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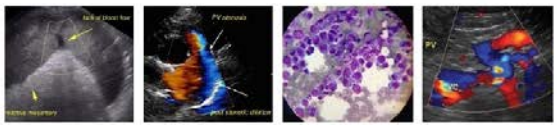


THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Lennon Thompson

SPECIES

Canine

BREED

Mastiff X

SEX

Spayed Female

AGE

9 Years

WEIGHT

30 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Preston Animal Clinic

REFERRING VET

Dr. Gerritsen

INVOICE

46284

DATE

3/29/23

PRESENTING CLINICAL SIGNS

Presenting with intermittent tremors lasting 20-30 mins at a time since beginning of March. PE NSF. Ongoing frunculosis bilateral hocks for 10months. Baytril previously for 2 months. Prednisone 50mgstarted Feb 6th (hocks responding well). Weaning current dose 12.5mg PO SID since March 6th. Is also on Interceptor and Bravecto.

Abnormal PE/Chem/CBC/UA Results: Urea 2.2(3.2-11.0)Potassium 6.1(4.0-5.4)Na:K ratio 24(28-37) ALP 700(5-160) GGT 14(0-13)Lipase 587(0-250)Spec cPL 657(0-200)T4 normal, Cortisol normal, 4DX negative

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 (5.83 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 (6.74 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 0.47 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 0.65 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.

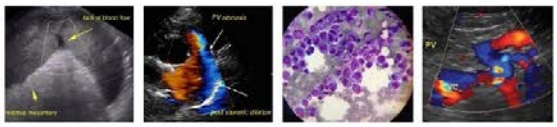
Spleen

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.



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Gastrointestinal

The stomach contains a large amount of shadowing fluid and 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. The significant amount of ingesta/fluid visualized in the gastric lumen prevents clear visualization of the pyloric region and much of the cranial abdomen.

Some of the visualized areas of jejunum and ileum have a relatively uniform diameter with mild to moderate 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 0.37 cm. Visualized peristalsis appears appropriate. The large amount of fluid distention in the stomach makes visualization of the pyloric region and many areas of the cranial abdominal abdomen difficult.

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, 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

- Large stomach distended with fluid and ingesta – Correlate these findings with feeding history. Per history the patient was fasted for 14 hours. These findings could be consistent with delayed gastric emptying or a partial outflow tract obstruction. Visualization of the pyloric region and much of the cranial abdomen was difficult due to the shadowing ingesta.

- Moderate diffuse fluid distention of the small bowel – While no point of obstruction is visualized, there does appear to be some moderate fluid distention of the small bowel. This can be seen with passing ingesta, generalized ileus, or a partial/complete obstructive process.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The stomach appears significantly distended with fluid and ingesta. Correlate these findings with abdominal radiographs and the feeding/drinking history. If this patient has truly been fasted for 14 hours, this would be an abnormal finding, likely consistent with either delayed gastric emptying or possibly a partial outflow tract obstruction, etc. I am surprised to not hear of a vomiting history. This concerns me and makes an obstructive process less likely.

You could consider a single dose of Metoclopramide and reevaluation of the stomach in several hours to ensure that it is emptying. I cannot definitively rule out the possibility of ingested foreign material, as visualization is poor in the cranial abdomen, but not point of obstruction is visualized. No overt mass lesions are observed, and a cause for the ALP elevation is not visualized. No focal lesions are visualized associated with the liver or gallbladder.

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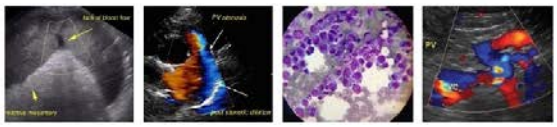

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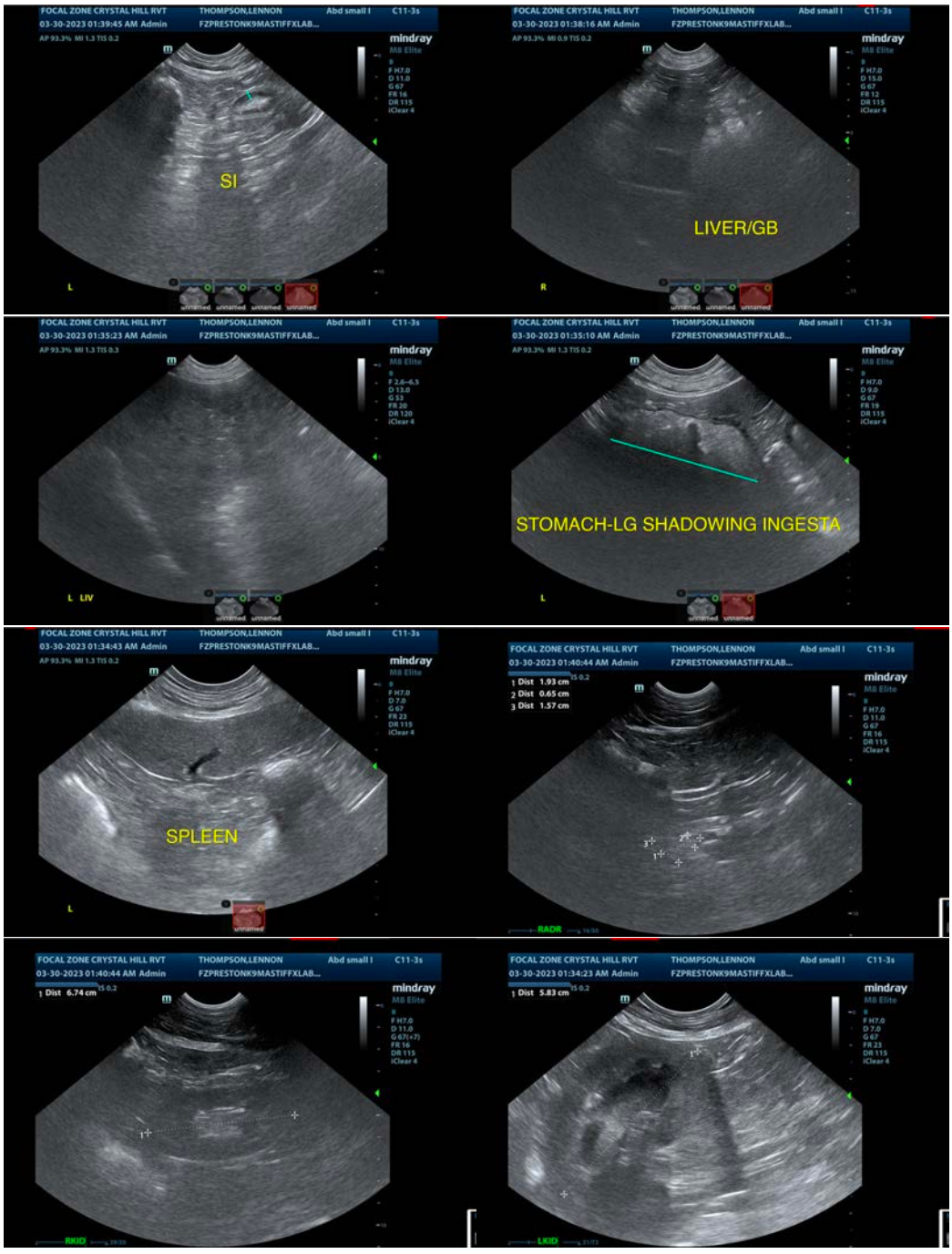
Recommend serial imaging of the stomach and small bowel (radiographs +/- ultrasound) and possibly medical treatment for gastroenteritis. If ingested material is a big concern and/or diffuse ileus, often GI biopsies are helpful in trying to determine a cause. Additionally, you could consider a GI panel to Texas A&M for a qualitative PLI, TLI, cobalamin and folate to further evaluate the pancreas and small intestine. A fine needle aspirate (provided coagulation parameters are normal) and a liver function test could be considered to further evaluate the liver.



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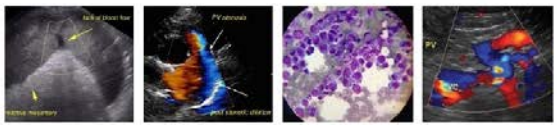

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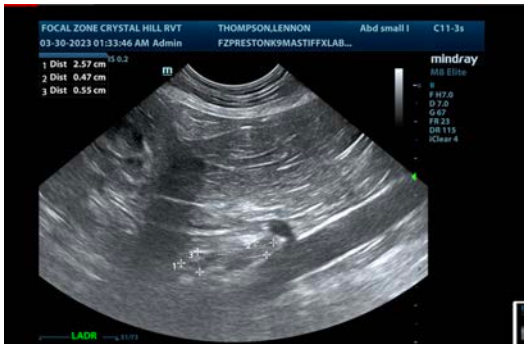

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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