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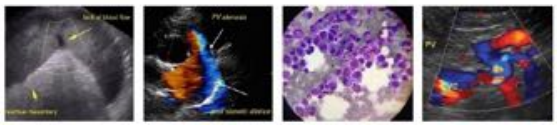


THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Meimei Maclachlan

SPECIES

Canine

BREED

Chow

SEX

Spayed female

AGE

7 years

WEIGHT

29 kg

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Kelly Reshny, RVT

HOSPITAL NAME

East Plains AH

REFERRING VET

Dr. Visconti

INVOICE

43999

DATE

4/25/23

PRESENTING CLINICAL SIGNS

History: Chronic history of vomiting, inappetence, and indigestion (> 2 years) Diet change to PVD DRM resolved issue for a period of time, but vomiting in the morning has returned and reluctance to eat has returned PE is unremarkable Current Medications Stilbestrol 1 mg weekly, Metacam once monthly or less for mobility
Abnormal PE/Chem/CBC/UA Results: All bloodwork WNL. 4DX WNL.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and visible pelvic urethra were of normal thickness. The ureters were not visible which is normal. There was normal wall layering with no masses, uroliths or abnormal thickening visualized. Urine was anechoic. No evidence of inflammatory or neoplastic changes were noted.

The kidneys have a smooth capsule and with hazing of corticomedullary definition to the point of inability to determine cortical/medullary ratio. No evidence of pelvic dilation was present. Visualization of right kidney was slightly limited possibly making measurement inaccurate. This is commonly related to breed related anatomical positioning. The left kidney measured 5.65 cm and the right kidney measured 6.31 cm.

Adrenal Glands

Both adrenal glands were visualized and recognized. Both were subjectively prominent with normal echogenicity and no specific masses or nodules seen. 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 2.89 cm in length and 0.8 cm at the caudal pole and 0.92 cm at the cranial pole. The right adrenal gland measured 2.54 cm in length and 0.86 cm at the caudal pole and 2.22 cm at the cranial pole.

Spleen

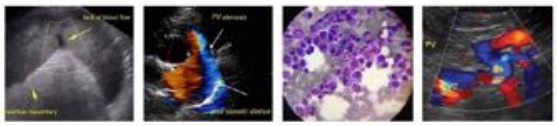
The spleen was normal in size with a slightly mottled parenchyma and slightly irregular capsule. Normal splenic vasculature with no signs of congestion or thrombosis.

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

Gastrointestinal

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.



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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.

Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

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.

Lymph Nodes

No clinically significant lymphadenopathy or abnormalities noted.

Free Abdomen

No masses or free fluid were noted.

ULTRASONOGRAPHIC FINDINGS

1. Normal GI tract
2. Prominent adrenal glands
3. Splenic parenchymal changes with irregular capsule
4. Degenerative renal changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is no ultrasonographically evident cause of reported GI signs in this abdominal study. Pancreas and GI tract are within normal limits. Consideration for dietary indiscretion, food sensitivity/allergy or mild inflammatory bowel disease is reasonable. While not sonographically evident, pancreatitis cannot be completely ruled out. Empiric treatment for GI signs including anti-nausea, appetite stimulant and fluid support as clinically indicated is warranted. A diet trial with hydrolyzed protein or select protein diet could be considered if food sensitivity is suspected clinically. If signs are persistent or recurrent, additional diagnostics to be considered include GI panel (TLI/PLI/cobalamin/folate), baseline cortisol +/- ACTH stimulation test, fecal pathogen panel, thyroid testing, bile acid profile, and thoracic radiographs to rule out occult neoplasia, cardiac disease and esophageal disease as potential causes. Ultimately GI biopsy may be required for more definitive diagnosis if the patient is not responsive to medical treatment.

Adrenomegaly is bilateral and may represent stressful illness or hormonal stimulation as is seen with pituitary dependent hyperadrenocorticism. If corresponding clinical signs are present, testing for hyperadrenocorticism should be considered (ACTH stimulation test vs LDDST).

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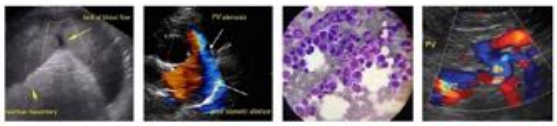

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Splenic changes are a common benign age related change, but infiltrative disease (lymphoma, MCT, other) cannot be definitively ruled out. No significant disruption of architecture noted to suggest significant pathology. Fine needle aspirate could be considered to further characterize parenchymal changes if clinically indicated, especially if any weight loss is noted or for baseline cytological assessment.

Renal changes are likely age related degeneration. Correlate clinical significance with blood work/urinalysis findings and clinical signs.

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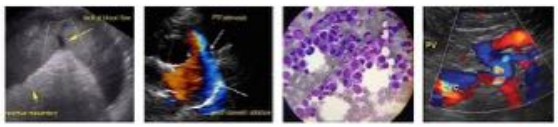

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Dr Brittany Sinclair, BVSc(hons), DACVECC
info@SonoPath.com