

**DATE**

8.10.2023

PATIENT

Kobie Gondeck

SPECIES

Canine

BREED

Australian Shepherd

SEX

Neutered Male

AGE

2/23/2015

WEIGHT

57.4 lbs

INTERPRETED BYBeth Johnson, DVM
DACVIM**HOSPITAL NAME**

Paradise AH

REFERRING VET

Dr. Riehl

INVOICE

14018

PRESENTING CLINICAL SIGNS

History: SEVERE hip dysplasia. Total hip replacement, on chronic carprofen/gabapentin. Recently started Atopica/ketoconazole for allergic skin disease (unresponsive to Apoquel/Cytopoint). Recent (8/1/2023) hematemesis. Inappropriate rubricytosis on CBC (3 nRBC/hpf with normal PCV/TS, no retics).

Current Medications: Carprofen, ketoconazole, cyclosporine, gabapentin, reconcile.
 Date of Previous IntraPet Ultrasound: No previous.
 Sedation: Not required to complete full diagnostic ultrasound.
 Stat Report: Not requested.
 Imaging Performed By: Rachel Brillhart, RDMS.

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

Left kidney is normal in size (6.80 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 in size (6.63 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 (0.67 cm at cranial pole / 0.75 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.91 cm at cranial pole / 0.65 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). An approximately 1.00 cm in diameter hyper- to anechoic non-capsule-disrupting nodule is noted. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. 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

The visible stomach wall is normal in thickness 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.

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 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. The mesenteric and 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.

Other

There is no evidence of heart base or pericardial pathology noted in these images at this time. If cardiac function evaluation is desired a full echocardiogram is recommended.

ULTRASONOGRAPHIC FINDINGS

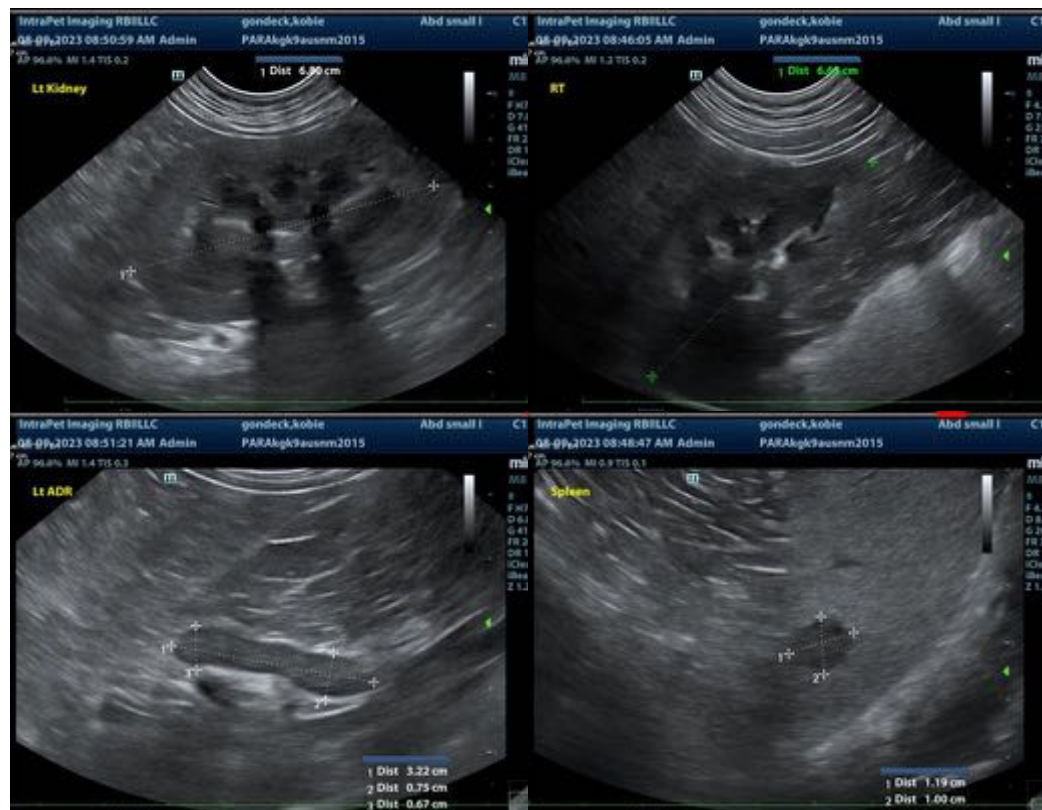
Findings

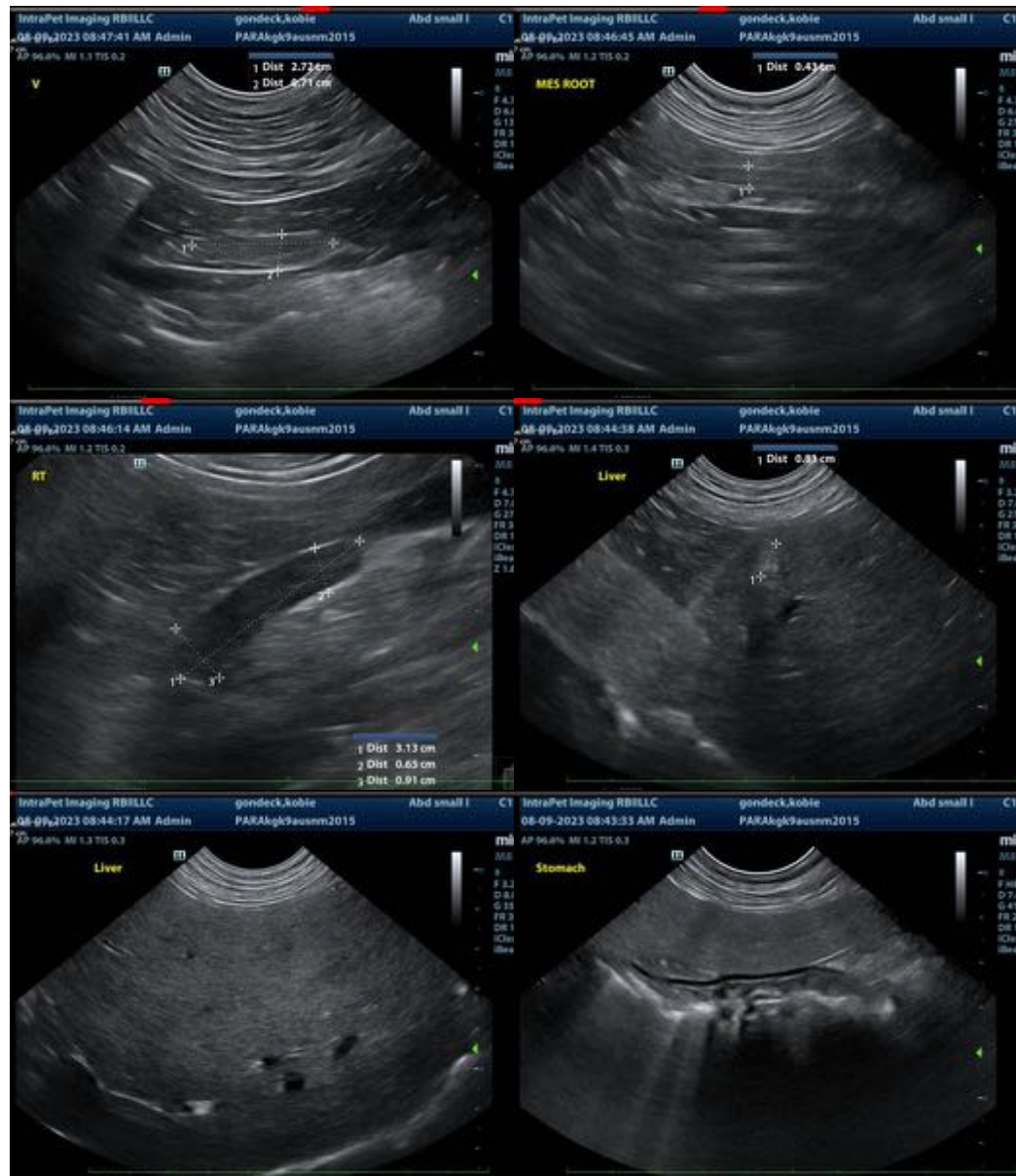
- Heterogenous Liver – These changes are most consistent with benign processes such as nodular hyperplasia, steroid (vacuolar) hepatopathy, extramedullary hematopoiesis or possibly chronic inflammatory disease and less commonly infiltrative round cell or metastatic neoplasia.
- Hypo- to anechoic splenic nodule – likely represents a benign lesion such as a cyst, hematoma, nodular hyperplasia, extramedullary hematopoiesis, etc., however while considered less likely, infiltrative neoplasia can mimic benign lesions, and cannot be ruled out.
- Reactive mesenteric and medial iliac lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- There is no definitive ultrasonographically visible evidence of a gastrointestinal bleed. However, microulceration cannot be definitively ruled out based on ultrasound.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Ruling out other causes for possible gastrointestinal bleed can be considered, beginning with:

- A baseline cortisol – if less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.
- Follow with empirical deworming with a 5-day course of Panacur.
- Ideally, if quality of life can be maintained in this patient off of a nonsteroidal, then recommendations are to discontinue the nonsteroidal, implement other more gastrointestinal-friendly pain management, while managing suspected microulceration in the form of gastric protectants, sucralfate, etc.
- Ultimately, however, if nonsteroidals cannot be discontinued and/or clinical signs persist, upper GI gastroscopy/endoscopy should be considered for further visual evaluation, and biopsies.





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
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