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Clinical Sonography & Telecytology
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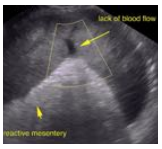
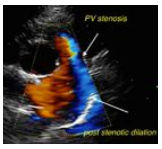
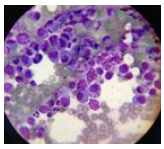
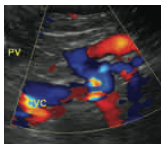





SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Ragnar Acosta Iraola

SPECIES

Canine

BREED

Schnauzer

SEX

Neutered male

AGE

9 months

WEIGHT

12 lbs

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Dr. Ferrer

HOSPITAL NAME

Paseos VC

REFERRING VET

Dr. Acevedo

INVOICE

95550

DATE

1/26/22

PRESENTING CLINICAL SIGNS

Presented as a referral for an abdominal ultrasound. The ultrasound is to evaluate and rule out non-radio-opaque gastric foreign body. Pt has a history of multiple episodes of diarrhea, vomiting, and inappetence every 2 weeks since Nov 2021. Jan 7th was hospitalized with fever and gastrointestinal problems. Current diet Royal Canin Hydrolyze
Abnormal PE/Chem/CBC/UA Results: BW: 1-7-22 Cbc: WBC:18.61 (6-17) Neutro: 15.8 (3-12) Mon: 1.53 (0.2-1.5) PLT: 161 (165-500) CHEM: GLobulins 2.2 (2.3-5.2) The rest was wnl.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The prostate is normal in size (0.45 cm) and shape for this neutered male dog. The parenchyma is homogenous and the external margins are smooth. The prostatic urethra appears normal with no evidence of irregularity, invasion, mass effect or calculi.

The left kidney has a normal shape and size (4.14 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.0 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

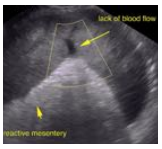
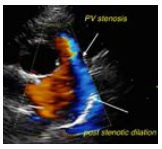
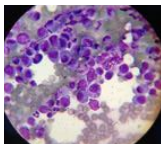
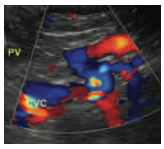
The left adrenal gland is normal in size measuring 0.36 cm at the caudal pole It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.34 cm at the caudal pole It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size, echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

Liver

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The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed. The gallbladder lumen is moderately distended. The wall of the gallbladder is not thickened and has a smooth mucosal surface. The gallbladder wall measured 0.11 cm. Luminal contents are primarily anechoic. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.7cm 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.

The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal fluid distension. Wall appears subjectively, mildly increased. The duodenum and jejunum both measured 0.42 cm. Bowel loops follow a typical curvilinear path with distinct wall layering. 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. The colonic wall measured 0.12 cm. 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 pancreas is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There are occasional prominent, mesenteric lymph nodes measuring 0.33 cm and 0.3 cm. Additionally there is a larger lymph node visualized and measured 0.75 x 1.62 cm. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

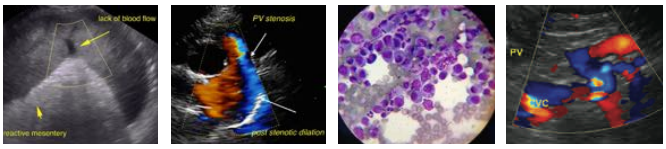
PRIMARY FINDINGS:

Questionably thickened small intestine. The mild small intestinal wall changes may be a normal variant in this patient or could be consistent with an inflammatory process (e.g., inflammatory bowel disease).

Mild mesenteric lymphadenopathy. The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The ultrasonographic lesions observed on today's study are mild. There is no obvious evidence of an



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obstructive pattern, but ruling out some types of foreign material can be very difficult with the chronic long term nature of the history, a foreign body seems less likely.

Consider metabolic causes of vomiting and diarrhea. I recommend full blood work if not already done. I recommend an ACTH stimulation test to rule out Addison's disease and a liver function test if there is any indicator of abnormal liver function.

If systemic disease is thought unlikely based on your work-up then consider primary GI causes, many of which are difficult to definitively diagnose by ultrasound alone. Possible causes could include dietary indiscretion, dietary intolerance, GI parasites, dysbiosis, pancreatitis (not visualized on today's exam) and much less likely intestinal neoplasia.

- Consider a hydrolyzed protein/novel protein diet.
- Recommend chronic probiotic therapy.
- You can consider a FNA of the large mesenteric lymph node, but prominent lymph nodes can sometimes be normal for young dogs.
- I recommend deworming and testing for GI parasites.
- If symptoms persist despite additional diagnostics and therapeutic intervention then you can consider obtaining GI biopsies.

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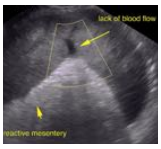
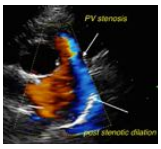
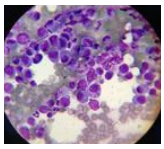
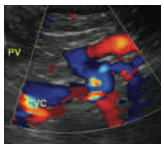

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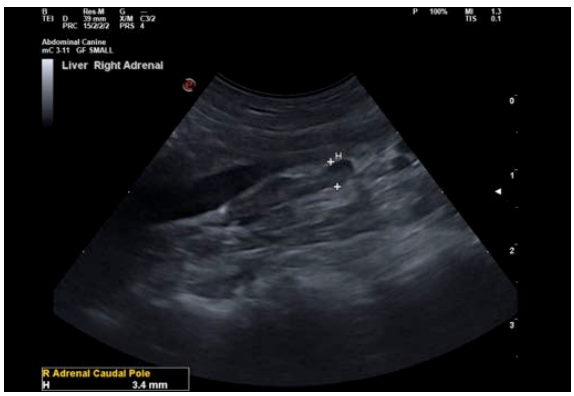

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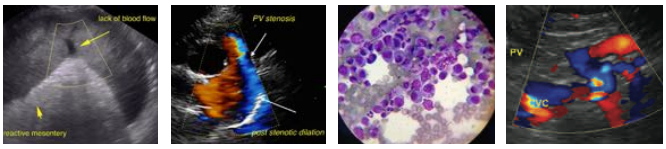

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)
kathleen.sennello@sonopath.com