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SVS Mobile Imaging CT 262 - 366 - 5970
fredgromalak@gmail.com

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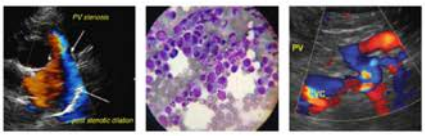

SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

PATIENT
Saydee Mears

SPECIES
Canine

BREED
Goldendoodle

SEX
Spayed Female

AGE
3 Years 2 Months

WEIGHT
50 Pounds

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Tom McNeill

HOSPITAL NAME
SVS Imaging CT

REFERRING VET
Dr. Meyers

INVOICE
36783

DATE
4/6/22

PRESENTING CLINICAL SIGNS

Ingestion of butter two months ago. Recurrent lipidosis of the cornea. Chronic vomiting and diarrhea more recently, unresponsive to metronidazole.
Abnormal PE/Chem/CBC/UA Results: Bloodwork was within normal limits. Resting cortisol was normal.

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 (6.62 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 (6.0 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 (0.45 cm at the cranial pole and 0.44 cm at the caudal pole), shape and contour. The middle of the adrenal gland has a slight bulge that measures 0.78 cm, of no clinical consequence. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.48 cm at the cranial pole and 0.51 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 mildly enlarged 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 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. Pyloric outflow tract appears patent.

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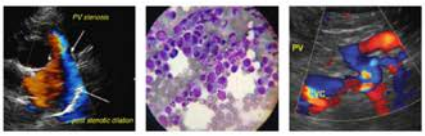

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The visible small intestines are normal in wall thickness except for the duodenum, which is mildly thick, measuring 0.64 cm with normal layering maintained. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

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 is no evidence of peritoneal effusion. Mild mesenteric lymphadenopathy measuring 0.8 cm thick and mild medial iliac lymphadenopathy measuring 1.03 cm thick is noted.

ULTRASONOGRAPHIC FINDINGS

- Subjective mild hepatomegaly – rule out normal patient variant versus a steroid or reactive hepatopathy. Infiltrative neoplasia such as round cell neoplasia is possible, but considered less likely.
- Mild lymphadenopathy – rule outs include both reactive lymphadenopathy as well as infiltrative neoplasia disease.
- Thick duodenum – rule outs include parasitic, infectious or inflammatory enteropathy. Infiltrative neoplasia is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the gastrointestinal signs, thick duodenum and lymphadenopathy, recommendations include a gastrointestinal malabsorption panel including TLI, PLI, folate and cobalamin to Texas A&M GI laboratory as well as a fecal enteropathogen PCR panel to Texas A&M GI laboratory for further assessment of the gastrointestinal tract for possible infectious or inflammatory bowel disease.

Given the lipid in the cornea, a thyroid panel could also be considered. In the meantime, empirical deworming with a 5-day course of Panacur is recommended followed by a diet change beginning with a novel protein or hydrolyzed protein diet, followed potentially by a bland, easy to digest diet, followed potentially by a higher fiber diet with diets being used on a trial and error basis, monitoring for effect.

If clinical signs do not resolve with deworming and diet change, especially if there are abnormalities on the gastrointestinal panel, biopsies of the duodenum may be necessary to determine the underlying cause of this patient's gastrointestinal signs. Prior to biopsies, a fine needle aspirate of the liver and/or enlarged lymph nodes could be considered as a less invasive way to definitively rule out round cell neoplasia such as lymphoma.

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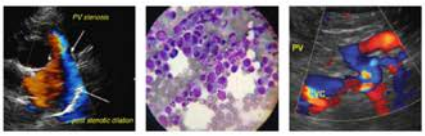

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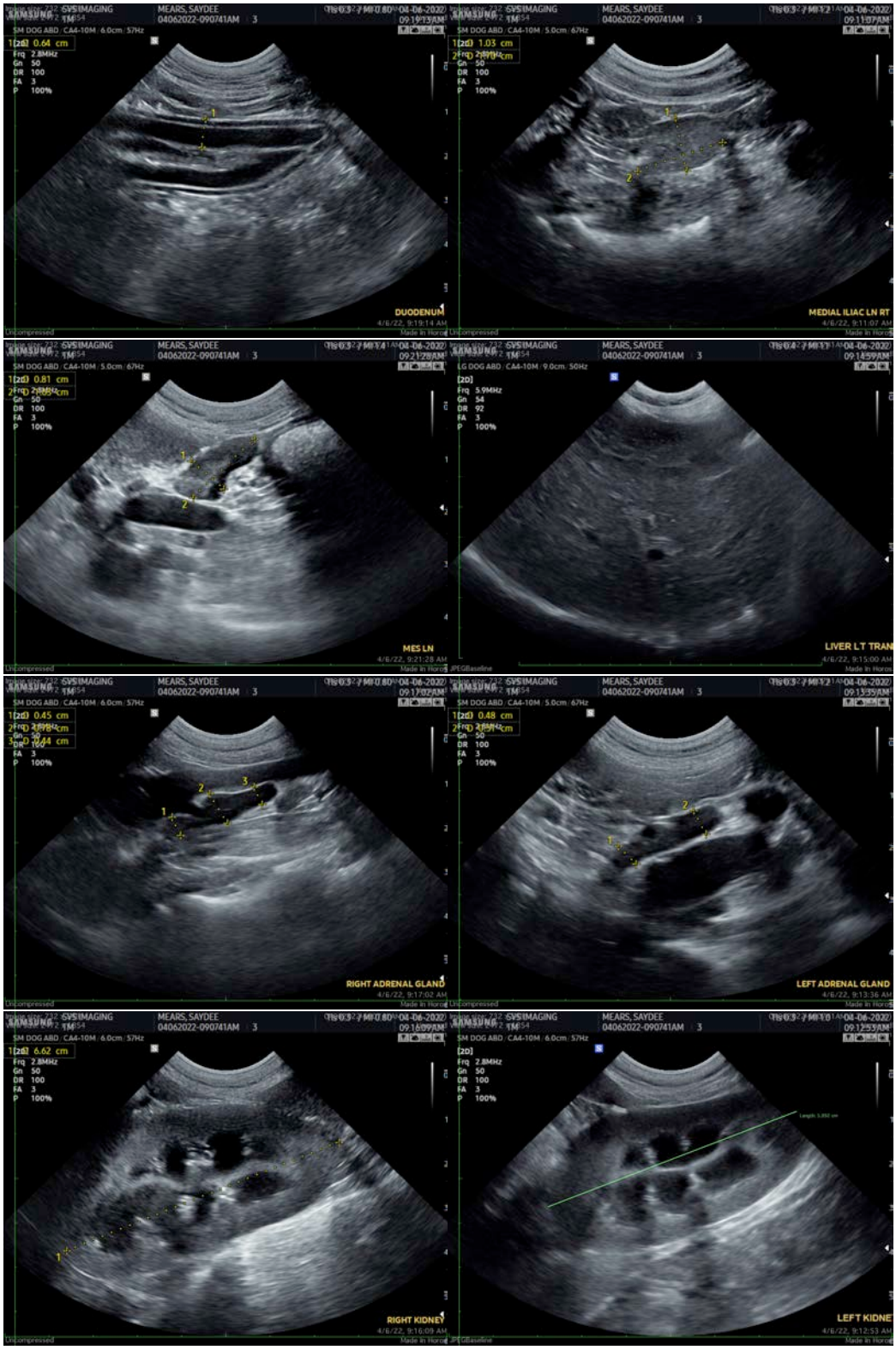

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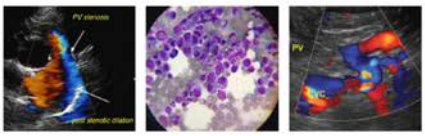

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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