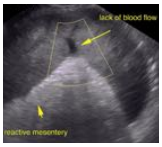

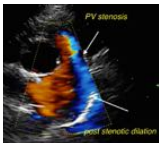

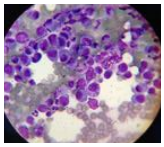
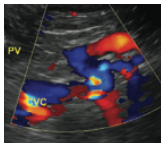

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1-800-838-4268 info@sonopath.com

PATIENT

Daisy Voigt

SPECIES

Canine

BREED

Mix

SEX

Spayed female

AGE

18 months

WEIGHT

58 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Cutchin

HOSPITAL NAME

Friendship Springs VC

REFERRING VET

Dr. Cutchin

INVOICE

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7/13/22

PRESENTING CLINICAL SIGNS

For about two months patient vomits after drinking water in larger (but not abnormal) volumes, but does not vomit after eating. However, owner has described some episodes after eating that suggest pt is about to vomit, but then succeeds in not vomiting. We observed this behavior in the clinic and this is actual vomiting and not regurgitation. No diarrhea, constipation, or other abnormalities are observed. Abnormal PE/Chem/CBC/UA Results: CBC, chems, UA and AXR are unrewarding and no abn are noted.

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.

Left kidney is normal is size (5.7 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 is size (5.2 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 (0.72 cm at cranial pole and 0.55 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is not well visualized in these images. Examination of the area was done without evidence of pathology.

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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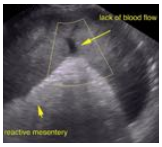

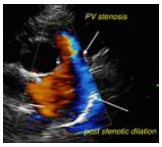

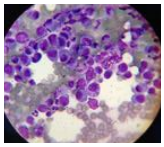
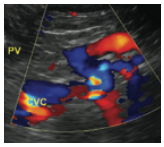

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Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease until the patient was given water at which time the stomach becomes mildly fluid distended, but no evident pathology is appreciated. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering. 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 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

There is no evidence of peritoneal effusion. 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. A mildly enlarged, hypoechoic, cranially abdominal lymph node believed to be a pancreatic or duodenal lymph node surrounded by enhanced hyperechoic fat was noted.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

Reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely. Enlarged cranial abdominal lymph nodes with evidence of inflammation around the lymph node characterized by enhanced fat. Differentials for which include likely reactive node, infiltrative neoplasia cannot be ruled out, but is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Gastric pathology cannot be definitively ruled out especially given the concurrent lymphadenopathy in the area. However, it is not definitively visualized in these images. Outflow obstruction would be atypical given the fact that this patient keeps food down, but vomits water. Therefore, further recommendations include empirical therapy for gastroesophageal reflux disorder with twice a day Omeprazole and if clinical signs do not resolve a barium study can be considered using straight liquid barium as well as a potential barium coated food as is done with a swallow study. Ultimately if a diagnosis cannot be obtained with imaging and if clinical signs persist then gastroscopy/endoscopy may be warranted for further visualization of the gastric outflow tract.

Given the mild lymphadenopathy empirical deworming with a 5-day course of Panacur as well as potentially Helicobacter treatment protocol could be considered as well.

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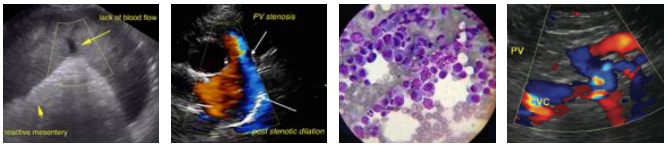

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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