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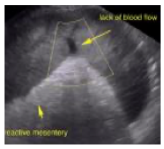
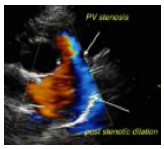
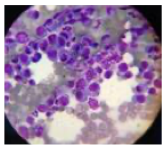
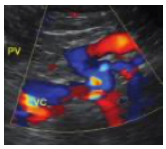
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

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

PATIENT
Rogue Jessop

SPECIES
Canine

BREED
Pitbull Terrier

SEX
Neutered Male

AGE
6 years

WEIGHT
86.6 lbs

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Dr. Jessie Evoniuk

HOSPITAL NAME
State Avenue VC

REFERRING VET
Dr. Jessie Evoniuk

INVOICE
12788

DATE
4.18.23

PRESENTING CLINICAL SIGNS

History: Vomiting and not eating started Sunday, lethargic, unsure if has diarrhea, no new food/treats P has an ear infection and allergies are flaring up currently, lame on LH, told by WDV P has a torn ACL Has been on meds for leg, PRN Not one to get into toys and destroy things No travel. Not likely to get into anything. Taste of the Wild normal food Currently on IV fluids and cerenia at the clinic

Abnormal PE/Chem/CBC/UA Results: WBC- 22.55 10^9/l NEU- 18.83 10^9/l HGB- 22.3 g/dl HCT- 62.45 % GLU-134 * mg/dL

Dr. Johnson would appreciate any follow-up available on the outcome of this patient (beth.johnson@sonopath.com)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately 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 fully visualized in these images.

Left kidney is normal in size (6.90 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.

Right kidney is normal in size (6.50 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

Left adrenal gland is normal in size (0.65 cm at cranial pole and 0.72 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.66 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. The cranial pole is unable to be fully visualized in these images. Visible surrounding vasculature appears normal.

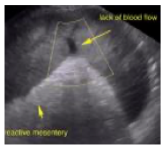
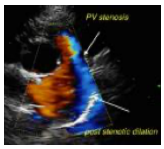
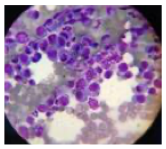
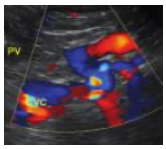
Spleen

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

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.

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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Gastrointestinal

The visible stomach wall is normal in thickness and layering. The stomach is mildly distended and contains an echogenic interface with distal progressively shadowing material consistent with hairball density (or similar fluid absorbing material) noted.

The visible small intestine demonstrates areas of thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. The lumen of the small intestine is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction or foreign material noted. In the right cranial abdomen, there is a loop of bowel that contains similar-appearing contents as the stomach, if small bowel is concerning for nonobstructive foreign material. However, it could be colon and can't be definitively traced in these images.

The visible colon is normal in wall thickness and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The observed pancreas appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

Mesenteric lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. Mildly hyperechoic enhances mesenteric fat surrounding the right cranial bowel loop described above.

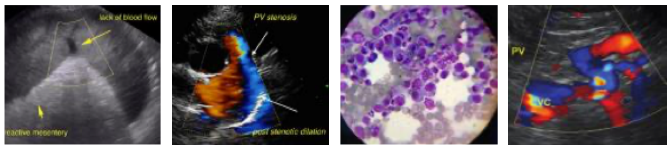
ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Gastric Hairball – similar density soft foreign material cannot be ruled out. Given the post-prandial appearance of this study, normal ingesta/gas and kibble, etc. can't be definitively ruled out.
- Inflammatory bowel disease (IBD) pattern – Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No aggressive lymphadenopathy, loss of layering, etc. is noted to make lymphoma more probable, but lymphoma cannot be definitively ruled out without tissue sampling.
- Reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- If the material within the stomach is foreign material, it is suspected to be extending into the proximal small bowel in the right cranial abdomen. However, as stated above, the bowel loop in the right cranial abdomen cannot be definitively traced in these images, and therefore can't be definitively identified as small bower versus potentially large.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the bowel changes, lymphadenopathy, etc., further evaluation for possible underlying gastrointestinal disease, while providing supportive/symptomatic medical management and monitoring this patient, could be pursued a conservative approach, characterized by a gastrointestinal



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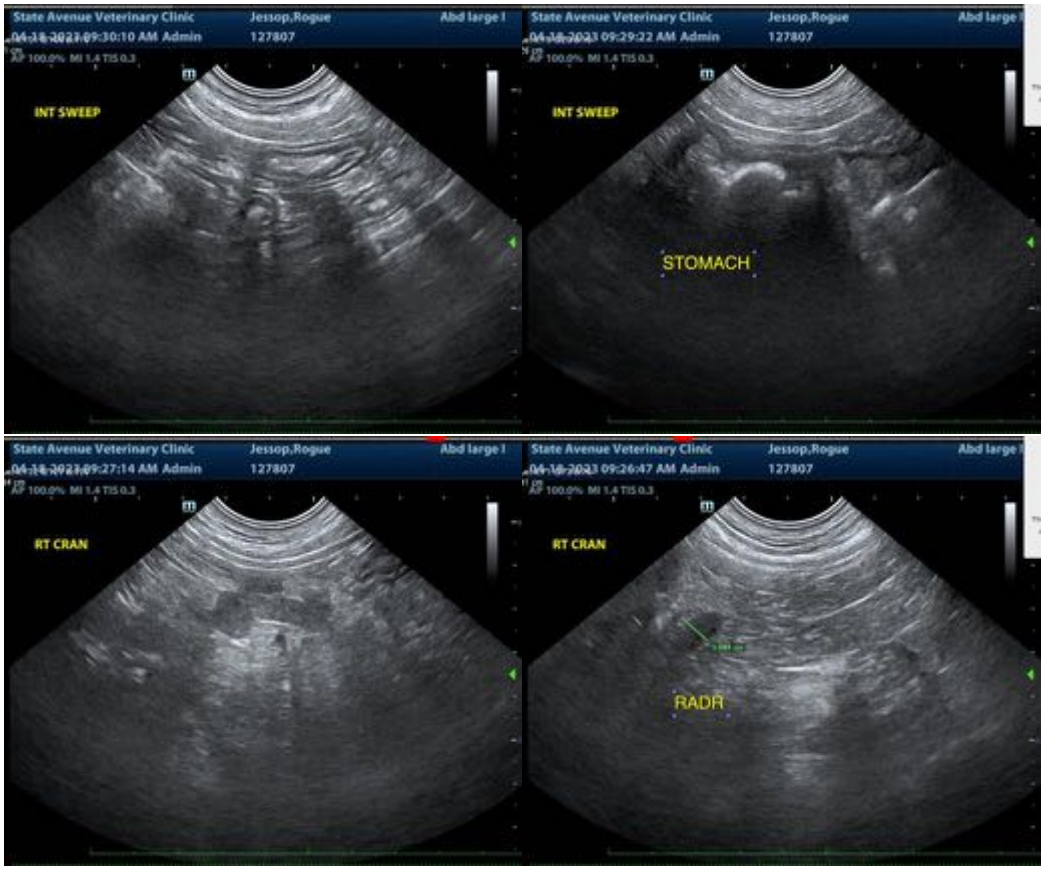
malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function, fluid therapy, antiemetics, gastric protectants, empirical deworming with a 5-day course of Panacur, and an additional 12-24 hours of fasting, followed by recheck imaging at that time (or sooner if vomiting persists despite fasting).

Alternatively, an exploratory laparotomy could be pursued sooner to further investigate/rule out/remove gastric and/or proximal small bowel foreign material, and/or if not discovered, full thickness biopsies of the GI tract could be obtained at that time. While ultrasound cannot definitively guarantee the success of one approach versus the other, given the lack of plication or definitively obstructive pattern, etc. to help make the argument for foreign material stronger, the conservative approach at this time is believed to be a safe option. However, if vomiting persists and/or imaging changes, that recommendation changes as well.



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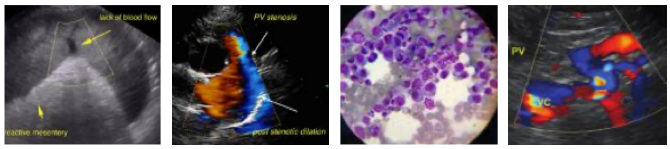

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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