

**PATIENT**

Alice Davis 9463B

SPECIES

Canine

BREED

Golden Retriever

SEX

Spayed Female

AGE

4 Years 4 Months

WEIGHT

22.8 kg

INTERPRETED BYBeth Johnson, DVM
DACVIM**IMAGING PERFORMED BY**

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VET

MVS - Dr. McDaniel

INVOICE

39424

DATE

7/12/22

PRESENTING CLINICAL SIGNS

Alice presented for suspected gastroesophageal reflux. She was previously diagnosed with moderate lymphoplasmacytic and eosinophilic duodenitis in 2019. She had been doing well on the Royal Canin HP diet but over the past few months her symptoms have returned. She has had no recent vomiting or regurgitation episodes. Once around the weekend of July Fourth, she stopped and when Tim tried to pull her off the path she vomited three times. When they turn around to go home when she stops on a walk, she will be completely normal afterwards. During other types of activity like running around the yard, she never has any issues. She does not have any symptoms of nausea when she stops, no lip licking or hypersalivation. Her appetite, water consumption, and voids have been normal. When they gave metoclopramide yesterday before their walk, Alice did not show any significant difference.

Abnormal PE/Chem/CBC/UA Results: Bloodwork and UA performed in May was unremarkable.

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 (7.17 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 (4.33 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 mineral or infarcts observed. Very scant pyelectasia is noted.

Adrenal Glands

The right adrenal gland is normal in size (0.56 cm thick), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.46 cm at the cranial pole and 0.49 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.

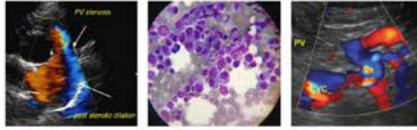
Liver

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 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.



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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.

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The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

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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.

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Free Abdomen

There is no evidence of free peritoneal effusion noted in these images.

Medial iliac and mesenteric 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.

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ULTRASONOGRAPHIC FINDINGS

- Reactive medial iliac and mesenteric lymph nodes – likely secondary to this patient’s reported previously diagnosed inflammatory bowel disease.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the previous diagnosis and recurrence of clinical signs, considerations could include reassessment of absorption with a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory for further evaluation of GI and pancreatic function.

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Beth Johnson, DVM
DACVIM

A baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

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Given the lymphadenopathy, empirical deworming with a 5-day course of Panacur is recommended. In the meantime, management of suspected GERD or gastroesophageal reflux could be initiated with twice daily Omeprazole. I'm unsure if this patient walks on a collar or a harness, but given the reported vomiting when being turned around on a walk, if she is being walked on a collar, transition to a harness may also help reduce pressure on her neck, which may stimulate some of her clinical signs.

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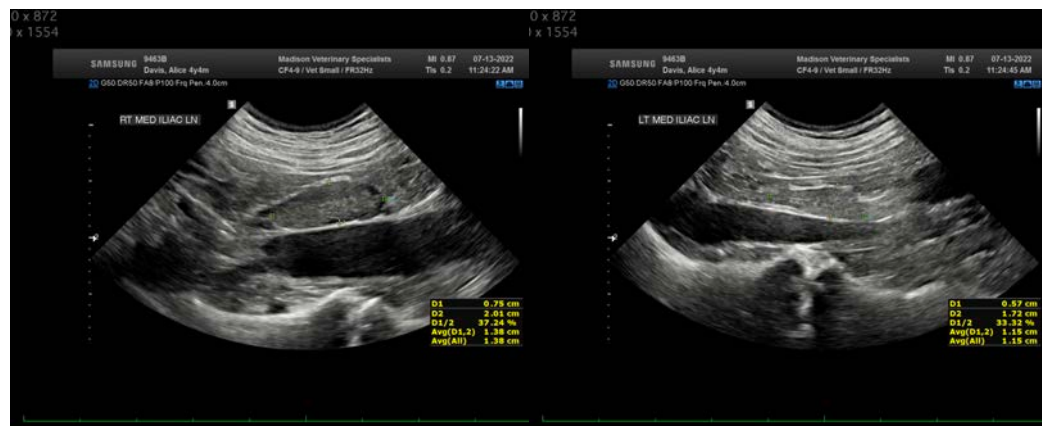
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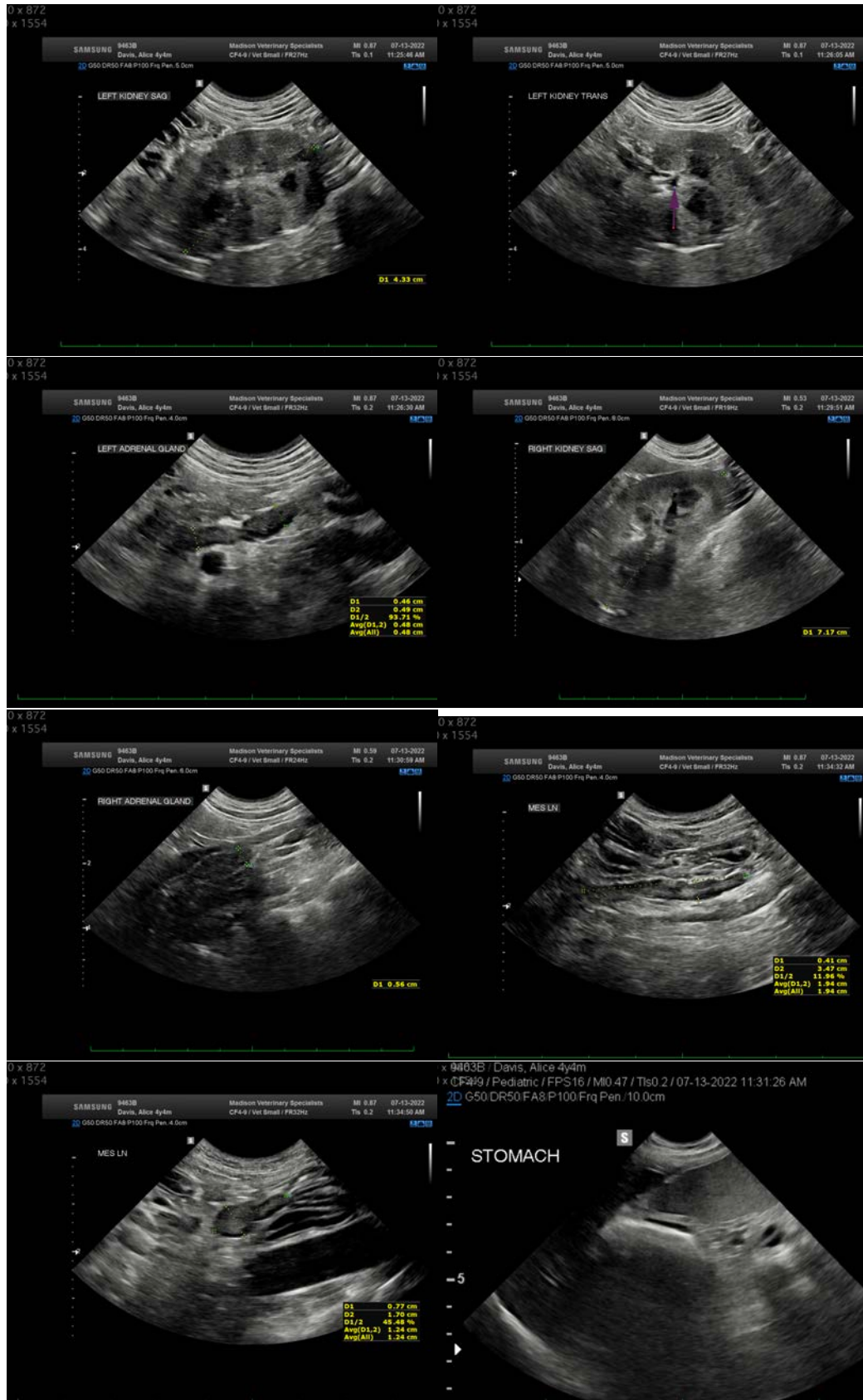
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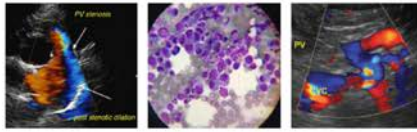
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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