SonoPath
Clinical Sonography & Telecytology
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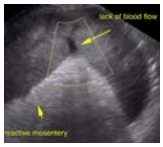
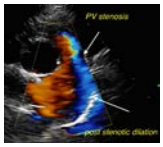
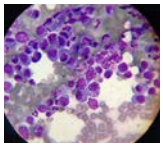
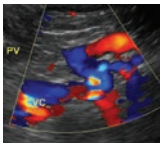

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Maggie Top

SPECIES

Canine

BREED

Labrador Retriever

SEX

Spayed Female

AGE

10 Years

WEIGHT

63.8 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Goodman

HOSPITAL NAME

Evandale Blue Ash PH

REFERRING VET

Dr. Goodman

INVOICE

43114

DATE

6/13/23

PRESENTING CLINICAL SIGNS

Patient has had diarrhea since beginning of April 2023. On 4/3/23, administered ProPectalin (3.5 tabs TID), Metronidazole 500mg (1 tab SID), and Proviable (1 cap SID). Sent home Royal Canin GI low fat dry and wet. On 4/5/23, owner reports that stool is firm and looked good. 4/6/23, owner reports her diarrhea has start again, came in for exam. Abdomen soft on palpation, no pain elicited. Rectal - no overt masses or strictures palpated, gas filled rectum, left anal gland was full - easily expressed thick brown contents. Fecal returned NPS but non-pathogenic yeast present. Sent home an additional course of Metronidazole 500mg but increased to 1 tab BID for 5 days. On 4/12/23, O reports that stool is still not back to normal. It will start to firm up slightly and then will go back to diarrhea. Sent home course of Panacur, Rx Clay and had her return for GI Panel. GI panel showed low normal cobalamin - owners approved starting B-12 injections (1 injection weekly for 6 weeks, then wait 4 weeks to administer the 7th injection, 4 weeks after that recheck GI Panel. Since starting the injections on 4/26, stool has continued to wax and wane. She has been eating Hill's i/d biome and is not getting any other treats that could be contributing to the diarrhea. Full BW performed 2/7/23 - everything WNL but did note USG is still low

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 (5.53 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 (6.01 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 0.68 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 0.70 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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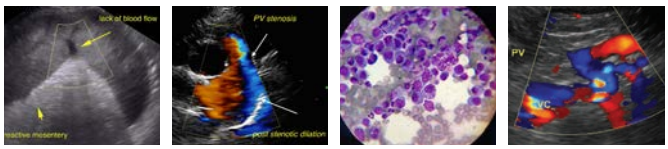

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Liver

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 mild and 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 <0.7cm 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. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal fluid distension. Wall thickness is increased. Bowel loops follow a typical curvilinear path. Some areas have reduced detail of wall layering. Jejunum wall measures 0.35 cm. Duodenum wall measures 0.49 cm. There is mucosal speckling visualized. 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

- Subjectively thickened small intestine with mucosal speckling visualized – Bright mucosal speckling has been postulated to represent dilated lacteals or focal accumulations of mucus, cellular debris, etc.. in the mucosal crypts.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is subjective thickening of the small intestine with some mucosal speckling. This can be an additional indication of small intestinal disease. Recommend current bloodwork to reevaluate for possible hypoalbuminemia, etc. Consider either a hydrolyzed protein/novel protein diet or an ultra-low-fat diet (back to the GI low-fat that previously worked) to try and see if these diets have more of an effect. Additionally, recommend chronic probiotic therapy. Based on the chronicity of the symptoms, the ultrasonographic findings and the low cobalamin levels, a primary enteropathy is likely. Consider obtaining GI biopsies to determine a definitive diagnosis and treatment plan.

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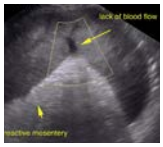
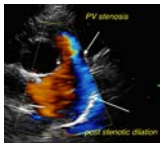
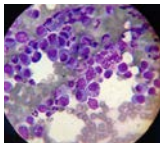
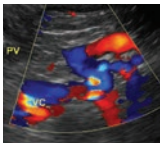

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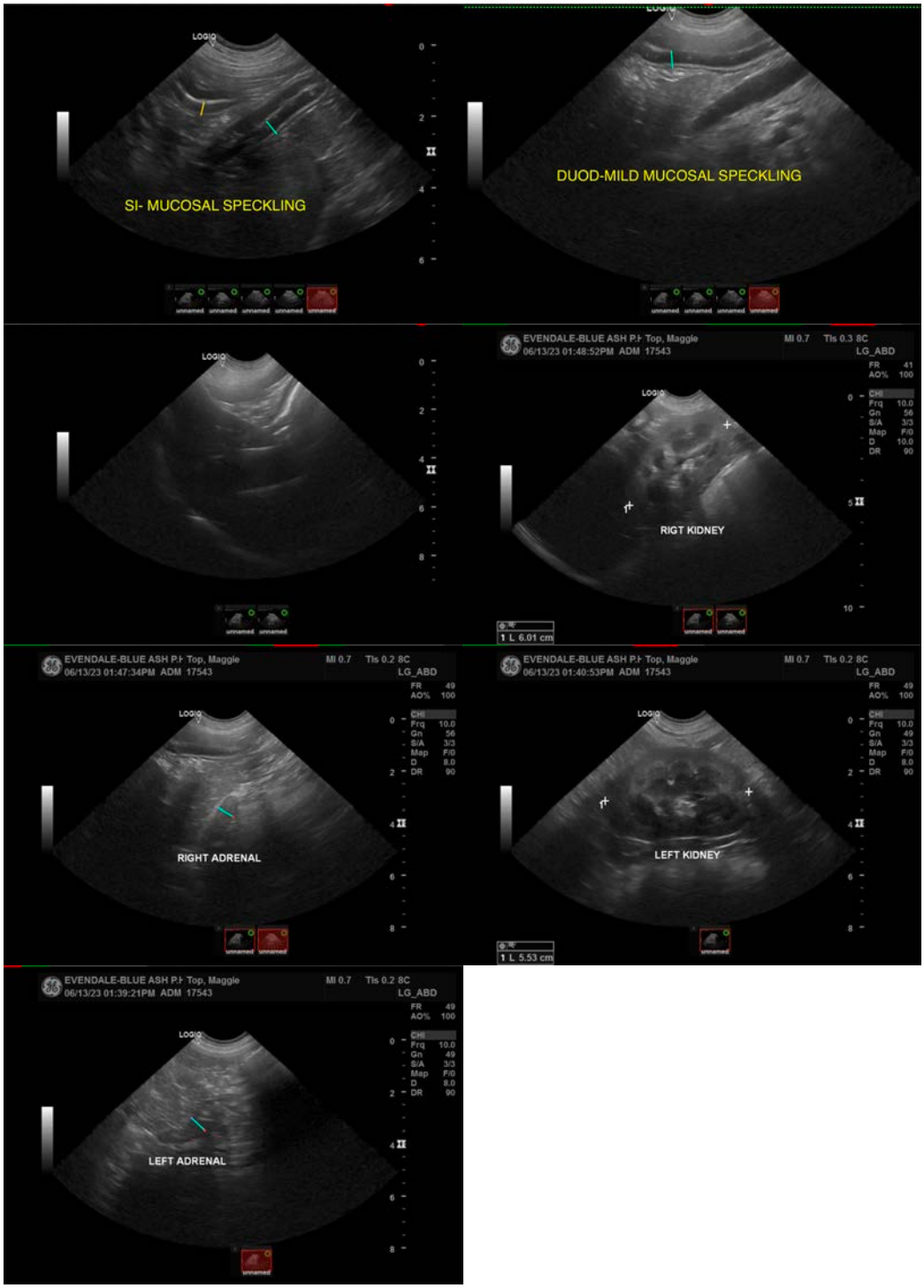

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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) info@sonopath.com