



PATIENT PRESENTING CLINICAL SIGNS

Luna Asam

History: 1 month history of intermittent vomiting and diarrhea despite continuous bland diet (EN), omeprazole, metronidazole and intermittent diarrhea. No known dietary indiscretion or diet changes. Previously healthy young active dog.

SPECIES

Canine

Abnormal PE/Chem/CBC/UA Results: 12/7/22: PE showed mild dehydration but otherwise unremarkable exam. Radiographs on that day were shortly post prandial so had a lot of digesta but no obvious FB or obstructive pattern noted. No abnormalities noted. (read by radiologist) 12/12/22: Dehydration and loose stool noted. CBC - WNL, Chemistry showed elevated amylase (>2500) and elevated lipase (5065) with abnormal snap cPL. 12/20/22: unremarkable exam. Recheck fasted abdominal rads were unremarkable (read by radiologist) 12/22/23: Baseline cortisol - 4.2 Collected fasted blood samples today for GI panel (cobalamin, folate, spec cPL) - results pending.

BREED

Australian Labradoodle

SEX

Spayed female

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder lumen volume is small and walls are diffusely thickened most consistent with pseudohypertrophy.

AGE

1 year

The kidneys were both normal size and structure, with smooth capsule and normal corticomedullary definition and ratio (cortex 1/3 of medulla). Medullary structure differed distinctly from that of the cortex. No evidence of pelvic dilation was present. The right kidney measured 5.36 cm. The left kidney measured 5.8 cm.

WEIGHT

29 lbs

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

Adrenal Glands

Both adrenal glands were visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The left adrenal gland measured 2.0 cm in length and 0.51 cm at the cranial pole and 0.44 cm at the caudal pole. The right adrenal gland measured 1.6 cm in length, 0.8 cm at the cranial pole and 0.37 cm at the caudal pole.

IMAGING PERFORMED BY

Dr. Harasimowicz

HOSPITAL NAME

Waterbury VH

Spleen

The spleen was normal with a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma and smooth capsule, with normal splenic vasculature with no signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarct changes were noted.

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Liver

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed. Gallbladder is moderately distended with normal wall thickness and anechoic contents. Common bile duct is non-distended and tapers normally

DATE

12/27/22



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Gastrointestinal

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The stomach contains minimal luminal contents. It measures at a normal thickness of with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

SPECIES

Canine

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed. The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness.

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Sections of colon are visualized with liquid fecal material visible in the distal descending colon. There is no observed focal or generalized colon wall thickening or loss of layering.

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Pancreas

AGE

1 year

The base and limbs of the pancreas were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour and parenchyma were normal. No overt evidence of active inflammatory or neoplastic disease was noted.

WEIGHT

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Lymph Nodes

Mild mesenteric lymphadenopathy measuring up to 1.2x0.75cm with normal echogenicity, structure and maintenance of normal length to width ratio. Enlarged perisplenic lymph node measuring 1.7cmx 0.84cm, structure and maintenance of normal length to width ratio.

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Free Abdomen

No masses or free fluid were noted.

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ULTRASONOGRAPHIC FINDINGS

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Primary Findings

1. Mild abdominal lymphadenopathy
2. Normal layering and thickness of GI tract
3. Diarrhea present in distal colon
4. Normal Pancreas
5. Thickened urinary bladder wall - suspect pseudohypertrophy

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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Abdominal lymphadenopathy with maintenance of normal lymph node length to width ratio and normal echogenicity is most consistent with a reactive change to mild inflammation in the abdomen, consistent with reported vomiting and diarrhea. Fine needle aspirate of the lymph nodes should be attempted to rule out less likely infiltrative disease such as juvenile GI lymphoma. The GI tract including the colon and the pancreas are ultrasonographically normal and no overt cause of intermittent diarrhea and vomiting



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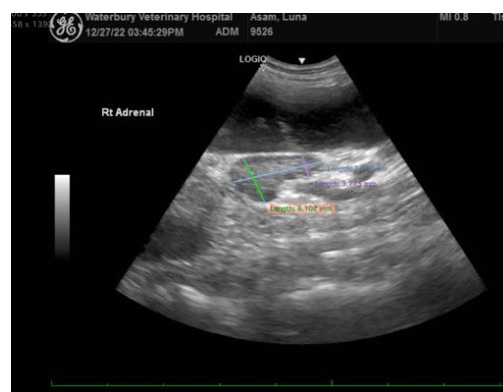
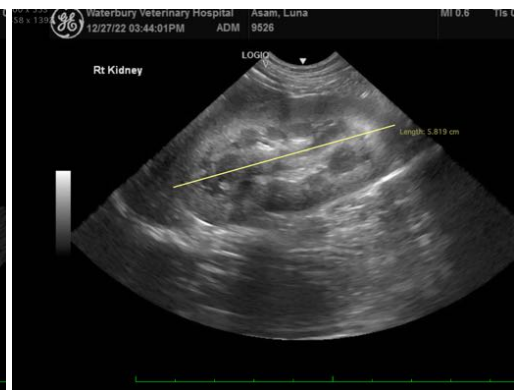
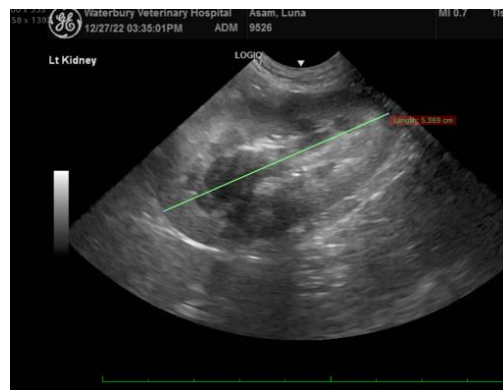
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is present on abdominal ultrasound. Pancreatitis cannot be ruled out as the inciting cause of clinical signs given elevated amylase/lipase and CPLi on 12/12, but may have normalized in ultrasonographic appearance by the time of the study, or clinical pancreatitis may not be ultrasonographically apparent. A course of probiotics may help rebalance the GI biome if it was disrupted by initial pancreatic inflammation. Additional work-up to be considered includes thorough assessment for intestinal parasitism and infection with fecal pathogen PCR, assessment for exocrine pancreatic insufficiency with measurement of TLI. If infection is unlikely or ruled out with empiric therapies and diagnostics, a protein hypersensitivity/allergy could be considered and a trial with select or hydrolyzed protein diet could be considered. Ultimately endoscopy or surgery for GI biopsy could be considered if no response to medical therapy.

Urinary bladder wall thickening is mild and is likely pseudohypertrophy secondary to low volume of urine and lack of luminal distension, however, true mural thickening, though not suspected, cannot be definitively ruled out. Re-examination when urinary bladder lumen volume is increased with time and/or fluid therapy should be considered if clinical suspicion for urinary bladder disease is high.





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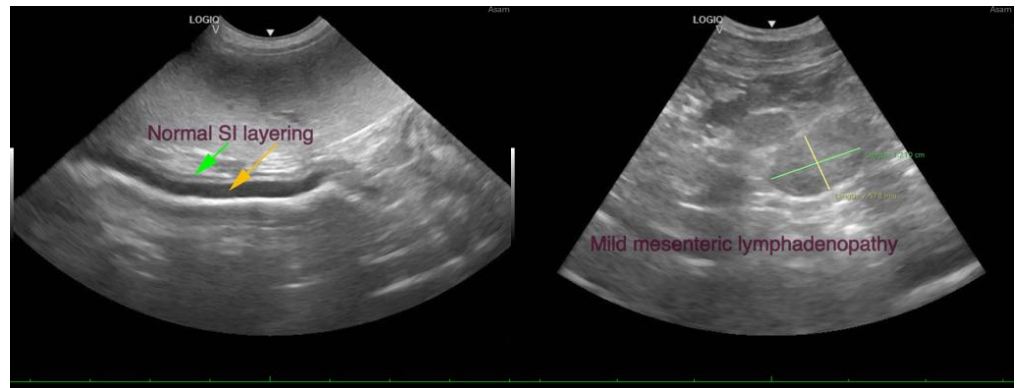
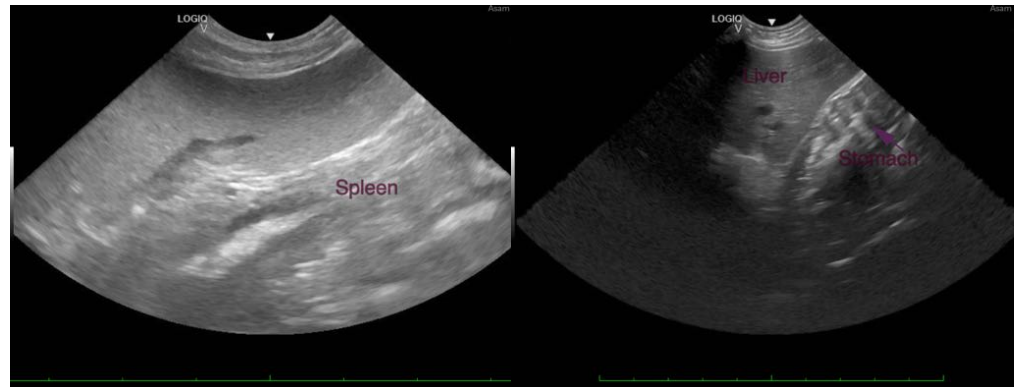
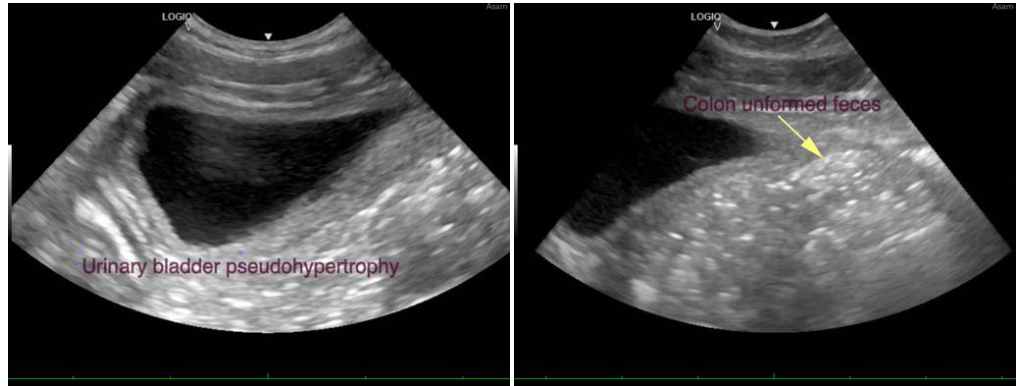
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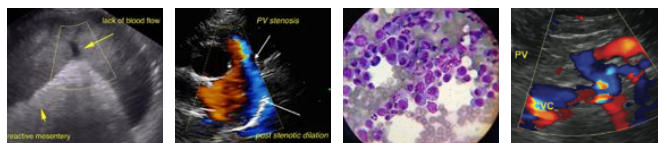
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

SPECIES

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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.

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info@SonoPath.com

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