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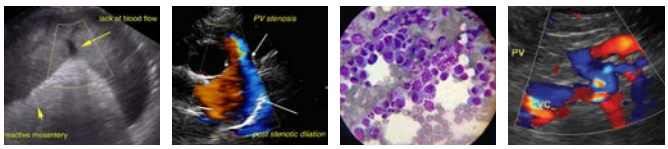
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Bjorn Mihuc

SPECIES
Canine

BREED
Husky

SEX
Neutered Male

AGE
5 Years

WEIGHT
61 Pounds

INTERPRETED BY
Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY
Dr. Charlie Rodriguez

HOSPITAL NAME
Bethany Family PC

REFERRING VET
Dr. Charlie Rodriguez

INVOICE
46583

DATE
4/12/23

PRESENTING CLINICAL SIGNS

Ate a portion of a rib bone on Sunday. Tuesday was when p started to vomit at least 7 to 10 times. No diarrhea O did not see p get into anything else, but p does tend to lick random things like the patio, the floor etc. P has not been able to keep water down, p will drink a lot of water then throw it up. refusing food. low energy levels. P can't keep anything down. No vomiting since 2 am this morning.

Abnormal PE/Chem/CBC/UA Results: Abnormal snap CPL Rad review: Focal enlargement of the small intestine may be associated with soft tissue opaque foreign body, intussusception, or intestinal mass lesion. The mineral component may represent additional foreign material or "gravel sign" indicating sedimentation secondary to partial obstruction from a mass or intussusception. There is evidence of additional foreign material which has passed to the colon.

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 prostate is unable to be visualized in these images.

The right kidney is normal in size (5.8 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 (6.9 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 (0.68 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. The cranial pole is unable to be well visualized in these images.

The left adrenal gland is normal in size (0.53 cm at the cranial pole and 0.52 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.

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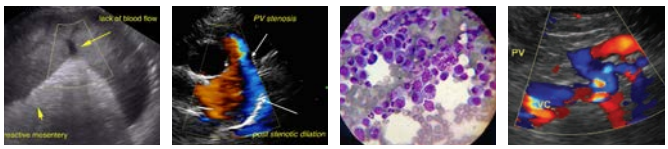

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Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. The pylorus is not well visualized.

Diffusely, 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 with no evidence of obstruction, foreign material or infiltrative disease. Focally, just medial to the spleen, there is a normal appearing loop of small bowel that appears to lead to and be attached to a loop of bowel that contains an intraluminal echogenic focus with strong acoustic shadow that could potentially represent foreign material. These images contain a large amount of reverberation artifact from gas, making it difficult to fully assess the gastrointestinal tract. The small bowel loop described above can't be definitively ruled out as colon, but isn't believed to be colon.

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 no evidence of free peritoneal effusion noted in these images.

There is no apparent lymphadenopathy noted in these images.

The loop of bowel described above with a suspect foreign body in it is surrounded by hyperechoic enhanced mesenteric fat.

ULTRASONOGRAPHIC FINDINGS

- There is a loop of bowel medial to the spleen that appears to be small bowel and has the appearance of an intraluminal foreign body characterized by strong acoustic shadowing. There is no obvious visible obstructive pattern, plication, etc. to definitively support an obstruction, but a foreign body is suspected.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the lack of ability to definitively define small bowel foreign body combined with the lack of a definitive obstructive pattern, etc., continued medical management as well as continued fasting with recheck imaging in another 12-24 hours could be considered. Having said that, given the strong suspicion radiographically of a foreign body or intussusception in the small bowel combined with the evidence of focal peritonitis surrounding the abnormal loop in these images, a more immediate exploratory laparotomy is likely the safer alternative.

Additionally, if more definitive evidence is elected prior to surgery, a barium swallow could be considered, and/or an abdominal CT scan.

Dr. Johnson would appreciate any follow up available for the outcome of this patient. Please email beth.johnson@sonopath.com Thank you!

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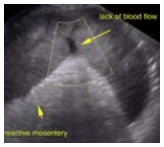
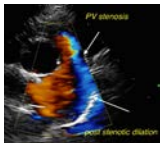
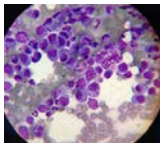
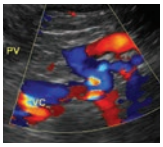

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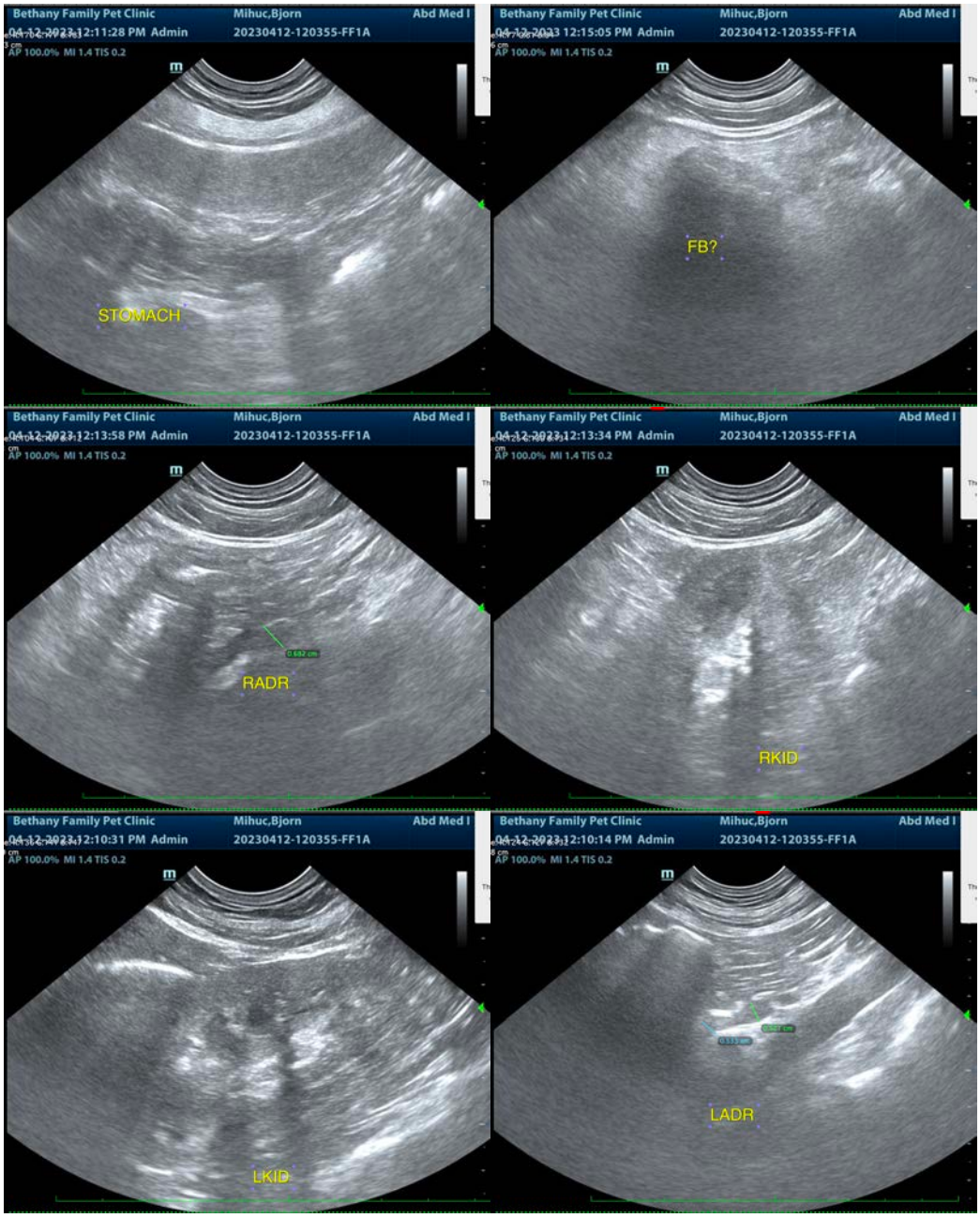

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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