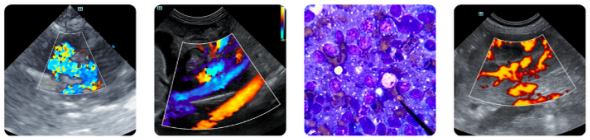

PATIENT

Enzo Benn

SPECIES

Canine

BREED

Boxer Mix

SEX

MN

AGE

6 years

WEIGHT

68 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Jasmine Palacios

HOSPITAL NAME

River's Edge Pet Medical Center

REFERRING VET

Dr. David Gray

INVOICE

11469

DATE

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PRESENTING CLINICAL SIGNS

- Got into trash and maybe corncobs other trash also possible.
- P currently on cerenia.

Abnormal PE/Chem/CBC/UA Results: Rads from rDVM: inflammation loss of detail.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended with primarily anechoic contents and occasional echogenic non-shadowing debris. Some mineral debris embedded within the wall, is suspected. Apical urinary bladder wall is diffusely thick (0.84 cm). Mucosa is hyperechoic and irregular. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface.

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

The right kidney is normal is size (7.92 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. A hyperechoic band parallel to the corticomedullary border is present. Non-obstructive linear multifocal hyperechoic diverticular foci with acoustic shadowing are noted. There is no evidence of pyelectasia or infarcts observed.

The left kidney is normal is size (7.96 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. A hyperechoic band parallel to the corticomedullary border is present. Non-obstructive linear multifocal hyperechoic diverticular foci with acoustic shadowing are noted. There is no evidence of pyelectasia or infarcts observed.

Adrenal Glands

The right adrenal gland is normal in size (1.4 cm at cranial pole and 0.66 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

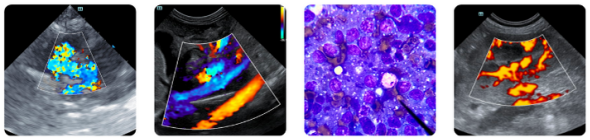
The left adrenal gland is normal in size (0.53 cm at cranial pole and 0.48 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

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 lesions except for a discrete homogenous, non-capsular disrupting, anechoic density mid spleen. 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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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 is moderately to significantly over distended with primarily fluid as well as some echogenic non-shadowing luminal contents and gas consistent with normal chyme. There is no evidence of obstruction, foreign material, or infiltrative disease. Pyloric outflow tract appears patent.

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. Some of the very proximal small bowel is mildly fluid dilated with no visible evidence of foreign material or obstruction.

The visible colon is thick, primarily in the mid to distal descending colon, measuring 0.75 cm thick with normal intact layering and is empty.

Pancreas

Pancreas is prominent (enlarged) in size and mildly irregular in shape with a slightly undulating contour. Parenchyma is coarse in echotexture and heterogenous to hypoechoic in echogenicity.

Free Abdomen

There is no visible free peritoneal effusion noted in these images.

Medial iliac lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

PRIMARY FINDINGS

- The gastric distension is likely ileus or delayed gastric emptying secondary to underlying gastrointestinal or other metabolic disease including potentially, irritation from dietary indiscretion as there is no definitively visible evidence of a foreign body or foreign material. Having said that, non-fully visible foreign material are not obviously shadowing but foreign material can't be definitively ruled out.
- Concurrent mild or emerging or potentially chronic low grade smoldering pancreatitis is a possibility.
- The thick colon trends in appearance toward benign and is consistnet with an inflammatory process secondary to parasitic, infectious, dietary related, other benign inflammatory disease, with infiltrative neoplasia being possible but considered much less likely.
- Moderate reactive medial iliac lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Bilateral Medullary rim sign with non-obstructive dystrophic mineralization bilaterally - 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 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.

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- Chronic cystitis - Urinary bladder wall changes are most consistent with chronic cystitis. Infiltrative neoplasia cannot be ruled out but is considered less likely give the location and diffuse nature of the changes.

SECONDARY FINDINGS

- Hypo to anechoic splenic nodule – likely represents a benign lesion such as a cyst, hematoma, nodular hyperplasia, extramedullary hematopoiesis, etc., however while considered less likely, infiltrative neoplasia can mimic benign lesions, and cannot be ruled out.

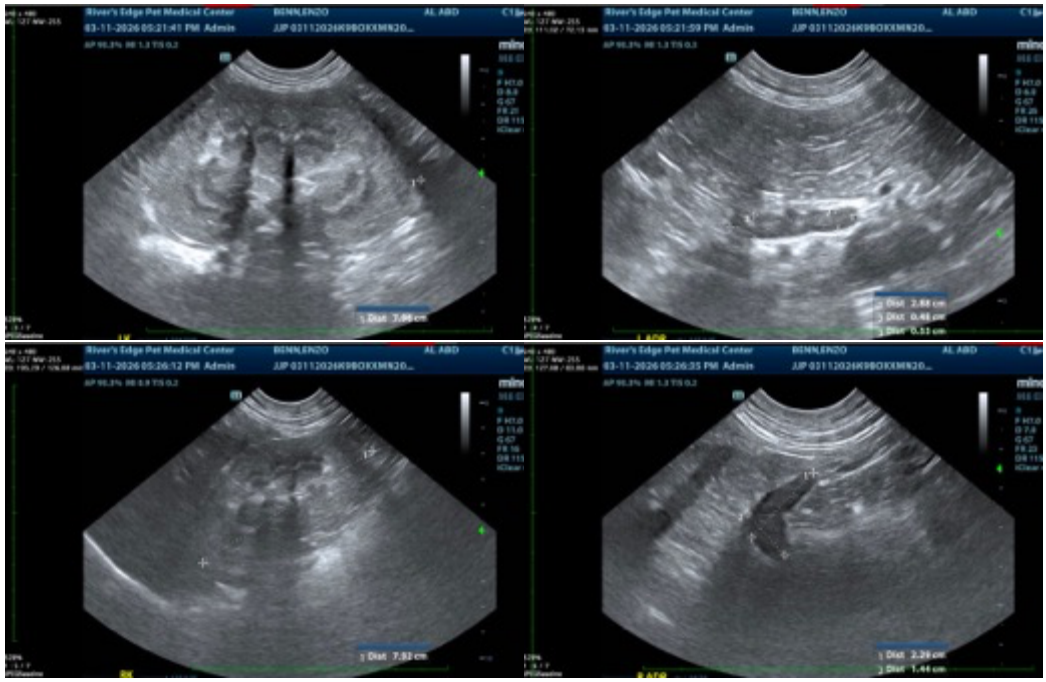
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not recently evaluated, a general metabolic health screen (CBC, chemistry panel with electrolytes and urinalysis) is recommended.

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.

Pending results of that, dependent on patient's clinical signs, additionally a routine fecal/giardia exam could be considered if not recently evaluated. As could a baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism. +/- A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

In the meantime, medical management of pancreatitis with anti-emetics, gastroprotectants, appetite stimulants or nutritional support as needed, pain management, broad spectrum antibiotics, and fluid therapy is recommended. Monitoring of the pancreas with power doppler is recommended to identify possible necrosis as well as other potential sequelae such as abscesses, etc.



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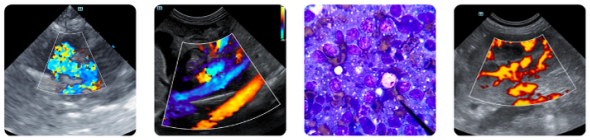

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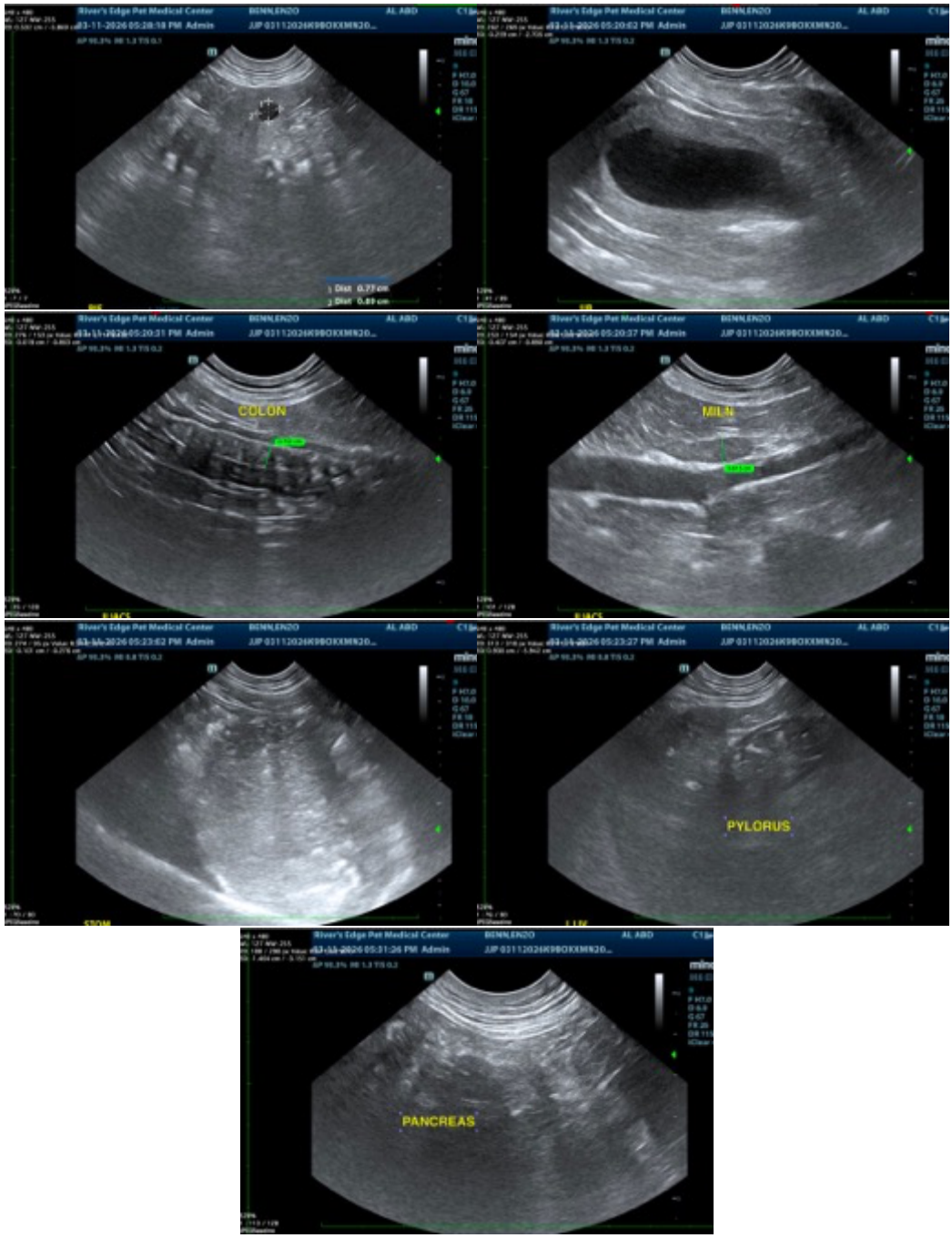

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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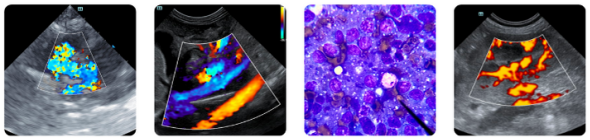

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