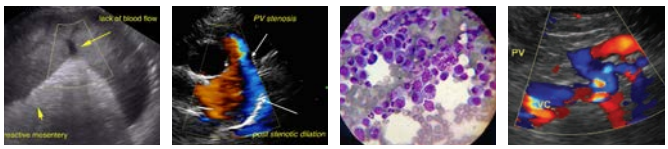
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Montana Lutz

SPECIES

Canine

BREED

Labrador Retriever

SEX

Spayed Female

AGE

8 Years

WEIGHT

55 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Shari Reffi, CVT

HOSPITAL NAME

Newton Vet Hospital

REFERRING VET

Dr. Barron

INVOICE

45745

DATE

3/8/23

PRESENTING CLINICAL SIGNS

Vomited 2 tampons pre sx. Persistent regurgitation 2 day post op enterotomy. Vomited 1 tampon 2 days post op.

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 (5.69 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 (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.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.49 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 0.86 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.

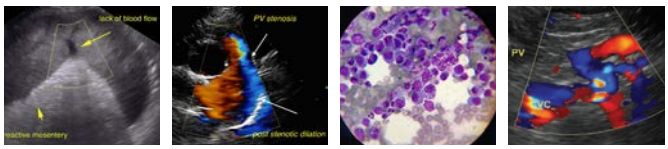
Liver

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 gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a moderate amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.

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. There is fluid dilation of the pylorus, not no overt shadowing obstruction is visualized.



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The visualized areas of duodenum, 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 0.29 cm. Visualized peristalsis appears appropriate. There is no evidence of a diffuse obstructive pattern. Some areas of small intestine are somewhat fluid dilated and there is a corrugated section of bowel, most consistent with a focal enteritis. No overt foreign body or obstruction is visualized.

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 right limb of the pancreas is large and hypoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is evidence of regional mesenteric inflammation. Consistent with mild pancreatitis.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is a prominent sublumbar lymph node measuring 0.44 cm. The omentum is diffusely hyperechoic.

ULTRASONOGRAPHIC FINDINGS

- Hypoechoic right limb of the pancreas with surrounding hyperechoic mesentery – The pancreatic changes are most consistent with mild pancreatitis/pancreatic inflammation. Recommend fPLI testing and continued monitoring for improvement or possible development of a pancreatic abscess. Consider fine needle aspirate if not improving.

- Moderate gallbladder debris – The significance of the aggregated gallbladder debris is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting but seems unlikely to be causing a current issue. Recommend continued monitoring.

- Significant dilation of the stomach with shadowing ingesta and fluid – Correlate with feeding history. If the patient was adequately fasted, then consider the possibility of delayed gastric emptying or a pyloric outflow tract obstruction (none clearly seen but cannot be ruled out).

- Areas of small intestine with mild to moderate fluid dilation and some corrugated regions – Findings are most consistent with ileus and focal enteritis. An obstruction is not observed but cannot be definitively ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The stomach is significantly dilated with fluid and shadowing ingesta. The pyloric region is difficult to evaluate because of this, and it appears fluid dilated, but I do not see evidence of an outflow tract obstruction. Unfortunately, this cannot be definitively ruled out. I suspect ileus is more likely and there is evidence of significant pancreatic inflammation in the right cranial quadrant possibly contributing.

Recommend treatment for enteritis and pancreatitis, as some areas of bowel also appear corrugated and somewhat fluid dilated. If the patient is uncomfortable and regurgitating, consider decompression of the stomach with a nasogastric tube and starting promotility medication with close monitoring of the stomach. If distention recurs, further evaluation of the esophagus and outflow tract may be necessary. There is significant inflammation in the abdomen, which I suspect is secondary to surgery. No focal areas of fluid were visualized consistent with septic peritonitis.

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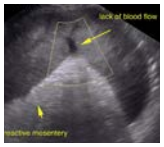
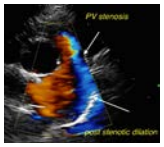
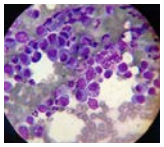
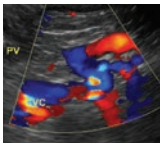

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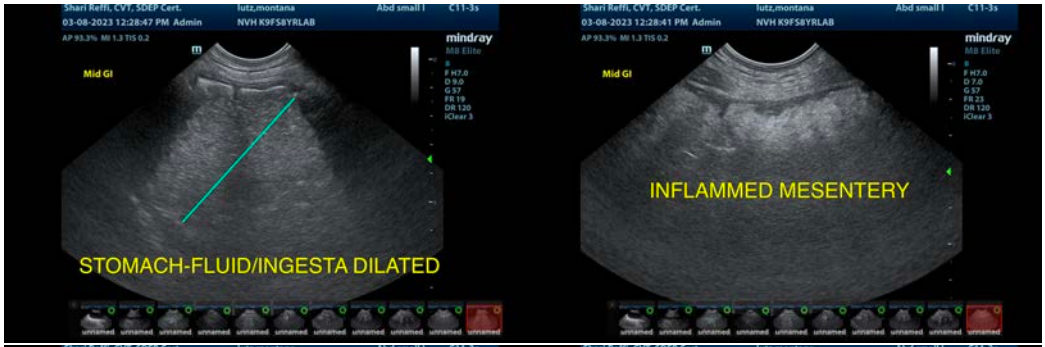

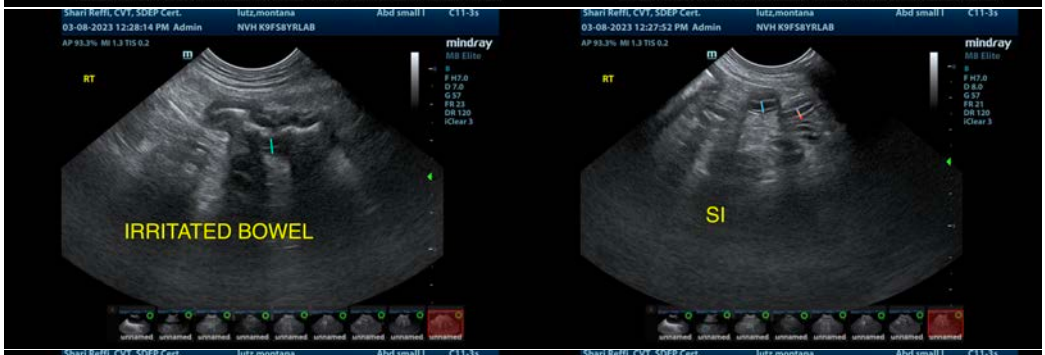

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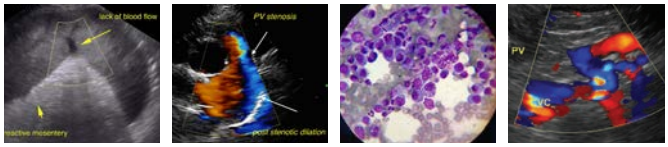

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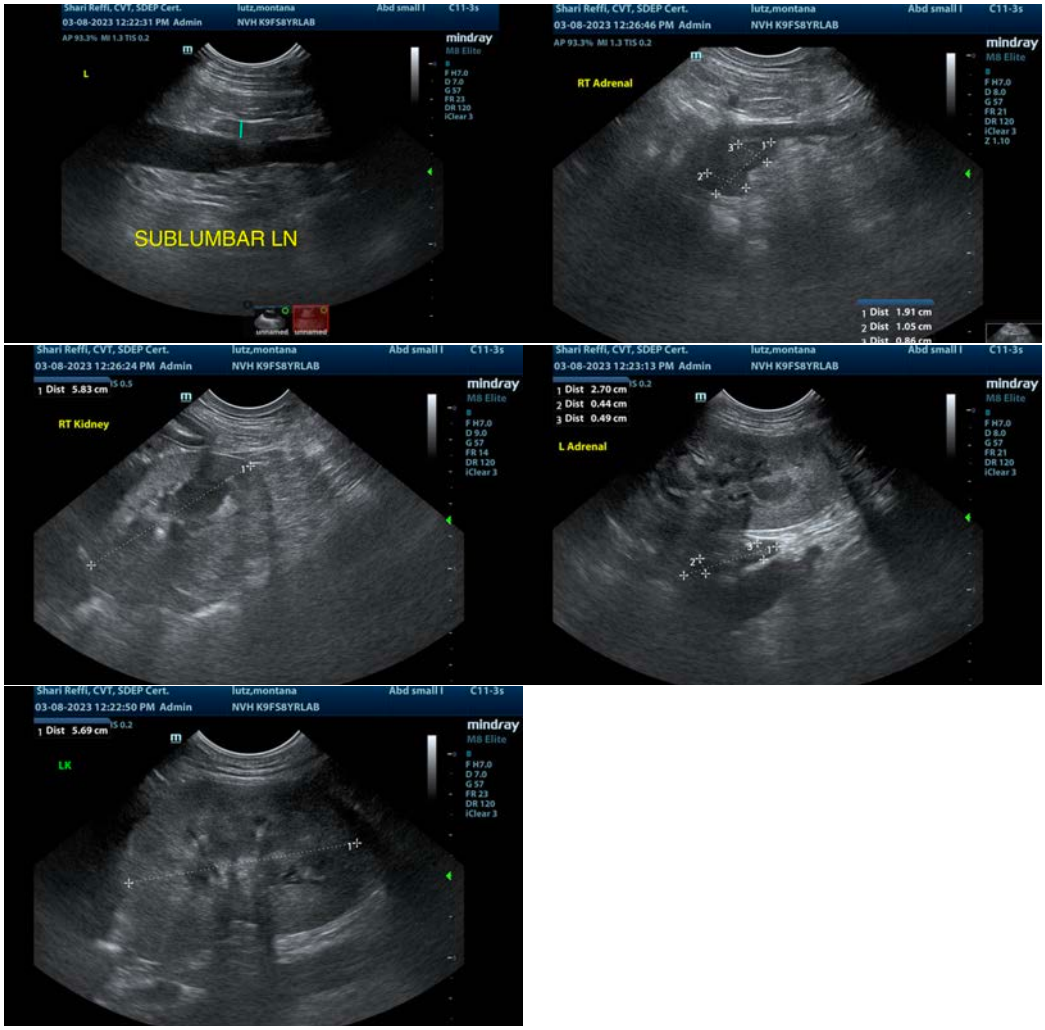

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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