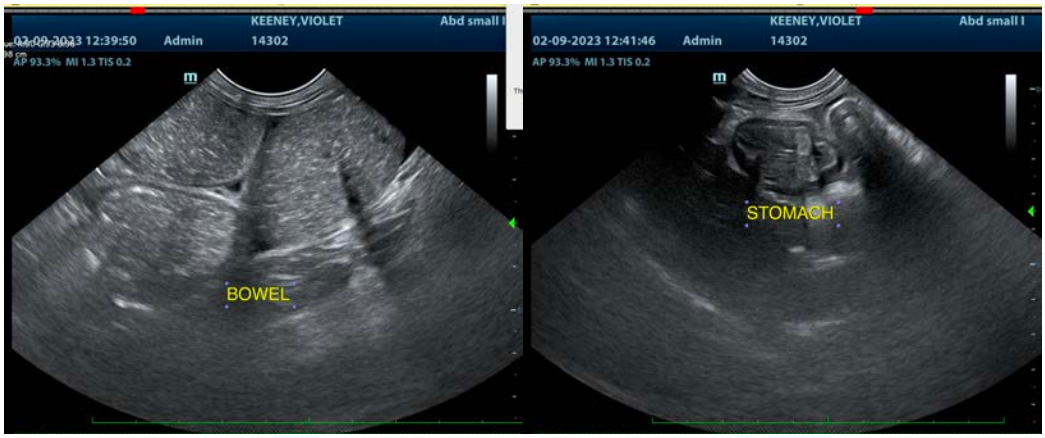
There is no apparent lymphadenopathy noted in these images.

## ULTRASONOGRAPHIC FINDINGS

- Intestinal intussusception - This appears to be fully obstructive, given the obstruction pattern.
- Marked amount of echogenic appearing free fluid – Subjectively more than would be expected post-operatively. Given the suspected obstruction caused by the intussusception, there is some concern that the previous enterotomy site (if performed during the last exploratory surgery) could be leaking due to the increased pressure caused by the obstruction. Alternatively, previously healthy appearing bowel could have become progressively devitalized, resulting in the fluid seen here.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Sampling of the free abdominal fluid, as is reportedly already pending, is recommended with immediate cytology, if possible, to look for evidence of intracellular bacteria/septic abdomen. Regardless, however, an exploratory laparotomy is recommended as soon as the patient is stable enough to undergo surgery for removal and likely resection and anastomosis of the intussusception.



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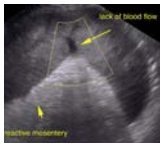
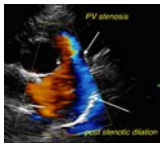
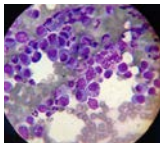
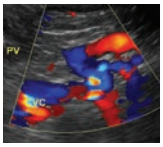

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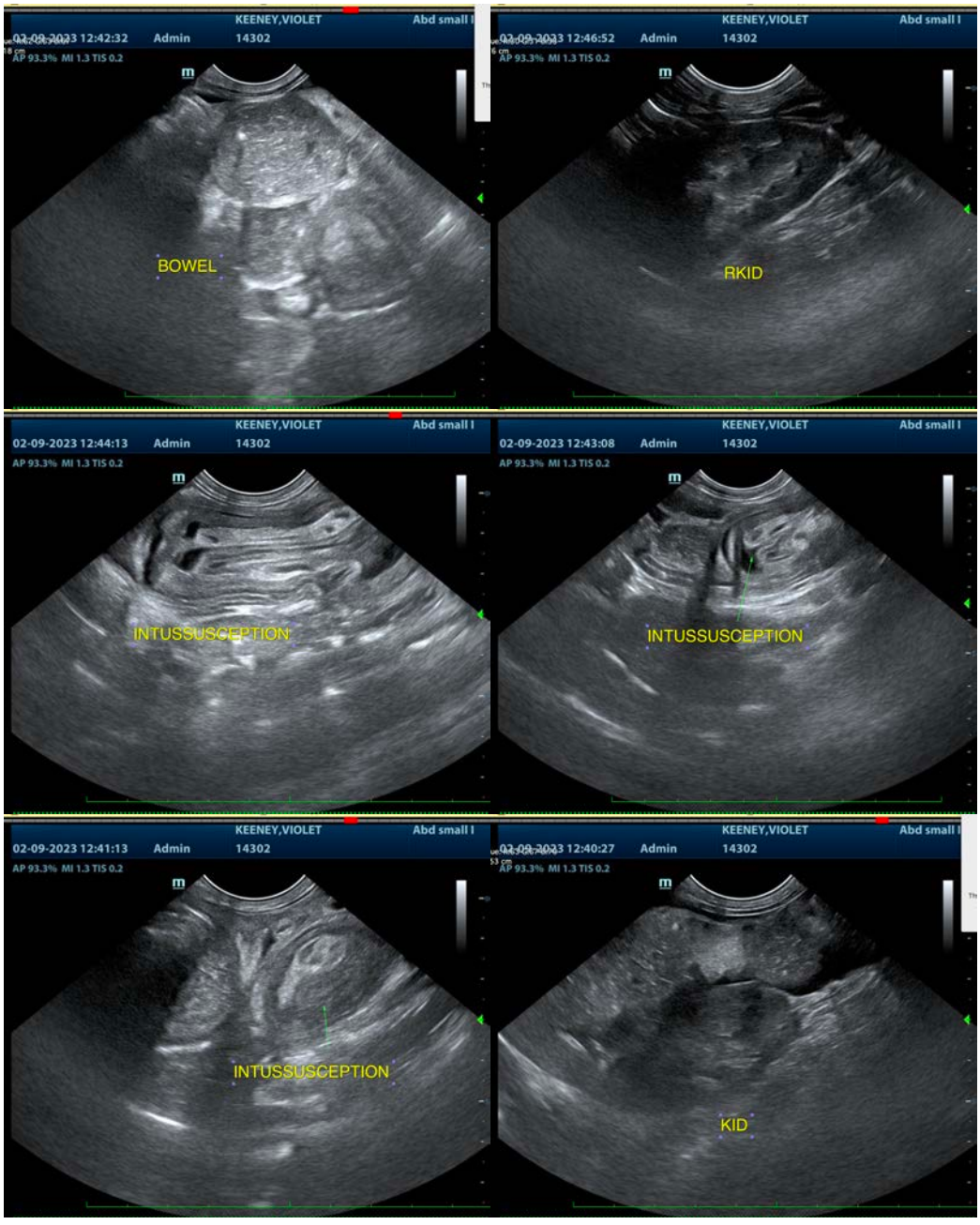

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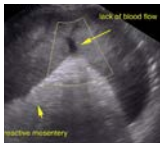
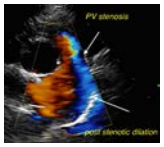
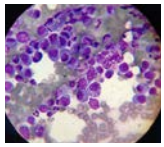
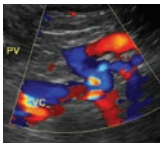

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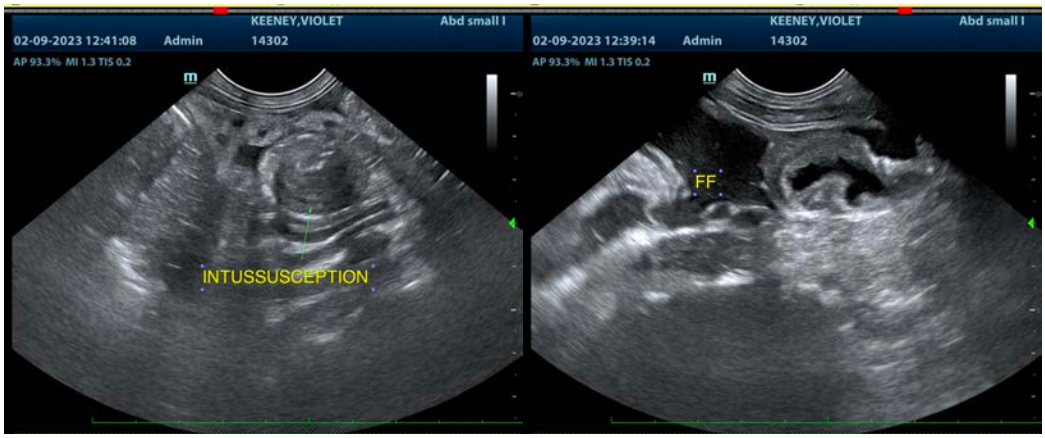


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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