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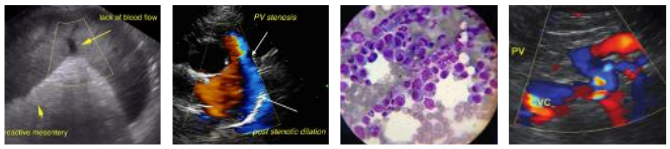


SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Brancel O'Leary

SPECIES

Canine

BREED

Retriever Mix

SEX

Neutered Male

AGE

7 Years 1 Month

WEIGHT

54.4 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Carly Pate

HOSPITAL NAME

VCA McKenzie AH

REFERRING VET

Dr. Wayland

INVOICE

16705

DATE

7/19/22

PRESENTING CLINICAL SIGNS

History: Presented to emergency Saturday evening for vomiting. Nausea medications administered but other treatments were declined. Saw pet Monday for ongoing inappetence. Pet did not vomit on maropitant but approx 20 hours after administration pet vomited.

Abnormal PE/Chem/CBC/UA Results: Monday (yesterday) pet was dehydrated on exam 5%. Abdomen tense (pet is very anxious usually so not interpretive) Liquid stool noted on rectal exam. Exam otherwise unremarkable. CBC/Chem/CPL all unremarkable.

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.

Prostate (neutered) is normal in size, echotexture and echogenicity for a neutered male.

Left kidney is normal is size (7.31 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 (6.48 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 (0.62 cm at cranial pole and 0.7 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.7 cm at cranial pole and 0.58 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

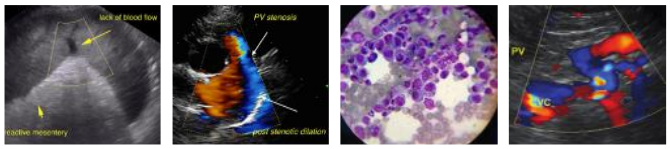
Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). Multifocal well-demarcated hyperechoic homogenous nodules are noted. Splenic vasculature 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.

Gastrointestinal



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Fundic mucosal hypertrophy with hyperechoic mucosa and some mucosal remodeling is noted. There is no loss of mural detail. Layering is normal. There is mild luminal fluid accumulation. No evidence of masses/nodules or foreign material present.

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, except in the mid left abdomen, there is a focal bowel loop that cannot be definitively determined to be small bowel versus colon but appears to be small bowel with a focal mildly thick wall. Layering is intact. The loop is mildly distended and contains echogenic contents with acoustic shadow. There is no evidence of plication or an obvious obstructive pattern. However, there is concern for early infiltrative bowel disease with some partial or early obstruction taking place.

The visible colon is normal in wall thickness 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 appreciable lymphadenopathy. In the area of the focal bowel loop described above, near the left kidney, there is a pocket of free fluid and enhanced hyperechoic mesentery.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Gastritis – Consistent with irritation secondary to dietary indiscretion or intolerance, infection (bacterial, viral, other), parasitic or protozoal disease, toxin, other metabolic disease such as pancreatitis, other. Microulceration cannot be ruled out.

- There is a focal, mildly fluid distended, thick-walled bowel loop that appears to be small bowel, that contains echogenic material with acoustic shadow, concerning for foreign material. The wall in this area looks thick, therefore, focally infiltrative bowel disease with secondary ileus and partial obstruction versus primary obstruction and secondary inflammatory change/edema cannot be determined. Focal free fluid and enhanced fat and mesentery are suggestive of a focal peritonitis around the bowel loop.

Secondary Findings

- Hyperechoic splenic nodules – most consistent with benign myelolipomas. Other differentials such as fibrosis or calcification caused by old hematomas or infarcts, chronic inflammation, granulomatous disease or metastatic disease cannot be ruled out, but are considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

There is concern for at least partial obstruction most consistent with small bowel, however, colon cannot be definitively ruled out based on location and appearance. Therefore, recommendations, if a

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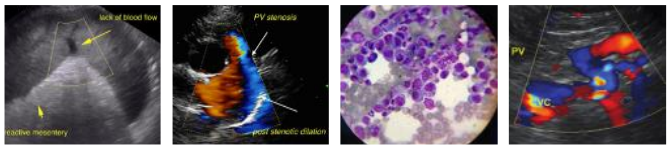

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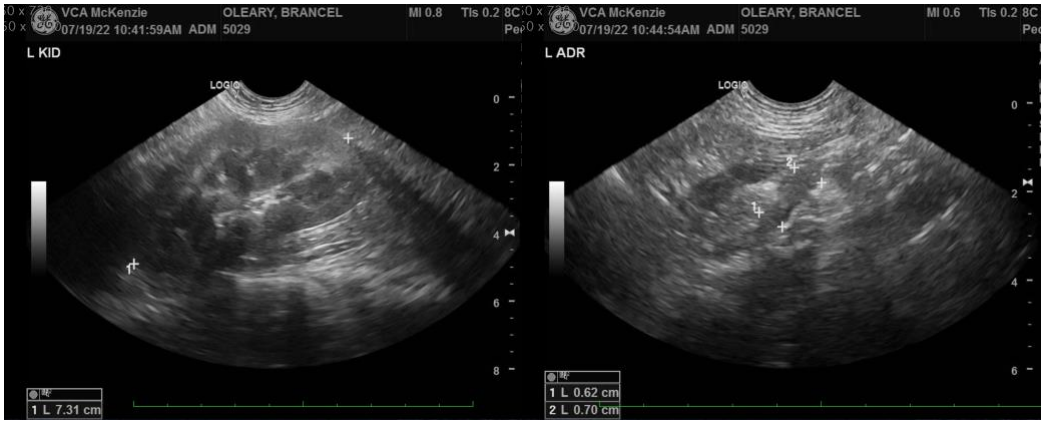
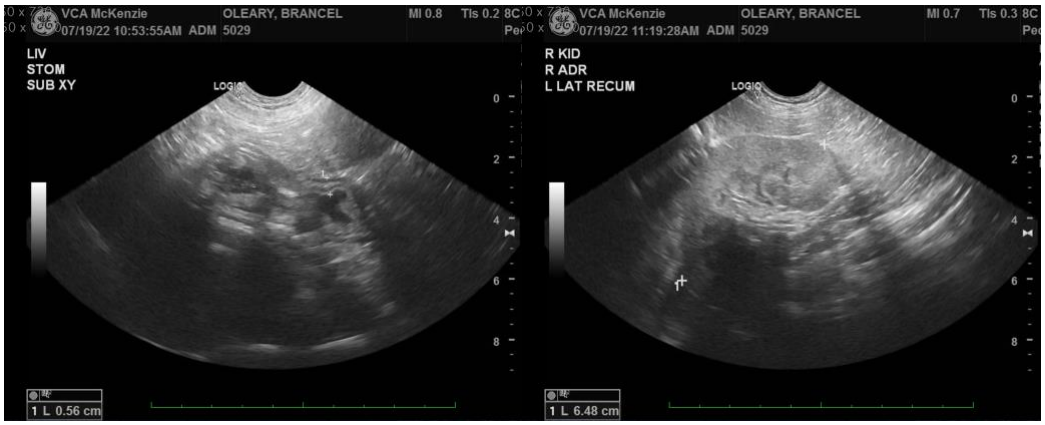
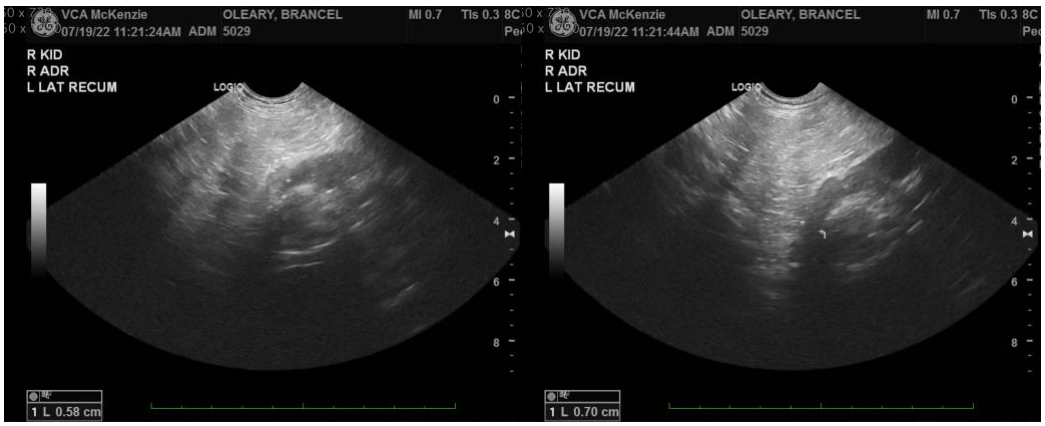
conservative approach is elected, include symptomatic supportive care, including fluid support, antiemetics, gastric protectants, pain management, if indicated, etc., as well as fasting for 24 hours with recheck, fasted abdominal x-rays and ultrasound. OR, if a more aggressive approach is elected, exploratory laparotomy is indicated for further examination of the focal bowel loops/focal peritonitis with biopsies/resection and anastomosis +/- foreign object removal, if present.







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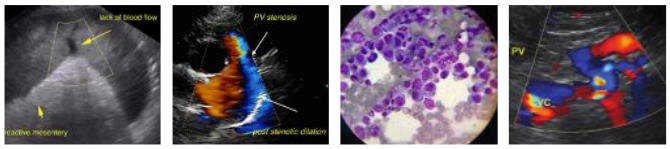

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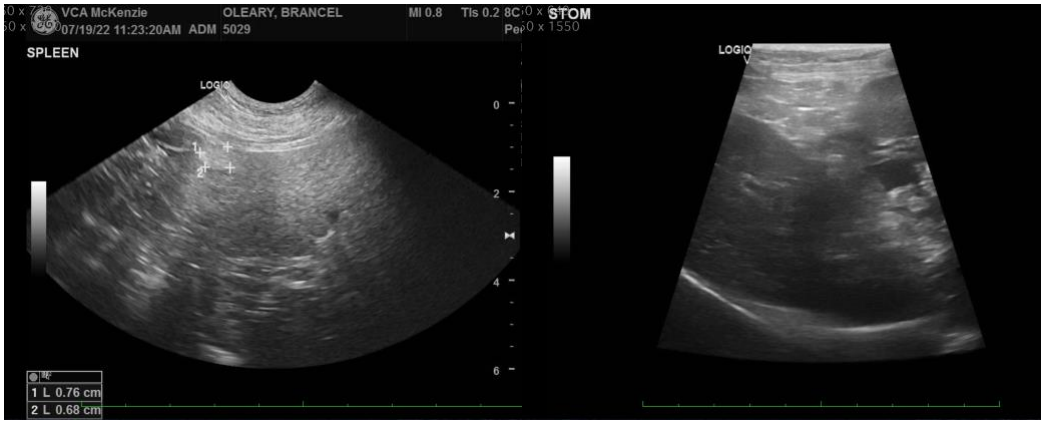

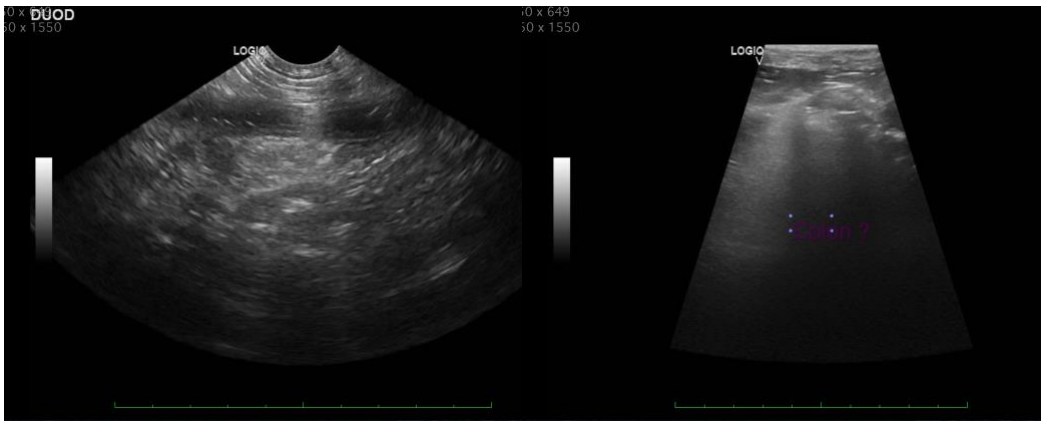

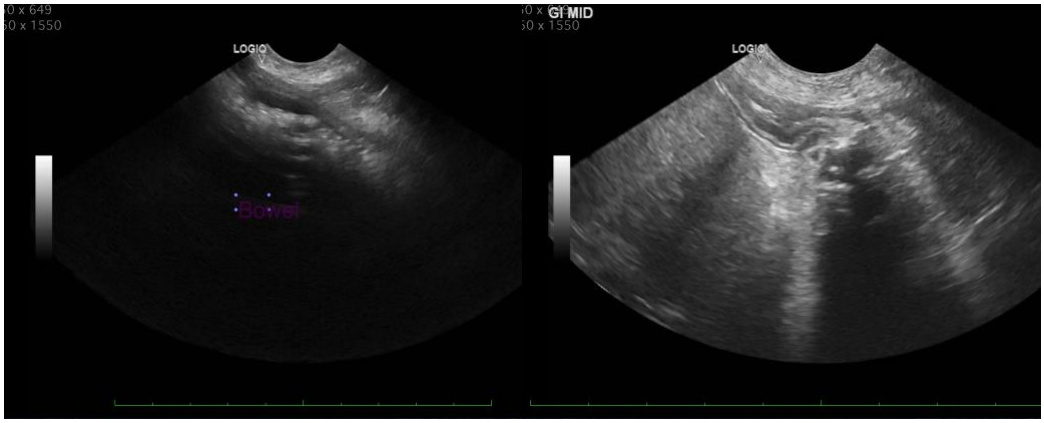

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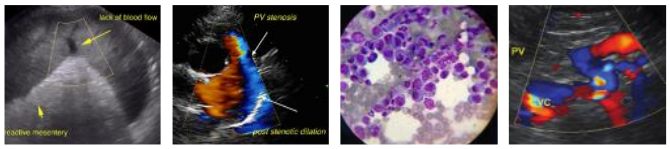

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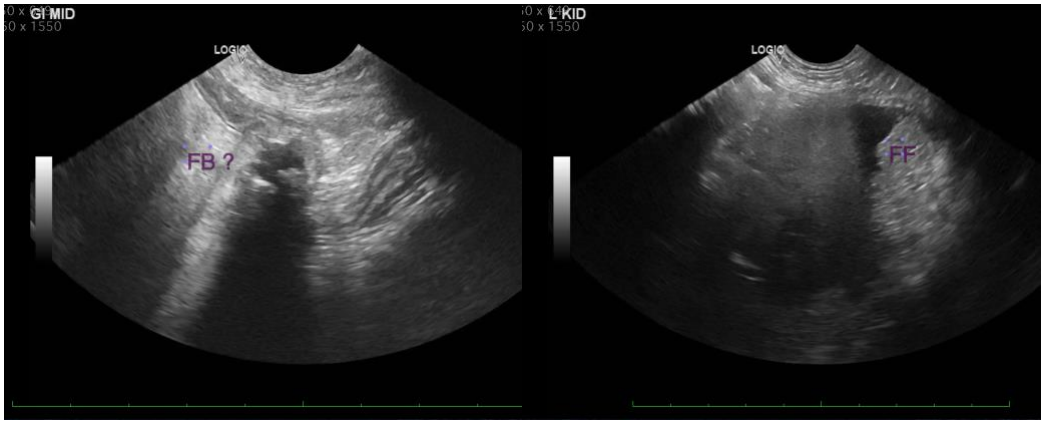

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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