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Clinical Sonography & Telecytology
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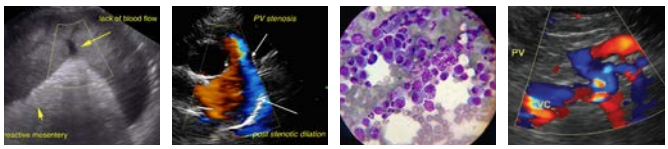

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1-800-838-4268 info@sonopath.com

PATIENT
Ivy Babb

SPECIES
Canine

BREED
Yorkshire Terrier

SEX
Spayed Female

AGE
2 Years

WEIGHT
1.5 kg

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

IMAGING PERFORMED BY
Dr. Sarah Barthelemy

HOSPITAL NAME
Animal Clinic Downtown

REFERRING VET
Dr. Waldman

INVOICE
46622

DATE
4/12/23

PRESENTING CLINICAL SIGNS

Initially presented for pain (thought to be back pain initially but at ER believed it was related to constipation. Patient started vomiting. Treated with GI supportive therapy. Small amount blood in stool today. Vomiting has discontinued. Labs unremarkable.

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 (2.44 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 focal perinephric inflammation or effusion. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (2.91 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 0.30 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 0.35 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 minimal luminal contents. 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 pyloric wall appears somewhat prominent, measuring 0.28 cm in wall thickness.

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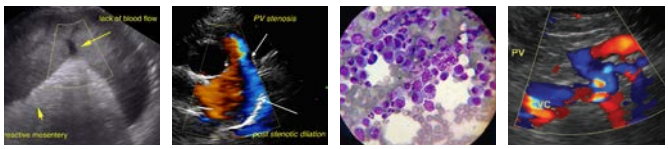

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The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. Duodenum wall measures 0.41 cm. Jejunum wall measures 0.22 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. Colon wall measures 0.11 cm.

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 occasional prominent mesenteric lymph nodes, examples measure 0.25 and 0.36 cm. The omentum is generally of normal echogenicity.

ULTRASONOGRAPHIC FINDINGS

- 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.
- Prominent/mildly thickened pyloric wall – Wall layering appears intact. Findings are most consistent with inflammation, much less likely neoplastic change.
- Mildly prominent mesenteric lymph nodes – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

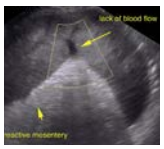
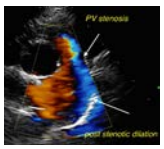
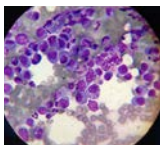
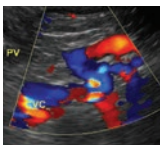
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal GI lesions are visualized to explain the pain and vomiting reported. There is a moderate amount of debris visualized in the gallbladder with no significant surrounding inflammation. If liver enzymes are elevated, then consider starting Ursodiol therapy. If not, continued monitoring of the gallbladder is warranted.

The pyloric wall appears slightly prominent on today's exam. This could be due to some mild inflammation from vomiting, although a more serious issue cannot be ruled out. If symptoms continue, consider reevaluation of this region.

Additionally, there are some prominent mesenteric lymph nodes, which are likely reactive in a patient this young.

Consider treatment for acute gastroenteritis. Additionally, you could consider a liver function test to rule out underlying hepatic disease. Additionally, you could consider a GI panel to Texas A&M for a qualitative PLI, TLI, cobalamin and folate, looking for evidence of pancreatic inflammation, chronic GI disease, etc. You could consider a novel protein/hydrolyzed protein prescription diet to treat for possible food allergy/dietary sensitivity. Dysbiosis has been associated with chronic vomiting. You could consider probiotic therapy. Consider screening for Addison's disease. If symptoms persist, consider

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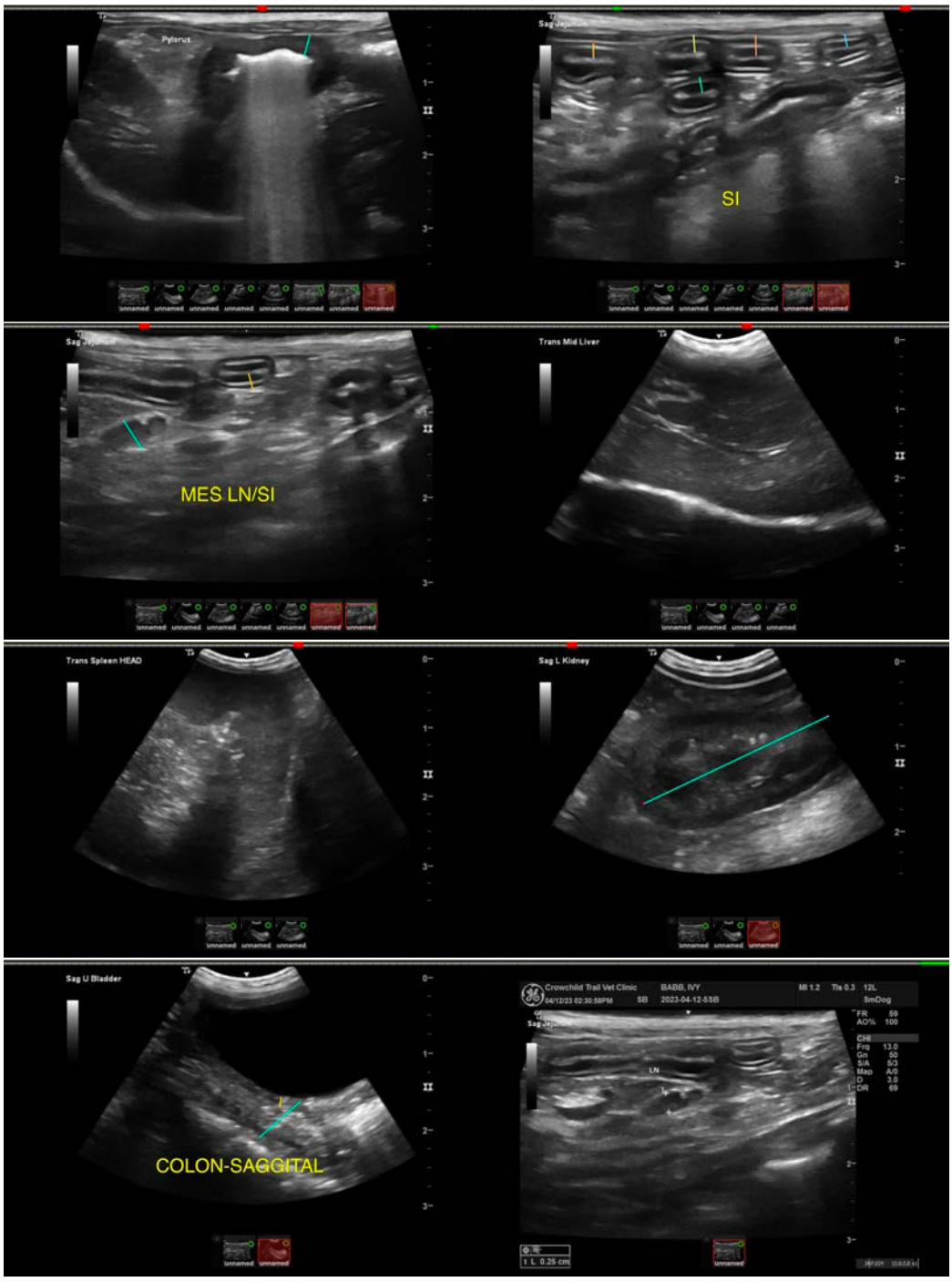

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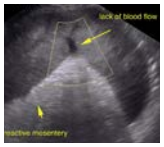
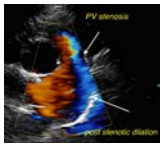
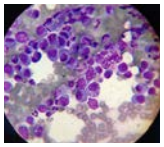
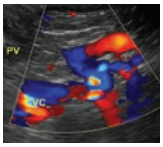

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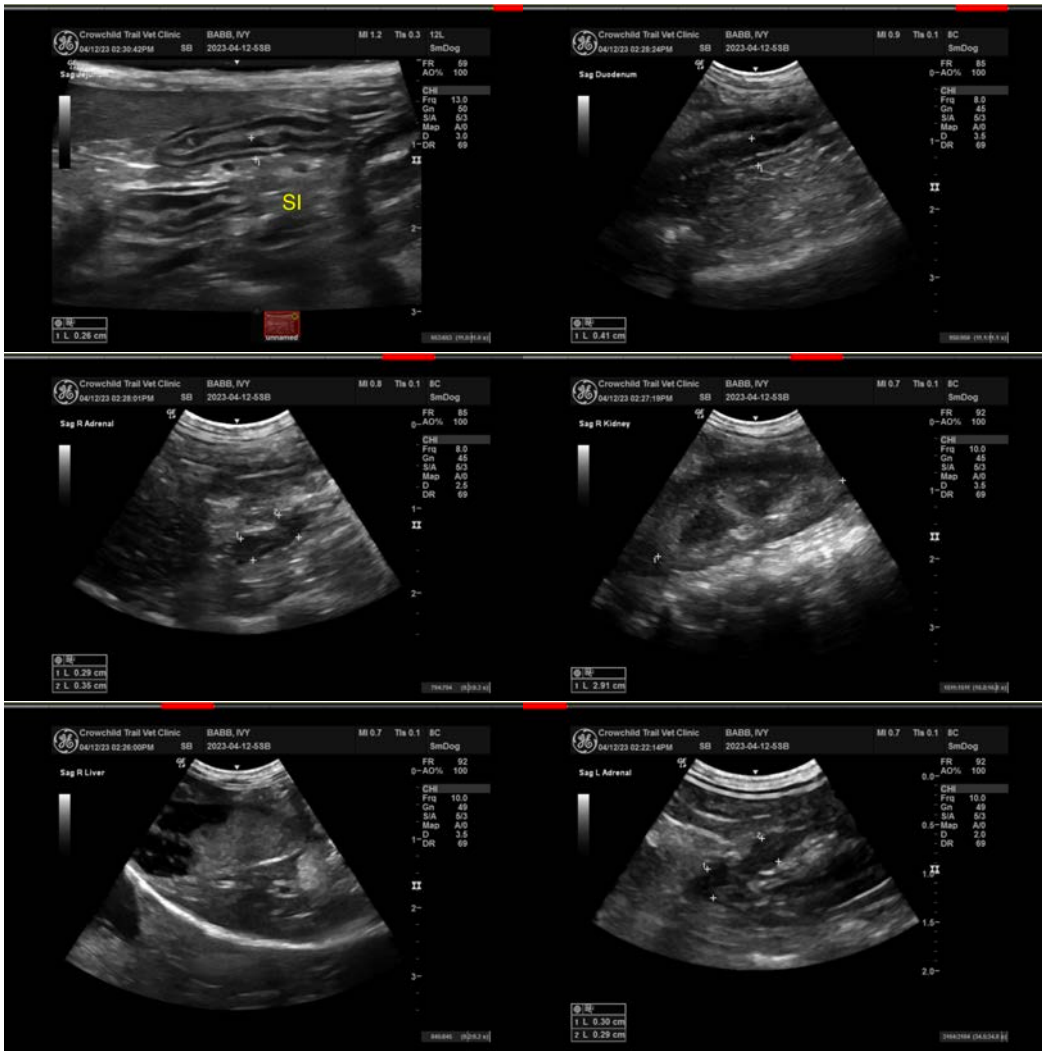

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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