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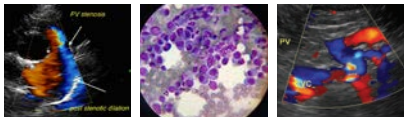

SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
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DATE

12/22/22

PATIENT

Penny Slater

SPECIES

Canine

BREED

Mixed

SEX

Spayed Female

AGE

10/22/20

WEIGHT

26.2 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Rachel Brilhart RDMS

HOSPITAL NAME

Hickory Vet Hospital

REFERRING VET

Dr. McNesby

INVOICE

43641

PRESENTING CLINICAL SIGNS

Patient presented 12/13/2022 for vomiting, diarrhea. Dx. with HGE based on clinical presentation and bloodwork (HCT 67%). Treated with IV fluids, Cerenia, Famotidine, Metronidazole, probiotic. Responded initially but developed a generalized papular rash. Added Diphenhydramine and rash improved/lessened. Vomiting resolved, but patient had decreased appetite and loose stool. Patient began vomiting again 12/20/2022 - vomiting water and even ice chips.

Current Medications: Metronidazole 250 mg mg BID - stopped 12/20/22, Famotidine 10 mg BID - stopped 12/20/22. Ondansetron 6 mg Q24 hours, Cerenia 12 mg Q24 hours, Visbiome 2 cap PO Q24 hours, Diphenhydramine 12.5 mg BID
Lab Results: See attached.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: STAT requested.

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 left kidney has a normal shape and size (4.54 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 (4.25 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 in size measuring 0.63 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 0.71 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 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 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 mild/moderate shadowing ingesta. 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. In some views, there is questionable mild thickening and surrounding hyperechoic tissue in the right cranial abdomen. In these regions, the stomach wall measures at 0.56 cm.

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 measures 0.30 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 prominent and mottled compared to the surrounding isoechoic 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, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Questionable mild gastric wall thickening with surrounding inflammation – This is highly questionable and could be due to imaging artifact. Findings could be consistent with gastritis.
- Prominent mottled pancreas – The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis. No overtly inflamed pancreas is visualized, but there is some inflammation in the right cranial abdomen in the region of the pancreas.
- Small to moderate amount of shadowing material within the gastric lumen – Correlate with feeding history. if the patient was adequately fasted, consider the possibility of delayed gastric emptying or a partial pyloric outflow obstruction (none observed).

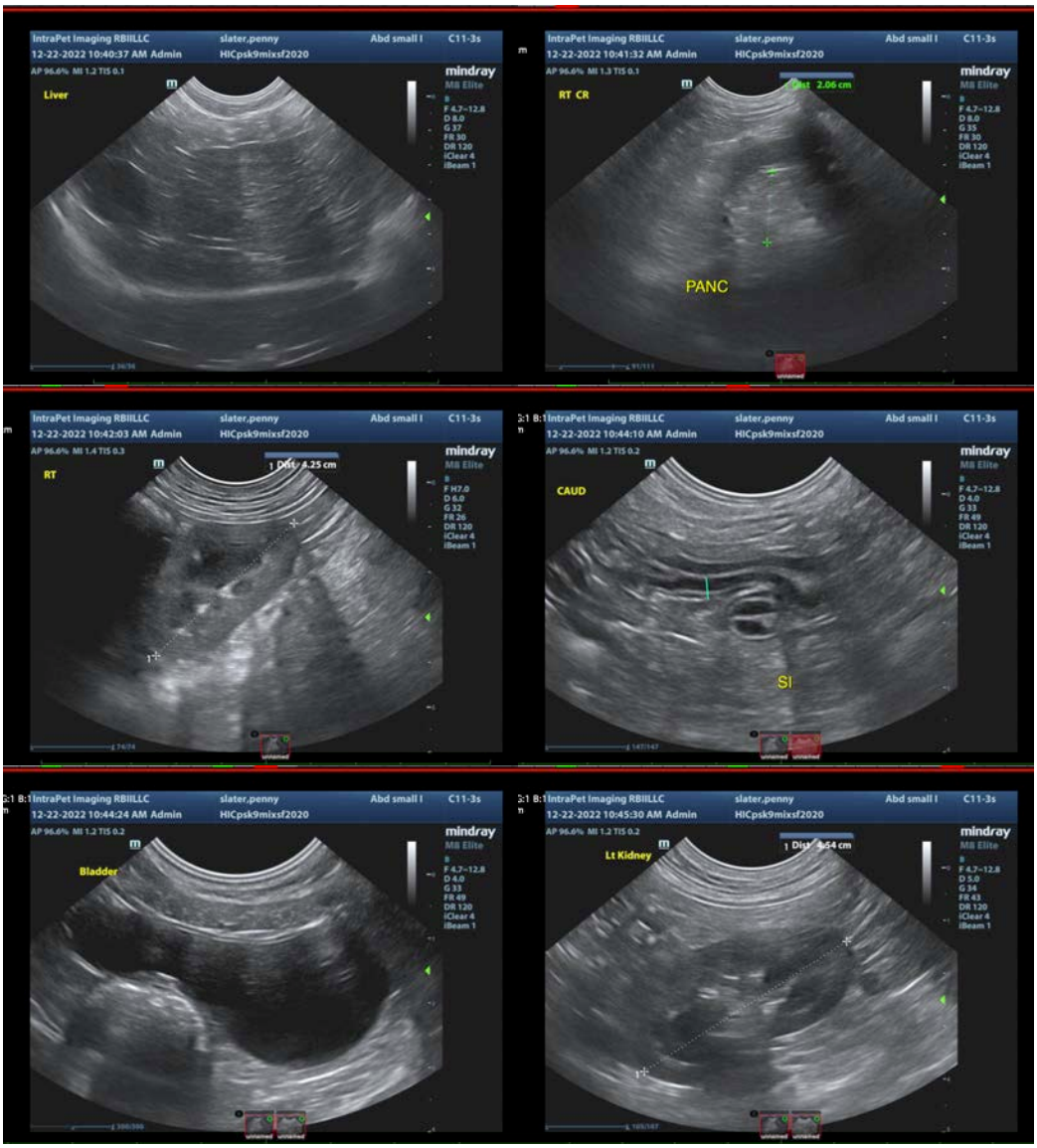
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

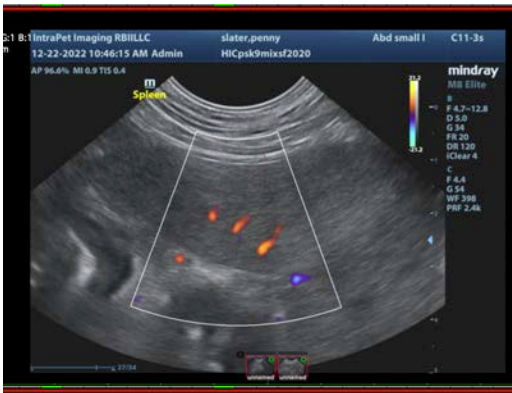
An obvious cause for the vomiting and diarrhea reported is not visualized. There is a small area of hyperechoic mesentery in the right cranial abdomen that on some views appears slightly associated with some prominent gastric wall. Additionally, this is the region of the pancreas, but not definitive repeatable lesion is observed.

Consider continued supportive care and treatment for possible pancreatic inflammation (consider correlation with a quantitative cPLI). Correlate findings with abdominal radiographs. Some of the

dermatologic lesions described could be due to drug allergy. Use caution with Cephalosporins, Penicillins, etc., and careful examination for any evidence of mast cell disease, etc.

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

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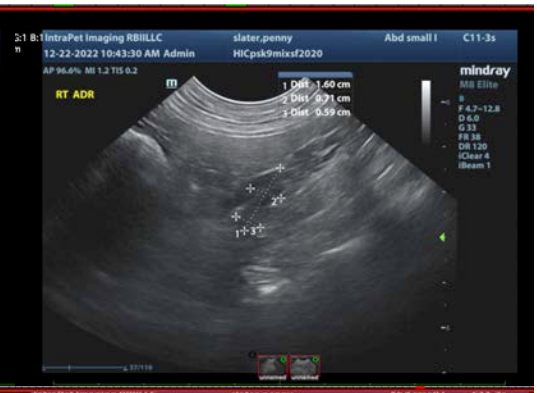
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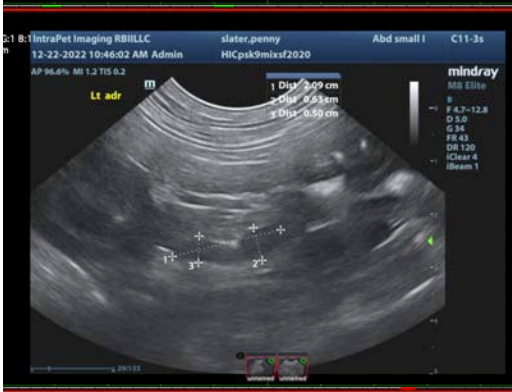
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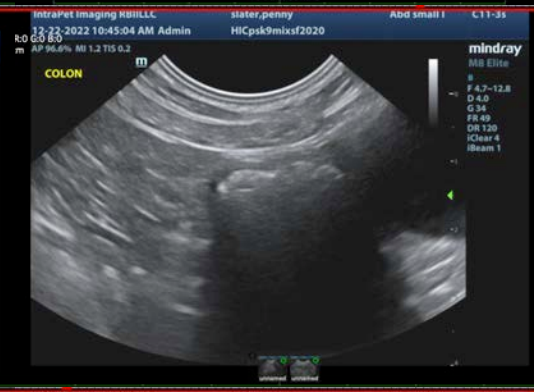
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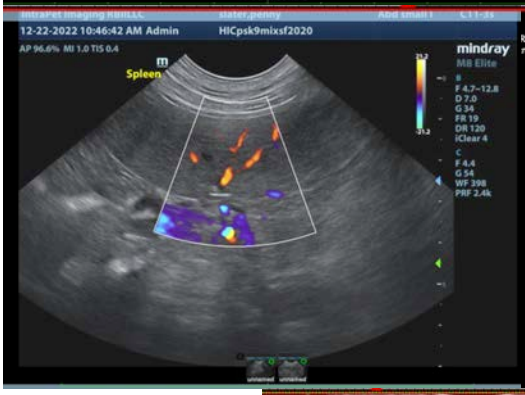
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PROM GASTRIC WALL/INFLAMMATION
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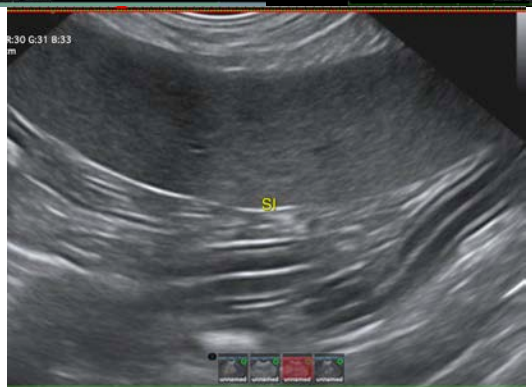
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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