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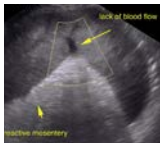
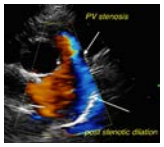
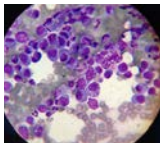
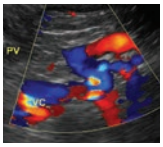

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Quinn Anglin

SPECIES
Canine

BREED
Australian Labradoodle

SEX
Neutered Male

AGE
8 Years

WEIGHT
11.3 Pounds

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Evan Bell

HOSPITAL NAME
Cedarview AH

REFERRING VET
Dr. Kim Holzman

INVOICE
41156

DATE
9/8/22

PRESENTING CLINICAL SIGNS

Episodic nausea and inappetence, may be more frequent in times of stress but will go on for days. Partly responsive to IV fluids, appetite stimulants, anti-nausea meds and diet. Seems to resolve with time but recurs.
Abnormal PE/Chem/CBC/UA Results: Bloodwork: inc random cortisol NSF otherwise

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 area of the prostate is examined without evident pathology.

The right kidney is normal in size (4.7 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.

The left kidney is normal in size (4.6 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 (0.53 cm at the cranial pole and 0.56 cma t the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.55 cm at the cranial pole and 0.41 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). A small anechoic nodule is noted in the mid body. 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.

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

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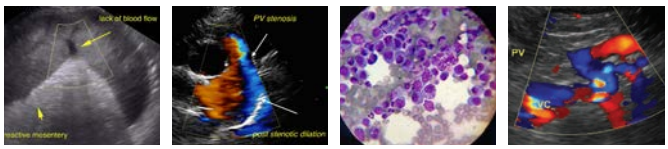

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Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is 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 (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease. Mild hyperperistalsis/corrugation is appreciated in the proximal duodenum, and in the mid to caudal abdomen there is a focally dilated loop of small bowel that isn't traced one way or the other, so a potential cause of the focal dilation cannot be observed.

The large bowel is normal in the mid and caudal abdomen with appropriate stool consistency and expected shadow. However, in the cranial abdomen, medial to the right kidney, there is a tubular structure filled with brightly echogenic fluid and no acoustic shadow as would be expected with colon. Possibilities do include liquid stool/diarrhea within the colon versus another structure. The abnormal appearing structure is not traced to be able to identify it as colon definitively.

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.

Free Abdomen

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

The 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.

**Structure medial to the right kidney described above under large bowel.

PRIMARY FINDINGS

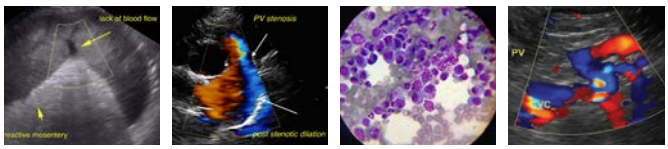
- Mild proximal duodenal hyperperistalsis/corrugation – consistent with focal enteritis, potentially secondary to dietary indiscretion or intolerance, bacterial or viral infection, parasitic or protozoal disease, toxin, other metabolic disease such as mild pancreatitis, etc., combined with a focally distended fluid filled loop of small bowel in the caudal abdomen, differentials for which include the same as described above. However, partial obstruction cannot be definitively ruled out without tracing of the bowel to where it returns to normal.

- A tubular, echogenic fluid-filled structure medial to the right kidney is most consistent with a fluid dilated colon, consistent with emerging diarrhea. However, the structure cannot be definitively traced to more normal appearing colon. Therefore, identity as the colon cannot be definitively guaranteed.

SECONDARY FINDINGS

- **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.

- **Gallbladder debris -** Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to



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hepatobiliary disease. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

- **Reactive mesenteric lymph nodes –** infiltrative neoplastic disease cannot be ruled out but is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

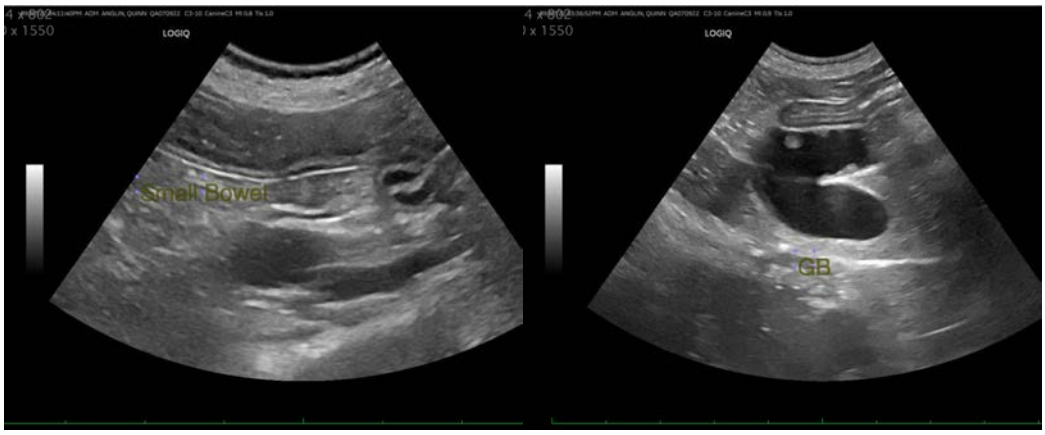
Overall, a partial obstruction given the focal small bowel dilation, etc. cannot be definitively ruled out. However, given the concurrent duodenal and suspected colonic changes, a diffuse gastroenteritis is considered most likely. If this patient's baseline cortisol is normal, next recommended steps include:

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

In the meantime, empirical therapies can include an empirical deworming with a 5-day course of Panacur, diet transition to a novel or hydrolyzed protein diet (if that helps). If it hasn't helped after 3-4 weeks, potentially a bland, easy to digest diet on a trial-and-error basis, or ultimately a high fiber diet, all used on trial-and-error basis could be considered, as well as cobalamin supplementation if indicated based on GI panel results. If diarrhea is present as suspected, a probiotic may be helpful.

If clinical signs persist, recheck abdominal imaging of the structures described above is recommended, being sure to trace each dilated loop to its connection with more normal bowel, which will aid in definitive identification of any suspected obstruction, as well identification of the abnormal appearing tubular structure medial to the kidney as definitive colon.



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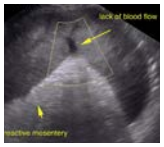
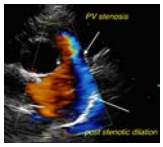
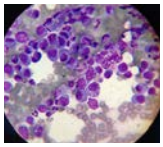
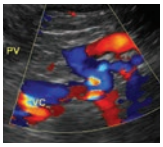

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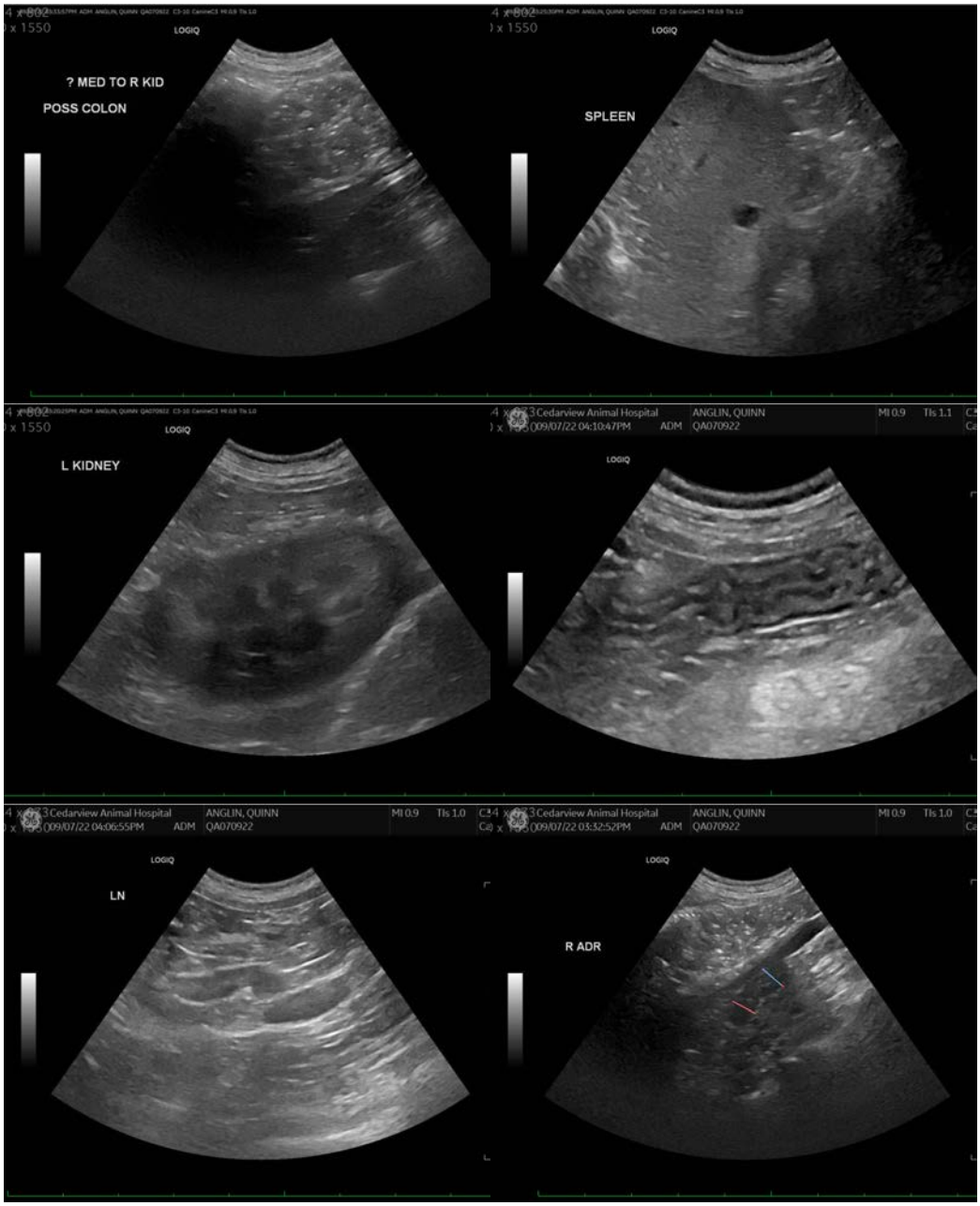

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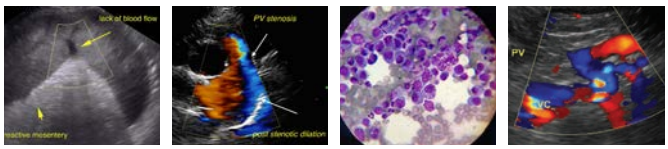

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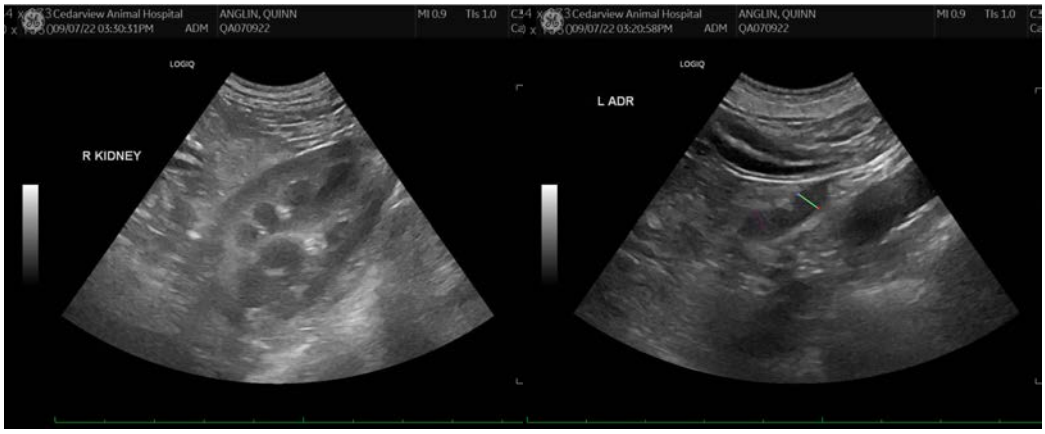

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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