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Clinical Sonography & Telecytology
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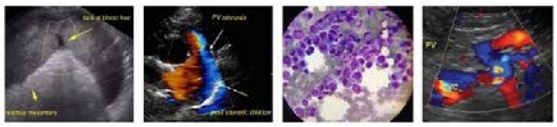


THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Bella Corvelo

SPECIES

Canine

BREED

Chi

SEX

Spayed Female

AGE

2 Years

WEIGHT

2.7 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

Nelson Animal Hospital

REFERRING VET

Dr. Frederick

INVOICE

43818

DATE

7/13/23

PRESENTING CLINICAL SIGNS

HGE, vomiting, diarrhea past 3 days meds: pantoprazole, cerenia

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 (3.29 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 (3.84 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 (0.90 cm at the cranial pole and 0.38 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 (0.41 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.

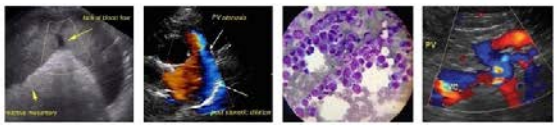
Liver

The liver is subjectively 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 empty with no evidence of obstruction, foreign material or infiltrative disease. 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.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. The colon is mildly fluid distended with some subtly enhanced hyperechoic mesenteric fat around the Ileocecocolic junction.

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. **See free abdomen.

Free Abdomen

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

There is no apparent lymphadenopathy noted in these images.

There is a focal, subtly enhanced area of hyperechoic mesenteric fat adjacent to the body of the pancreas.

ULTRASONOGRAPHIC FINDINGS

- This is a relatively unremarkable/normal study with a mildly fluid distended colon, consistent with the reported hemorrhagic gastroenteritis, and the subtly enhanced mesenteric fat is likely secondary to diffuse gastroenteritis. However, mild or emerging pancreatitis cannot be definitively ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If this is an acute episode, recommendations include an overall general metabolic evaluation (CBC, chemistry panel with electrolytes, coagulation panel, urinalysis and fecal exam if not recently evaluated) followed by supportive/symptomatic medical management of clinical signs (possibly HGE) including anti-emetics, gastroprotectants (including sucralfate), a probiotic (such as visbiome or proviable), empirical deworming with a 5-day course of Panacur, +/- metronidazole or tylosin and if tolerated a short term course of a bland, easy to digest or possibly fiber responsive diet.

If, however, there is any chronicity, then in addition to the above, further evaluation is warranted beginning with:

A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

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

A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease.

Ultimately, if clinical signs persist, and a diagnosis is not reached, further evaluation of the GI tract via upper and lower endoscopy for visualization and biopsies may be warranted.

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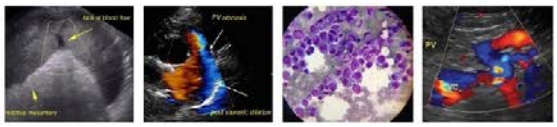

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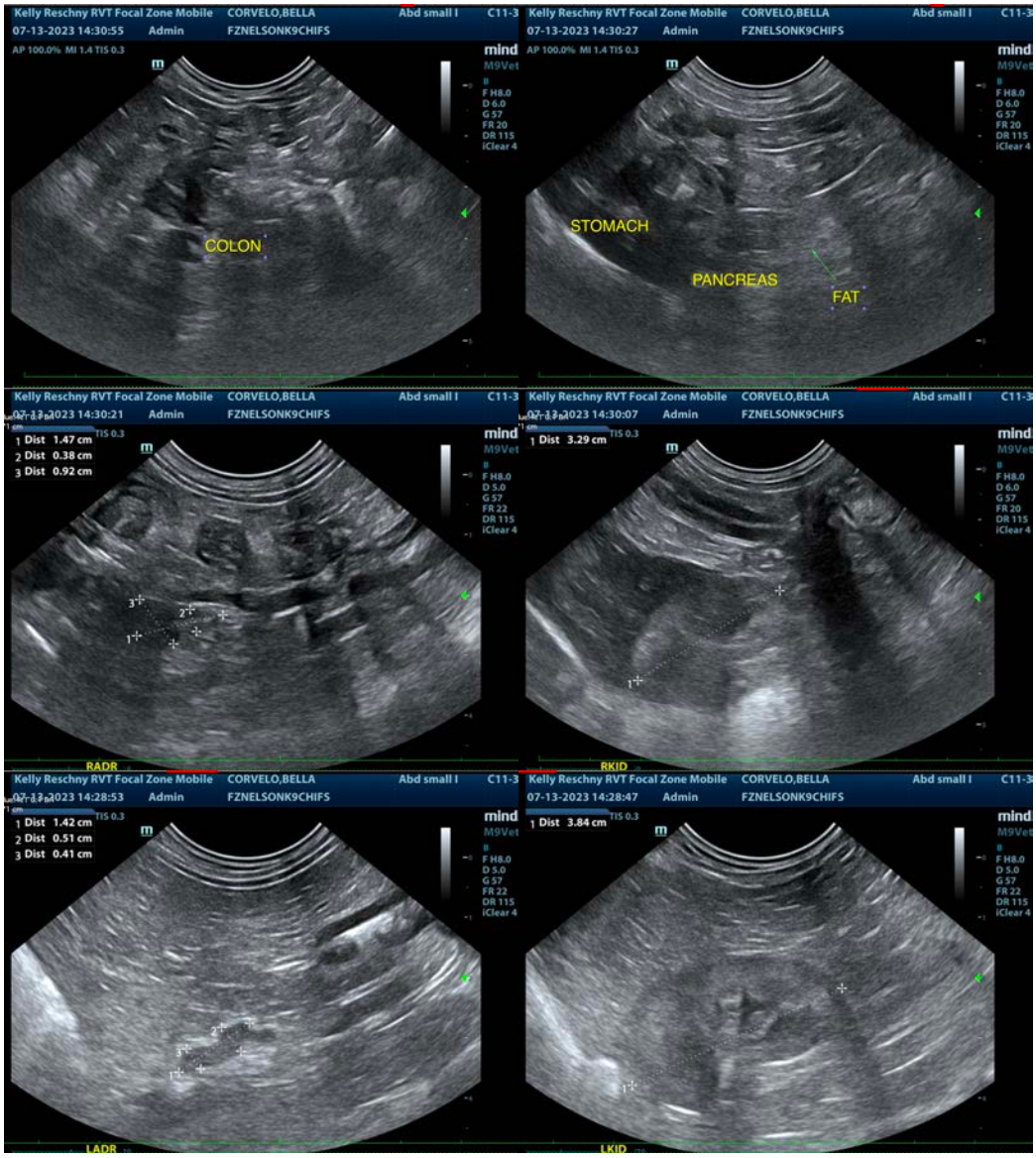

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
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