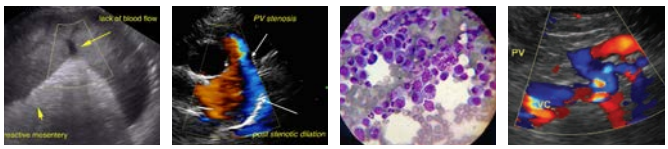
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Daisy Hartland/Gregory

SPECIES
Canine

BREED
Boxer X

SEX
Spayed Female

AGE
3 Years

WEIGHT
56 Pounds

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Dr. James Hornbuckle

HOSPITAL NAME
Golden Isles AH

REFERRING VET
Dr. James Hornbuckle

INVOICE
38993

DATE
6/23/22

PRESENTING CLINICAL SIGNS

Presented 6/2/22 with an acute hx of vomiting. No known FB, no toxin exposure, no diet change. Px was BAR on presentation but had vomited 8 x2-3 hours prior to presentation. IVFT and supportive care was begun and on 6/23/22 in am on presentation, additional vomiting occured. AUS was ordered to further explore vomiting
Abnormal PE/Chem/CBC/UA Results: Prev. rads were wnl Labs were wnl, (cbc/chem) cPLI tableside 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 (6.3 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 (6.4 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 (0.80 cm at the cranial pole and 0.74 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 (0.48 cm at the cranial pole and 0.60 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.

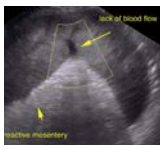
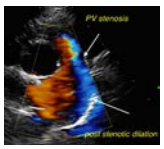
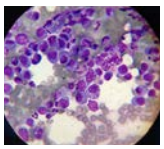
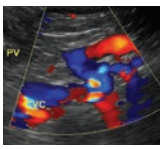
Liver

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.

Gastrointestinal

The visible gastric wall is normal in thickness and layering, but the stomach is markedly fluid distended. Other than fluid, the lumen appears empty with no evidence of foreign material or infiltrative disease, and the pyloric outflow tract appears patent.

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The visible small intestines are largely normal in wall thickness and layering (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). In the mid cranial abdomen there is a focal bowel loop that is mildly thick with some early emerging hypoechoic loss of layering suspected. However, this area has full visualization partially inhibited by surrounding dilated bowel, gas, etc. artifact. 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. It is mildly fluid distended, combined with granular echogenic contents.

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.

Medial iliac lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

Mesenteric lymphadenopathy is noted. Mesenteric lymph nodes are round, irregular, and hypoechoic.

ULTRASONOGRAPHIC FINDINGS

- Markedly fluid distended stomach with no evidence of obstructive material present, making focal ileus the top differential. However, the dilation followed by normal bowel is an obstructive pattern, and a partial or non-visible obstruction due to foreign material cannot be ruled out.

- Focal small bowel loop, potentially duodenum, suspected to be markedly thick with early loss of layering, surrounded by enlarged hypoechoic lymph nodes. These findings could be suggestive of infiltrative disease. However, reactive inflammatory changes secondary to a diffuse gastroenteritis versus other is also likely, and visualization is partially limited by gas artifact.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Medical management of acute gastroenteritis is recommended for this patient with antiemetics, gastroprotectants, fluid support, fasting, and potentially a promotility agent, considering the gastric dilation. However, a promotility agent should be considered cautiously, given the fact that these images cannot 100% definitively rule out a foreign body or partial obstruction. Medical management for 24-hours with recheck imaging in the form of abdominal x-rays +/- recheck ultrasound of the fasted GI tract at that point.

- If focal bowel thickening remains persistent, then recommendations to further workup possible infiltrative bowel disease include a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory for further evaluation of GI and pancreatic function, followed potentially by an exploratory laparotomy to definitively rule out a partial obstruction as well as biopsies of the suspected thickened bowel and enlarged lymph nodes.

- If gastrointestinal signs cannot be resolved medically, recheck imaging in the form of x-rays +/- a barium swallow, etc. could be considered before the 24 hours of medical management recommended above.

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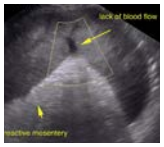
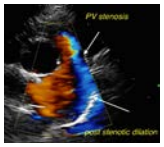
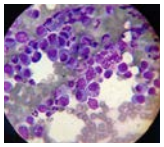
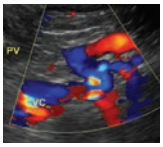

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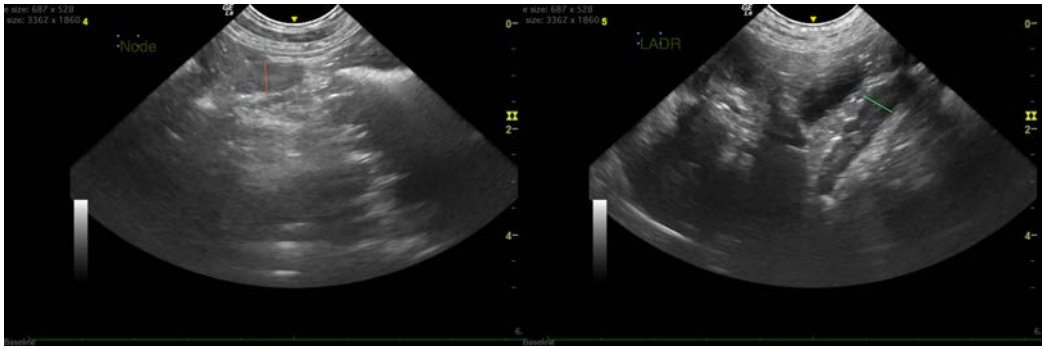

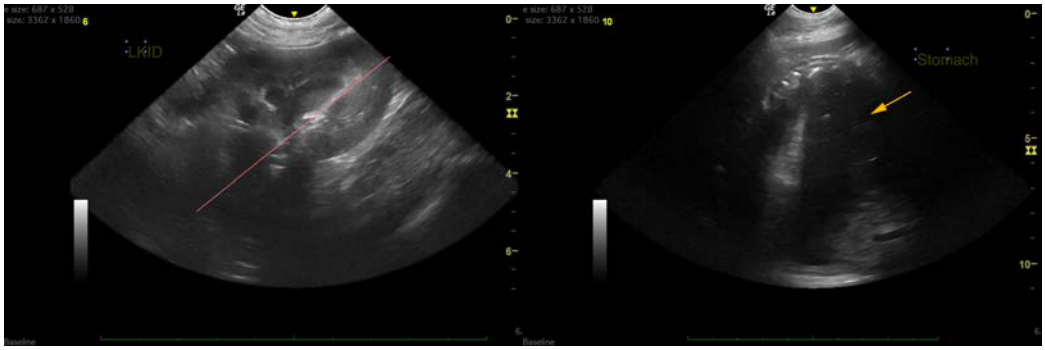

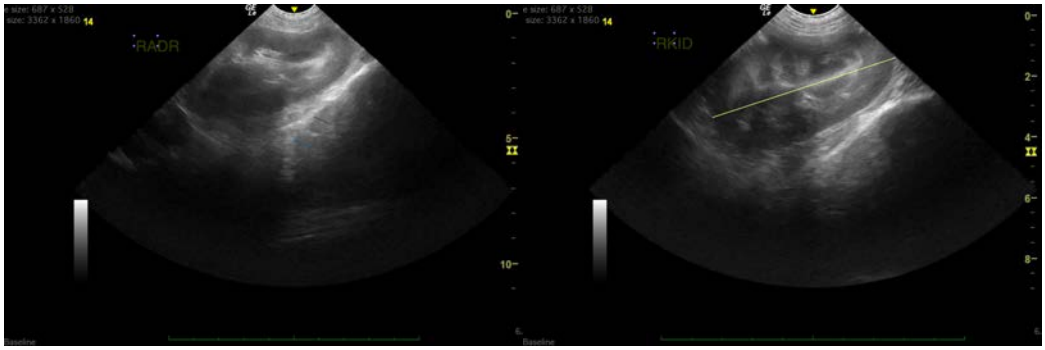

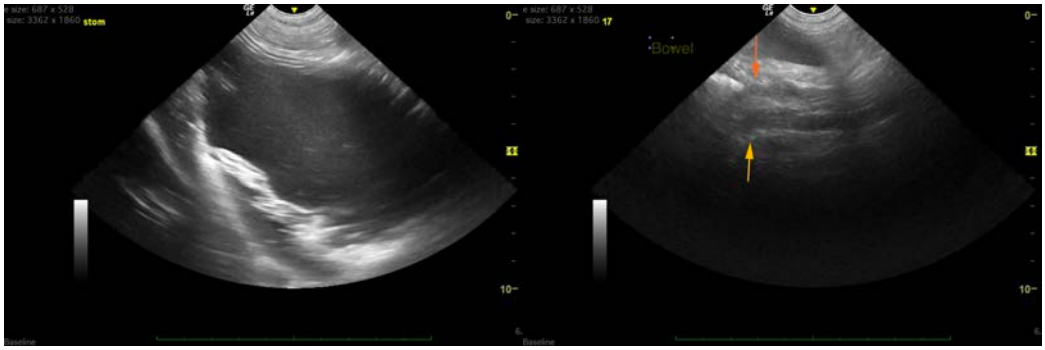

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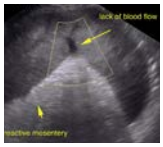
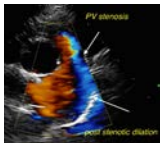
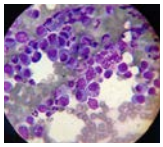
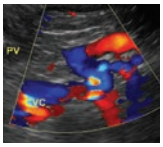

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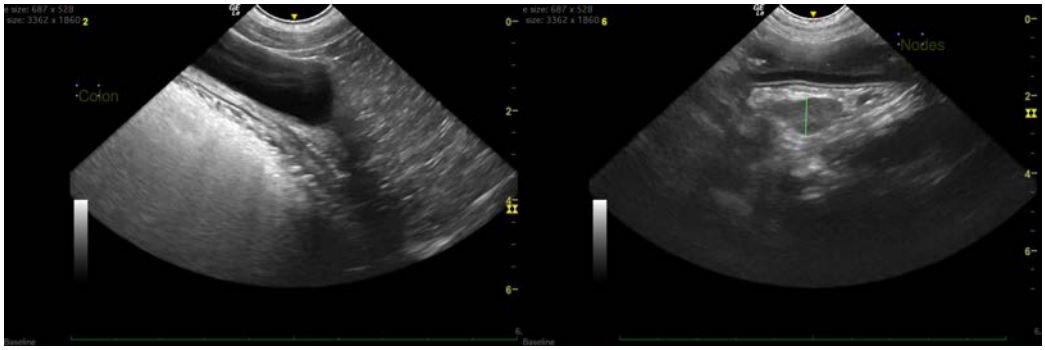

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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