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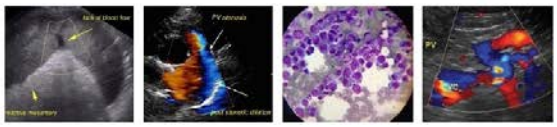

THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Gretchen Munro

SPECIES

Canine

BREED

English Pointer

SEX

Spayed Female

AGE

11 Years

WEIGHT

23.3 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

Graham AH

REFERRING VET

Dr. Lukacs

INVOICE

26570

DATE

10/21/21

PRESENTING CLINICAL SIGNS

5 day history of vomiting/hyporexia. Could not keep food down. Exam Oct. 18/21: cranial abdominal discomfort on abdominal palpation, hunched posture, QAR, dehydration. Has lost 4 lb since June 2021. Treatment Oct. 18/21: SQF, cerenia, famotidine, sulcrate Vomiting resolved but hyporexia/lethargy remains. currently on: cerenia 60 mg PO SID, sulcrate 5 mL PO BID on empty stomach, famotidine 20 mg PO q12h
Abnormal PE/Chem/CBC/UA Results: Oct. 18/21: decreased TP 30 g/L, globulins 2 g/L; PCV/TS 56%/6 g/dL rads: Oct. 18/21: orthogonal abdominal radiographs: decreased serosal detail cranial abdomen? rads attached.

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 right kidney has a normal shape and size (6.09 cm) with rare, non-obstructive nephroliths. 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, infarcts or hydroureter. Renal vasculature is normal.

The left kidney has a normal shape and size (5.79 cm) with pinpoint non-obstructive nephroliths. 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 0.92 cm. 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 0.68 cm. 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. The spleen echotexture is heterogenous and mottled, 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

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gall bladder lumen is moderately distended. The wall of the gall bladder has irregular polypoid projections and there is a moderate amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.

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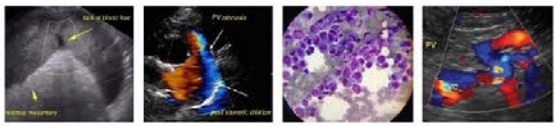

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Gastrointestinal

The stomach appears contains minimal luminal contents. It measures at a normal thickness of XX cm 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 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. Jejunum wall measured 0.2 cm. 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. 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.

PRIMARY FINDINGS

- Mild polypoid projections along the wall of the gallbladder – The significance of the gall bladder polyps and debris is unclear. This could represent an early mucocele, cholestasis, or chronic inflammation, or could be an incidental finding.

- Mildly mottled spleen – The diffuse splenic changes are non-specific and could be consistent with lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis.

- Mildly heterogeneous liver – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy.

SECONDARY FINDINGS

- Occasional small, non-obstructive nephroliths in both kidneys – The hyperechoic mineralized foci observed at the corticomedullary junction of the left/right kidney are consistent with small, non-obstructive nephroliths.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

An obvious lesion responsible for the acute vomiting reported is not identified. If blood work is abnormal, a metabolic cause for vomiting seems less likely, and I would most strongly consider primary gastrointestinal causes such as GI parasitism, dietary indiscretion, mild pancreatitis, bacterial dysbiosis, food allergy, IBD, and less likely intestinal neoplasia. Unfortunately, ultrasound can be insensitive in identifying some type of foreign material. Obstruction/foreign body cannot be 100% excluded, but no evidence of bowel dilation or an obstructive pattern is seen.

There is a significant amount of gas within the GI tract causing shadowing and obscuring visualization of some areas. Correlate these findings with serial radiographs. Hopefully this is a case of acute gastroenteritis, but if there is response to therapy then consider further evaluation by either

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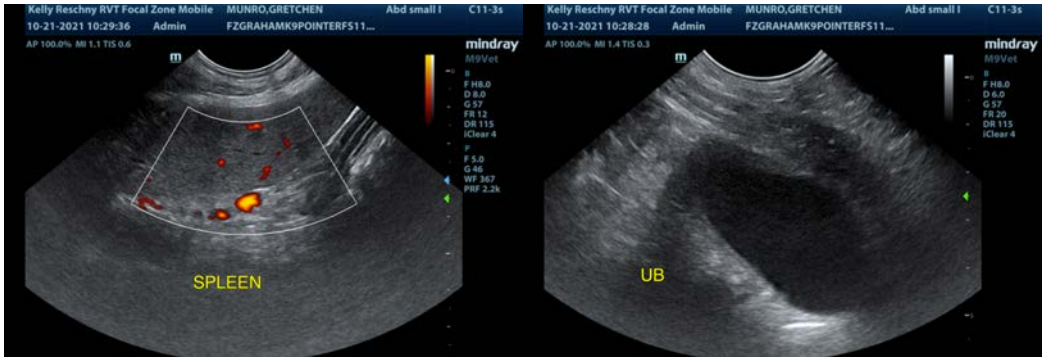
exploratory surgery, recheck ultrasound, CT scan of the abdomen, etc. Additionally, you could consider a GI panel to evaluate for pancreatic inflammation not seen on today's ultrasound and evaluate folate and cobalamin levels, which can be abnormal with chronic intestinal disease



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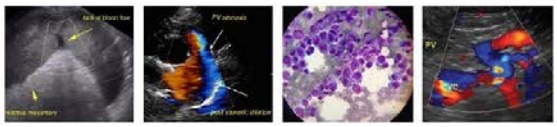

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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