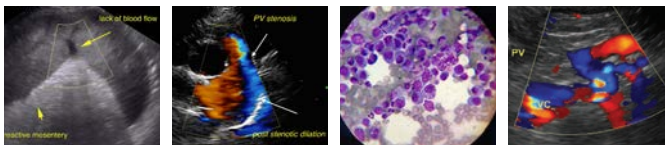
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Saffy Ciaburri

SPECIES
Canine

BREED
Pit Bull X

SEX
Spayed Female

AGE
8 Years

WEIGHT
75.2

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Marco Lichfield

HOSPITAL NAME
Sova Animal Hospital

REFERRING VET
Dr. John Ammeraal

INVOICE
46114

DATE
3/23/23

PRESENTING CLINICAL SIGNS

Pet has a history of vomiting and diarrhea for 2 days, blood and mucous in stool, extra images were obtained to R/O HGE or possible foreign body.

Abnormal PE/Chem/CBC/UA Results: Neutrophils- 12956 high, hemoglobin 21.6 high, Chloride was 101 low

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately 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.

The right kidney is normal in size (7.49 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 (6.97 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 right adrenal gland is normal in size (2.07 cm long x 0.80 cm at the cranial pole and 0.79 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 (2.71 cm long x 0.93 cm at the cranial pole and 0.80 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.

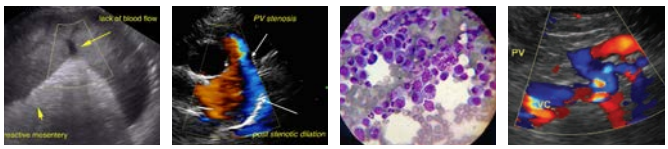
Liver

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.

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, gas, and some non-shadowing luminal contents. 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.



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

PATIENT
Saffy Ciaburri

SPECIES
Canine

BREED
Pit Bull X

SEX
Spayed Female

AGE
8 Years

WEIGHT
75.2

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Marco Lichfield

HOSPITAL NAME
Sova Animal Hospital

REFERRING VET
Dr. John Ammeraal

INVOICE
46114

DATE
3/23/23

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 except for very echogenic reverberation artifact diffusely from intraluminal gas. There are several focal fluid dilated bowel loops without evidence of luminal foreign material, plication, or other to suggest obstruction or foreign body. However, they can't be traced, so it is difficult to determine a true obstructive pattern versus gastroenteritis versus other.

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 appears to be a very scant amount of anechoic free fluid as well as hyperechoic enhanced mesenteric fat surrounding one of the mildly fluid dilated small bowel loops.

There is no appreciable lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

- Diffusely gas-filled GI tract as well as mild fluid distention of some of the small bowel loops – This appears more consistent with gastroenteritis/hemorrhagic gastroenteritis based on history. However, technically, some fluid dilated small bowel with some other empty small bowel is an obstructive pattern, and despite not being able to see foreign material or trace the dilated loops to definitively diagnose an obstruction, an obstruction can't be ruled out. There is evidence of inflammation/focal peritonitis around the fluid distended loops, which can occur with a severe gastroenteritis, as well as potentially an obstruction.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A fecal exam is recommended if not recently evaluated, as is a fecal enteropathogen PCR panel to Texas A&M GI Laboratory for further evaluation of possible infectious disease and a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory for further evaluation of GI and pancreatic function.

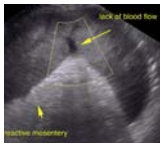
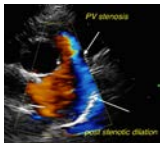
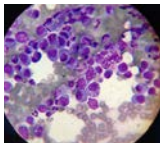
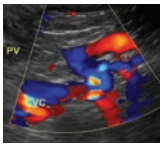
Pending results of the above, additional diagnostics, especially if clinical signs persist, could include a baseline cortisol. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

In the meantime, supportive/symptomatic medical management of clinical signs (possibly HGE) is recommended, including anti-emetics, gastroprotectants (including sucralfate), a probiotic (such as Visbiome or proviable), empirical deworming with a 5-day course of Panacur, +/- metronidazole or tylosin and if tolerated a short-term course of a bland, easy to digest or possibly fiber responsive diet.

If clinical signs persist beyond supportive care, recheck fasted imaging is recommended, being sure to zoon in and/or use a linear transducer on the bowel to help better visualize the bowel, as well as to try to trace dilated bowel loops to where they start and/or end being dilated.

Additionally, abdominal radiographs +/- a potential barium study could help more definitively rule out a foreign body/obstruction is vomiting is managed to minimize the risk of vomiting/aspirating barium.

SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

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

PATIENT

Saffy Ciaburri

SPECIES

Canine

BREED

Pit Bull X

SEX

Spayed Female

AGE

8 Years

WEIGHT

75.2

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Marco Lichfield

HOSPITAL NAME

Sova Animal Hospital

REFERRING VET

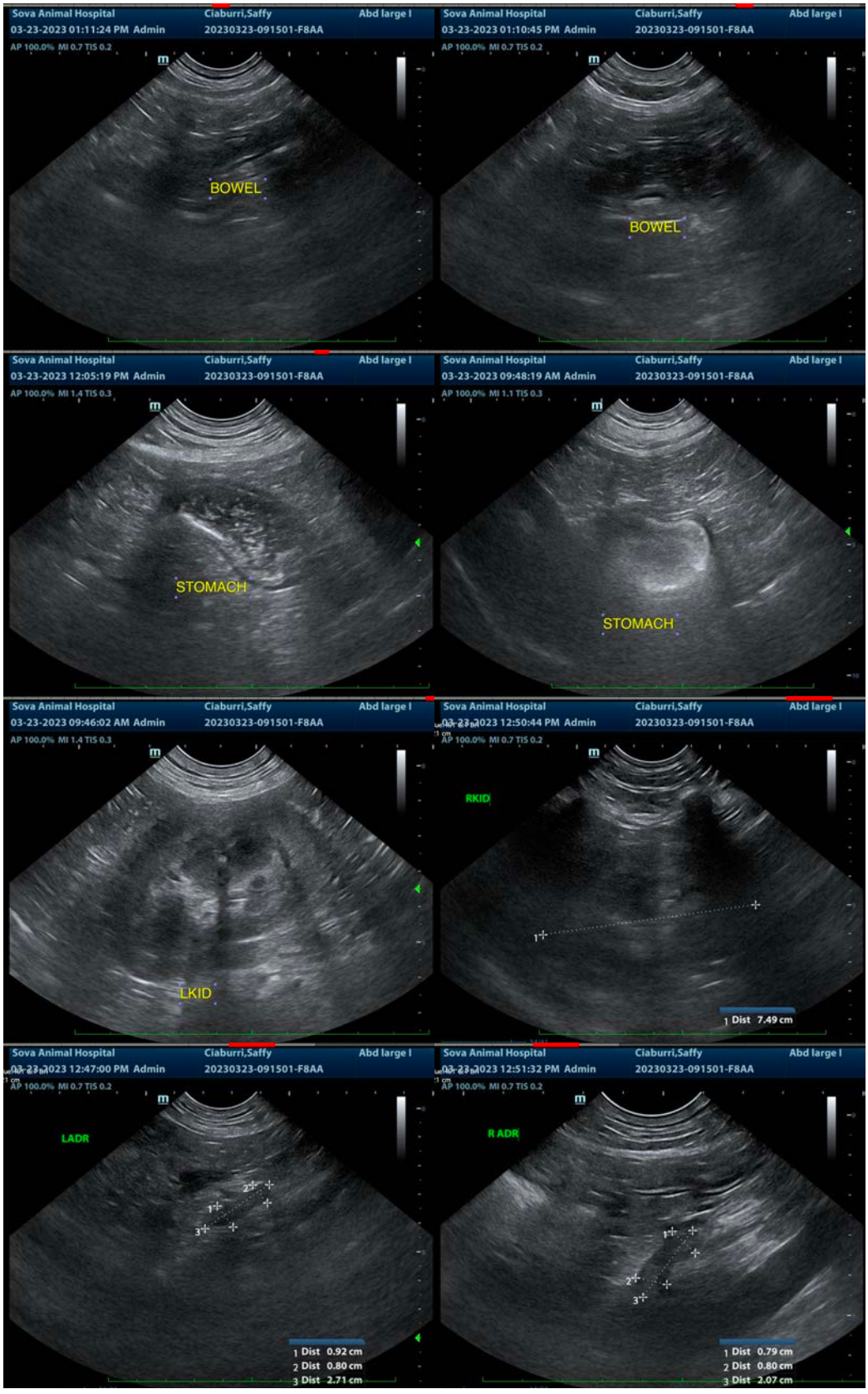
Dr. John Ammeraal

INVOICE

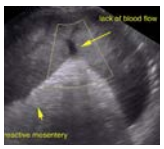
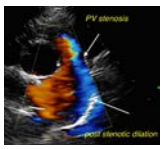
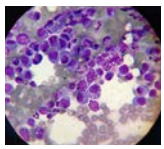
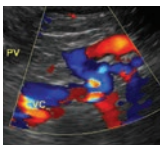
46114

DATE

3/23/23



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

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

PATIENT

Saffy Ciaburri

SPECIES

Canine

BREED

Pit Bull X

SEX

Spayed Female

AGE

8 Years

WEIGHT

75.2

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Marco Lichfield

HOSPITAL NAME

Sova Animal Hospital

REFERRING VET

Dr. John Ammeraal

INVOICE

46114

DATE

3/23/23

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