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Clinical Sonography & Telecytology
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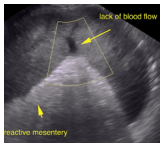

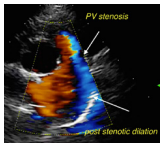

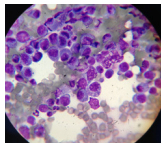
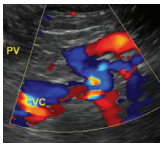

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Elvis Kollme

SPECIES

Canine

BREED

Great Pyrenees

SEX

Neutered Male

AGE

4 Years

WEIGHT

101 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Hadley Harris

HOSPITAL NAME

TotalBond VH

REFERRING VET

Dr. Jodi Werfal

INVOICE

36740

DATE

4/7/22

PRESENTING CLINICAL SIGNS

3 week history of anorexia and lethargy. Bloodwork on 3/23 revealed hypoalbuminemia (2.3) and anemia (HCT 24%). Patient takes movoflex and thyroid supplement. At this time he was having dark formed stool. A gi ulcer of unknown origin was suspected. Patient started on sucralfate. Recheck yesterday the patient still has poor appetite and lethargy but dark stool has normalized to normal color. PCV 30%. On 4/6, patient started having diarrhea and vomited once. PCV 32%. ddx: gi ulcer, gi neoplasia, IBD as primary differentials.
Abnormal PE/Chem/CBC/UA Results: see attached

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 (7.42 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.

The area of the prostate is examined without evident pathology.

Adrenal Glands

The right adrenal gland is normal in size (1.2 cm at the cranial pole, 0.92 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 (0.64 cm at the cranial pole, caudal pole is not well visualized, but there is no evident pathology), 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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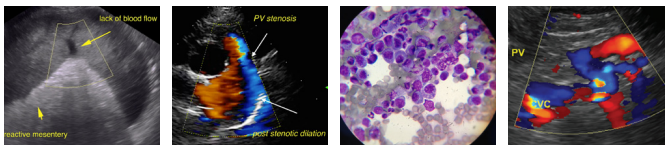

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Gastrointestinal

The 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 very echogenic reverberation artifact from intraluminal gas . 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.

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 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 cecum appears dilated, as a 2.3 cm hypo- to anechoic structure is located in the right cranial abdomen.

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. There is no apparent lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

- Gas distended stomach – Full evaluation is difficult, however no pathology is present in the visualized portions.
- The cecum appears mildly dilated

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This patient's gastrointestinal signs and reported melena could be related to the reported non-steroidal administration and discontinuation of the non-steroidals and continued therapy for gastric ulcer +/- concurrent gastritis with antiemetics, BID antacids such as Omeprazole, and Sucralfate in addition to empirical deworming with a 5-day course of Panacur could be considered and may just need to be continued longer. However, further diagnostic considerations could include a gastrointestinal malabsorption panel including TLI, PLI, folate and cobalamin to Texas A&M GI laboratory, as well as baseline cortisol. If the baseline cortisol is < 2.0, a follow up full ACTH stimulation test is recommended.

Given the gas in the stomach, recommendations could include recheck with an empty stomach. Given the dilated cecum, if abdominal pain is present, concurrent typhlitis should be considered. If abdominal pain is not present, the management recommended is considered reasonable, but if clinical signs persist and/or a gastrointestinal bleed persists, endoscopy with close evaluation of the cecum may be warranted.

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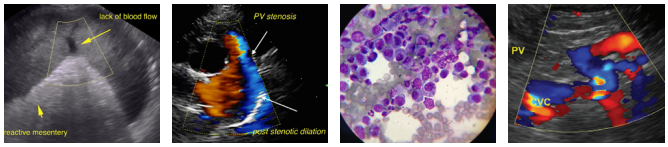

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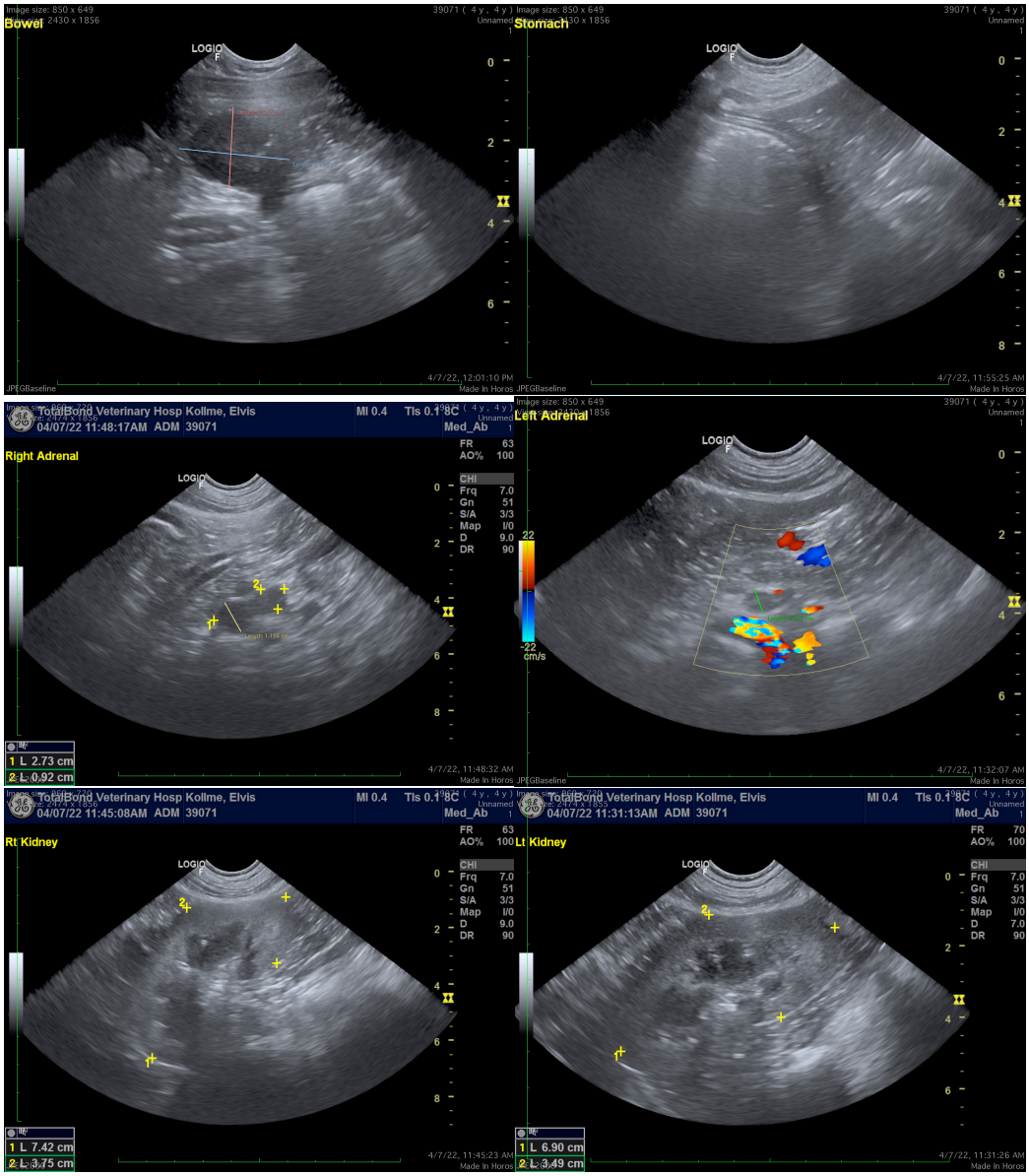

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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