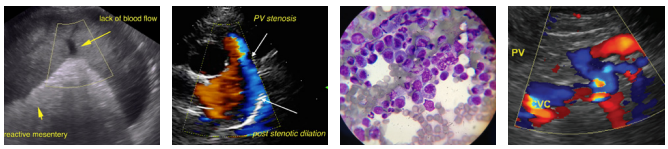
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Sugar Parker

SPECIES
Canine

BREED
DSH

SEX
Spayed Female

AGE
6 Years

WEIGHT
9 Pounds

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Dr. Kara Wallisch

HOSPITAL NAME
Sondel Family VC

REFERRING VET
Dr. Kara Wallisch

INVOICE
36033

DATE
3/9/22

PRESENTING CLINICAL SIGNS

History of eating small amounts multiple times per day over last few weeks. Then started vomiting after small amounts. Vomits once every other day, usually all food. No diarrhea. Eating Fancy Feast. Not on meds currently. O was sent to our clinic from rDVM for an abdominal ultrasound.
Abnormal PE/Chem/CBC/UA Results: Abdominal rads/chest rads: nsf. CBC/Chem nsf. UA nsf.

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 (3.5 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 (3.4 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 (0.30 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.36 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

**All 4 images are labeled “right”, but the two that I believe to be the left are noted as such an in the images below with a question mark.

Spleen

Spleen is subjectively enlarged in size with rounded margins but intact capsule. Parenchyma is homogenously coarse/mottled in echotexture and normal to hypoechoic in echogenicity. No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

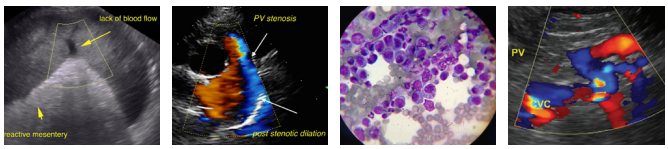
The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal 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 stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) and layering. The pylorus is mildly fluid distended. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness. Normal layering is maintained except for a diffusely disproportionately thick muscularis layer relative to mucosa. Small intestinal motility appears



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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 pancreas is diffusely prominent to enlarged with slightly irregular peripheral contours. The parenchyma is mildly coarse and hypoechoic relative to surrounding tissue. Peripancreatic area is mildly hyperechoic. There is no visible duct dilation.

Free Abdomen

There is no evidence of peritoneal effusion. There is no apparent lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

- Pancreatic changes consistent with chronic active pancreatitis with suspected gastric stasis secondary to pancreatitis and infiltrative gastrointestinal versus bowel disease.
- Thick muscularis – This finding has been reported in cats with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma.
- Coarse splenomegaly – can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Recommendations include a gastrointestinal malabsorption panel including a TLI, PLI, folate and cobalamin to Texas A&M GI laboratory, as well as a T4 if not recently evaluated. A fine needle aspirate of the spleen is recommended if patient's coagulation status is appropriate. Ultimately, biopsies of the gastrointestinal tract (being sure to include the ileum if possible) may be necessary to definitively diagnose and ultimately treat this patient's underlying pathology. However, immediate therapeutic recommendations include medical management of pancreatitis/gastric stasis with monitoring of clinical signs for improvement.

A diet change to a low-fat diet could be considered initially, and if there isn't clinical resolution, transition to a novel or hydrolyzed protein diet may be indicated in the future. Given the mildly fluid distended pylorus, if gastrointestinal signs do not resolve, recheck imaging of the area is recommended for monitoring of any progression or evidence of any obstruction not present or suggested in these images.

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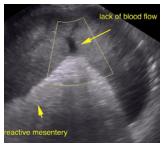

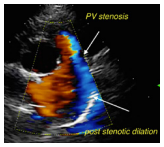

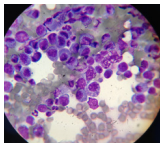
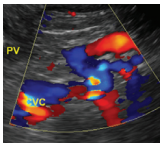

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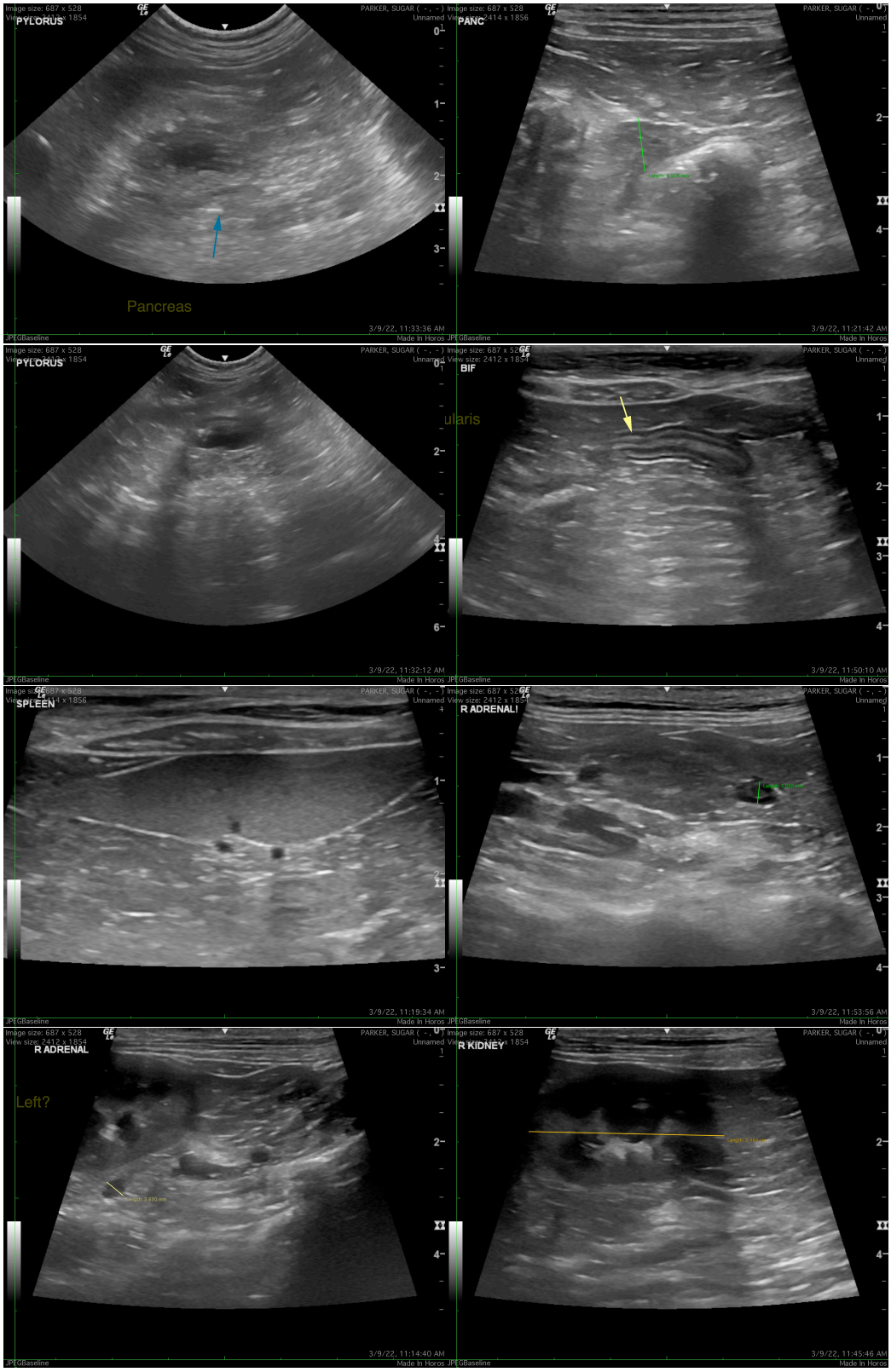

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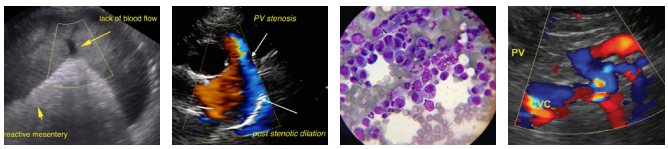

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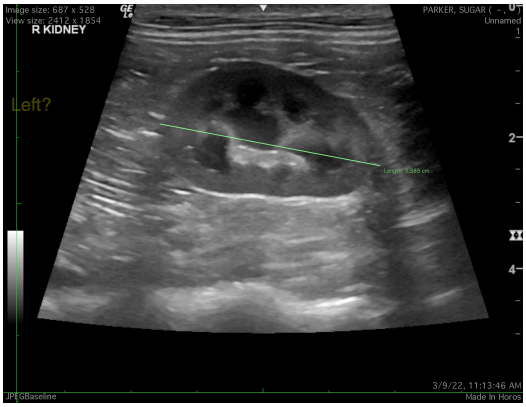

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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