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DATE PRESENTING CLINICAL SIGNS

10/28/22 Weight loss, vomiting, diarrhea. Per owner he is normal now.

PATIENT Current Medications: Metronidazole 500mg BID.

Lab Results: See attached.

Remi Wilhelm Date of Previous IntraPet Ultrasound: No previous.

Sedation: Dexdomitor/Torbugesic/Telazol IV.

Stat Report: Not requested.

SPECIES

Canine

BREED

Labrador

SEX

Neutered Male

AGE

4/26/12

WEIGHT

86.5 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Stephanie Warga
RDCS, RVT

HOSPITAL NAME

Edgewood Vet Hospital

REFERRING VET

Dr. Wright

INVOICE

42465

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 (2.0 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 (7.0 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal 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 (6.38 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal 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/borderline large measuring 0.98 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/borderline large measuring 0.85 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

The liver appears small and is normal in 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. While no focal lesions were visualized associated with the liver, visualization was impaired by the small size of the liver and intercostal imaging.

The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and primarily anechoic. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains moderate fluid. 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 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. Duodenum wall measured 0.39 cm. Jejunum wall measured 0.33 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.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There are visible/prominent sublumbar lymph nodes measuring 0.50 and 0.65 cm. The omentum is of normal echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Borderline enlarged adrenal glands – The bilateral adrenomegaly could be consistent with bilateral hyperplasia (e.g., secondary to pituitary-dependent hyperadrenocorticism), bilateral infiltrative neoplasia, inflammatory adrenal disease, other. Correlation with clinical findings is recommended.
- Subjectively small liver – Visualization was challenging intercostally. Correlate with abdominal radiographs to better estimate size.
- Moderate fluid dilation of the stomach – This was visualized intercostally. No focal lesions were observed. The pyloric outflow tract was somewhat obscured.
- Prominent sublumbar lymph nodes – 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

No obvious gastrointestinal lesions are observed to explain the weight loss, vomiting, and diarrhea reported. The liver subjectively appears small in this individual and was difficult to visualize intracostally. Correlate liver size with abdominal radiographs and consider a liver function test. If bile acids are abnormal, then further evaluation (contrast CT scan and liver biopsy) could be considered.

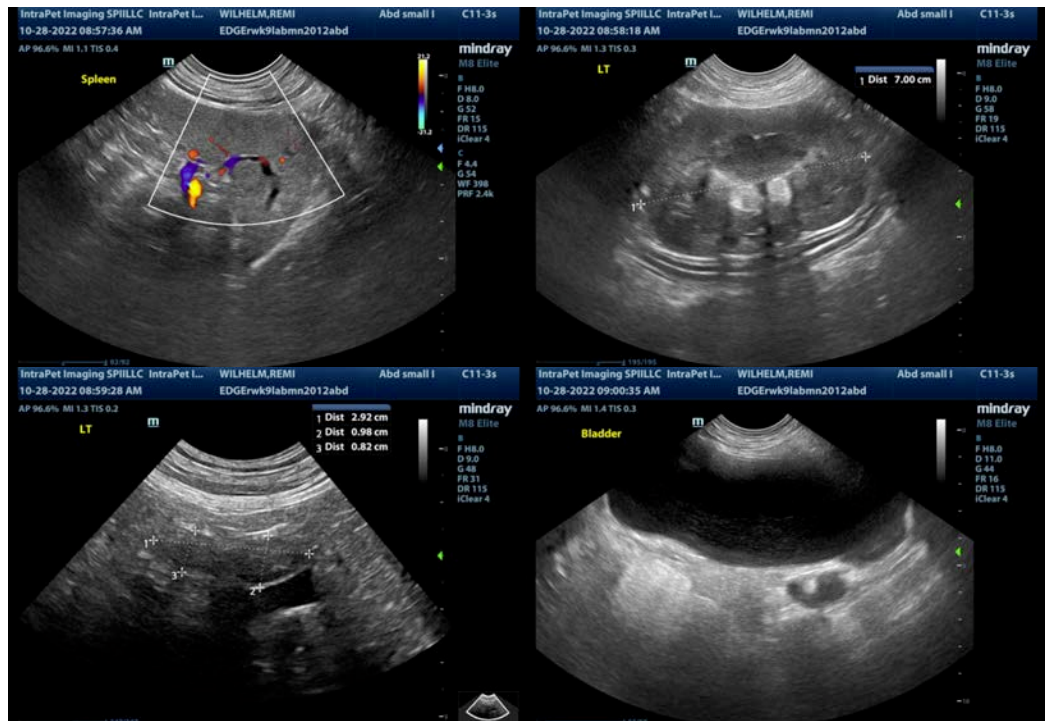
There is moderate fluid dilation of the stomach. This could be consistent with a recent ingestion of water, delayed gastric emptying, or a partial outflow tract obstruction. The pylorus was difficult to visualize intracostally.

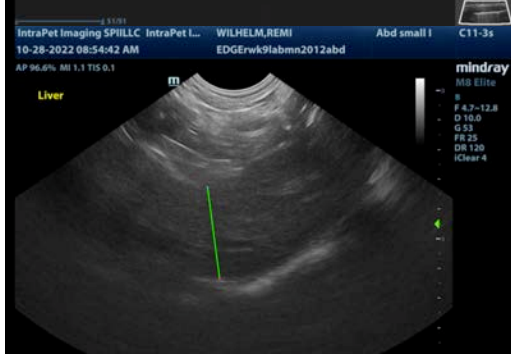
Mildly prominent sublumbar lymph nodes were visualized. Recommend a digital rectal exam to evaluate the anal glands and sublumbar lymph nodes.

If liver function is normal, then consider the possibility of primary GI disease. There are many causes for weight loss, vomiting, and diarrhea, which cannot be diagnosed by ultrasound alone.

- Consider such differentials as food allergy/dietary intolerance, GI parasitism, pancreatitis, dysbiosis, recurrent dietary indiscretion, IBD and less likely neoplasia, etc....
- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks)
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc.. to further evaluate for pancreatic/small intestinal disease.
- Recommend chronic probiotic therapy.
- If GI disease is thought very likely and this patient is not responding to symptomatic treatment, then consider obtaining GI biopsies.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.





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