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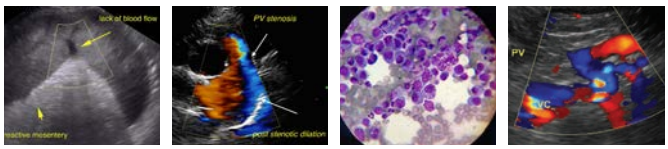

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1-800-838-4268 info@sonopath.com

PATIENT

Mr. Darcy Joyce

SPECIES

Canine

BREED

Golden Retriever

SEX

Intact Male

AGE

8 Months

WEIGHT

59.5 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Megan Cassels-Conway

HOSPITAL NAME

Central Broward AH

REFERRING VET

Dr. Megan Cassels-Conway

INVOICE

38045

DATE

5/26/22

PRESENTING CLINICAL SIGNS

Presented elsewhere 5/12 for vomiting and diarrhea. Treated with SQ fluids, vit B12 injection, proviable. Seen at ER 5/23 for ongoing vomiting, diarrhea and severe hypersalivation. CBC/chem wnl, Rads showed mild gas within GI. Treated with cerenia injection, metronidazole, propectalin. Seen at primary 5/24 not improving. Fecal neg, Giardia neg, CPL neg. Given cerenia PO 24mg SID (was advised to increase to 2 tabs on 5/25), Vit B12 injection, famotidine. Continued metronidazole and propectalin. Presented for 3rd opinion today. BAR, mm pk/m, crt<2s. Severe hypersalivation, lip smacking, possible regurgitation. Mild tense abdomen, gas within intestines and soft mucoid stool on rectal. Known foreign body eater primarily rocks and organic material. As puppy had coccidia and colitis, treated and resolved. Rads showed normal abdomen, mild gas within small intestines. Lepto SNAP neg. UA pending. Baseline cortisol pending.
Abnormal PE/Chem/CBC/UA Results: 5/24/22 CBC/chem wnl CPL neg Fecal neg Giardia neg Rads wnl 5/26/22 Baseline cortisol pending UA pending Lepto SNAP Neg

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 large in size (1.25 cm) but has a regular shape with smooth external margins. The parenchyma is heterogenous but no discrete focal lesions are present. The prostatic urethra appears normal with no evidence of irregularity, invasion, mass effect or calculi.

The left kidney has a normal shape and size (6.18 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of 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 (6.78 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of 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 0.39 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.

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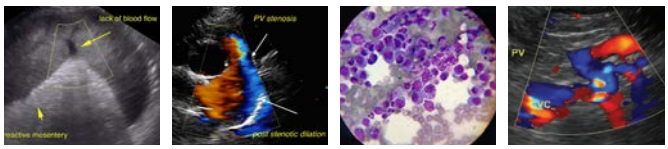

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Liver

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 primarily anechoic. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of 0.46 cm 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. Intraluminal gas precludes full evaluation of the stomach.

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 measured 0.34 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, 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.

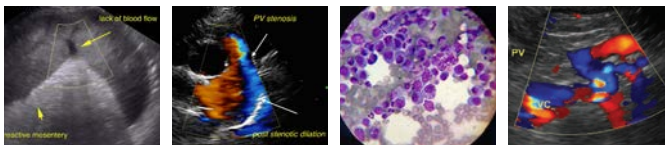
ULTRASONOGRAPHIC FINDINGS

- No significant lesions observed on today's scan

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Today's scan appears relatively normal. There is no evidence of an obstructive pattern. There is gas in the gastric lumen, so it was difficult to evaluate the wall in its entirety, but it does not appear significantly distended, and I do not appreciate severe pancreatic inflammation. Based on the history provided, consider esophageal disease as well as gastrointestinal disease. Consider thoracic radiographs and a barium esophogram(?) to look for a stricture, intraluminal material, etc., or you could consider upper GI endoscopy to evaluate the esophagus and the stomach and proximal duodenum and obtain biopsies.

Cortisol levels are pending. This is a great first step. Provided bloodwork is normal otherwise, metabolic disease is thought unlikely, and a primary gastrointestinal disease is thought most likely. Differentials would include food allergy/dietary intolerance, GI parasitism, dysbiosis, gastrointestinal foreign material, and less likely intestinal neoplasia (other differentials exist).



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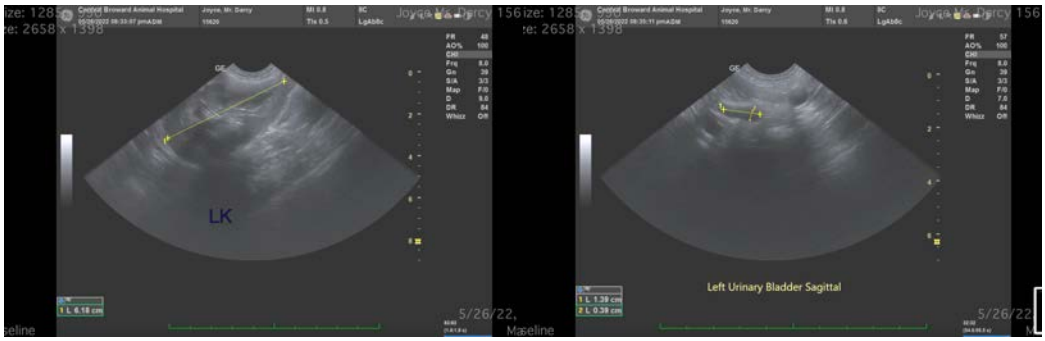
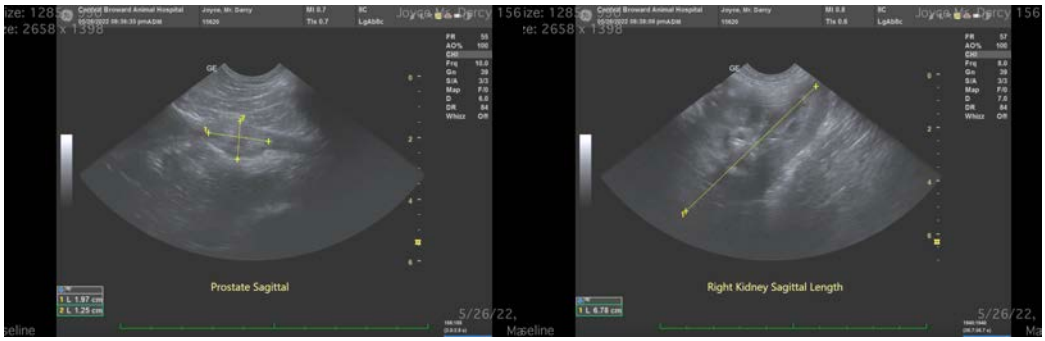
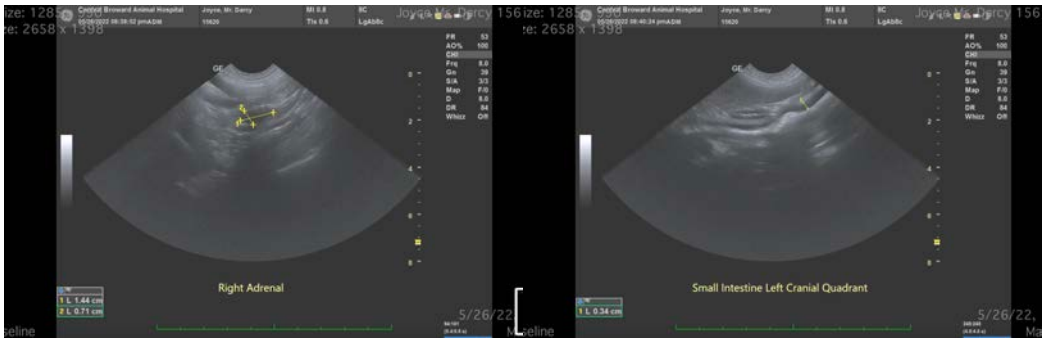
- Consider a GI panel to Texas A&M for PLI, TLI, cobalamin and folate to look for evidence of pancreatic inflammation, exocrine pancreatic insufficiency, dysbiosis, etc.
- Recommend a hydrolyzed protein/novel protein diet in case of a dietary sensitivity.
- Recommend empirical deworming and testing (if not already done).
- Recommend baseline cortisol level (this is currently pending).
- Recommend serial abdominal radiographs and radiographs of the thorax (to help evaluate the esophagus and to look for concurrent intrathoracic disease).
- If symptomatic therapy is not successful, then consider upper +/- lower GI endoscopy to evaluate the stomach and esophagus. Surgical biopsies may be necessary on larger dogs to obtain biopsies from the more distal small intestine.







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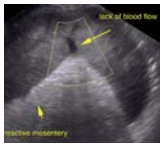
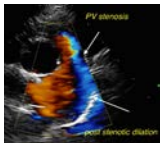
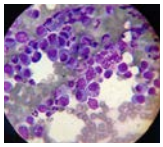
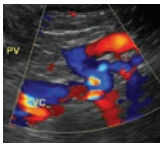

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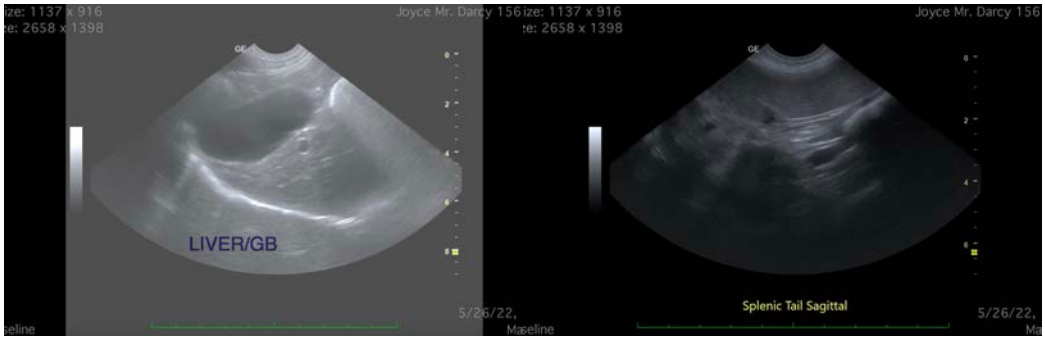

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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