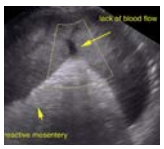
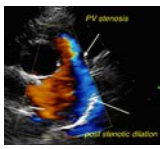
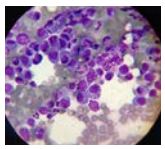
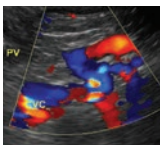
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

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

PATIENT
Rexy Hampel

SPECIES
Canine

BREED
GSD

SEX
Spayed Female

AGE
9 Years

WEIGHT
73.8 Pounds

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

IMAGING PERFORMED BY
Dr. Desen Ertunc

HOSPITAL NAME
Healing Spirit

REFERRING VET
Dr. Desen Ertunc

INVOICE
38484

DATE
6/7/22

PRESENTING CLINICAL SIGNS

Progressive hyporexia and occasional vomiting with mild fever (T=102.6-102.9). Progressive weight loss (7 Lbs in 3 months) Chronic regurgitation, has idiopathic megaesophagus diagnosed years prior. Radiographs revealed no evidence of bronchopneumonia.
Abnormal PE/Chem/CBC/UA Results: PE= T= 102.6 5/21/22: CBC- WBC= 21.4 (6-17), Lym= 0.74 (1-4.8), Neut= 19.5 (3-12), Hgb= 19.8 (12-18), HCT= 58 (37-55), otherwise WNL. Chem- Alb= 2.5 (2.5-4.4), TP= 4.8 (5.4-8.2)

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 (6.39 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 (5.47 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 0.67 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 region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. 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.

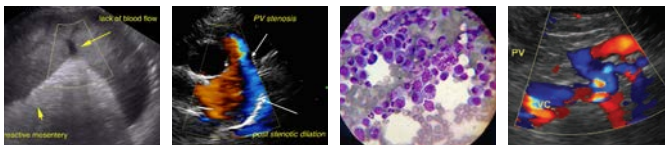
Liver

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

Gastrointestinal

The stomach is moderately dilated with fluid and irregular shadowing material most consistent with normal ingesta and gas. It measures at a normal thickness of <0.7cm with some variability due to the



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presence of rugal folds. The distinction of the gastric wall layering 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 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. The duodenum measured as normal (between 0.3-0.5cm in wall thickness) and the jejunum measured as normal (between 0.2-0.47cm.) 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

- Moderate ingesta within the gastric lumen – correlate with feeding history and abdominal radiographs. Findings could be consistent with a recent meal, delayed gastric emptying, or an outflow tract obstruction (none observed).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

An obvious focal lesion is not observed to explain the reduction in appetite, vomiting and fever reported. There is some persistent ingesta within the gastric lumen. Correlate these findings with abdominal radiographs and the feeding history.

Based on the history, my primary differential would still be pneumonia, based on the megaesophagus history, as these mild recurrent pneumonias are sometimes difficult to identify radiographically initially. If this is thought very unlikely, then you could consider causes for low albumin other than sepsis/infection. This would include protein losing enteropathy, nephropathy, or liver disease, and you could consider a liver function test, evaluation of urine protein/creatinine ratio, and a GI panel to Texas A&M to evaluate a PLI, TLI, cobalamin and folate to look for additional evidence of underlying small intestinal disease.

If vomiting and inappetence continue despite treatment for pneumonia and acute gastroenteritis, then consider serial imaging to look for evidence of retained foreign material, etc., as ultrasound can be insensitive in picking up some types of foreign material.

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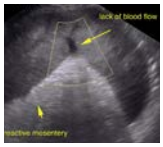
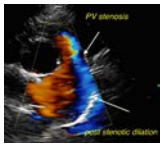
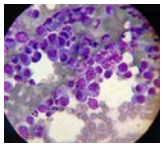
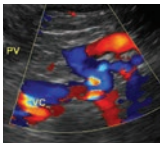

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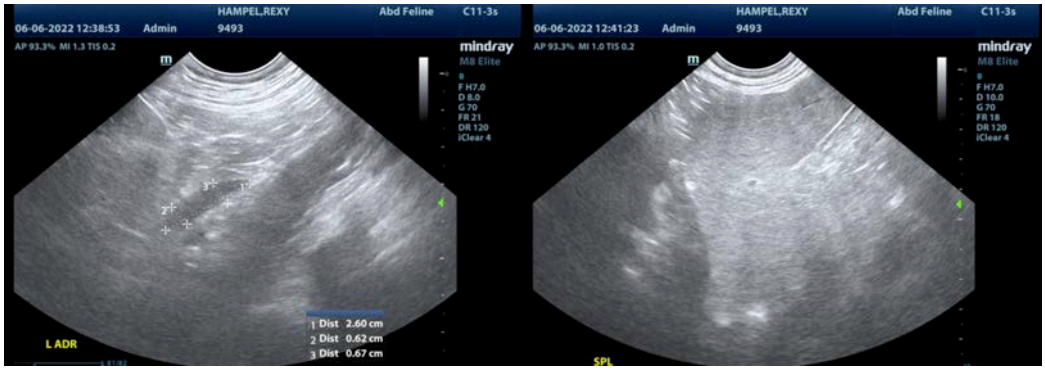

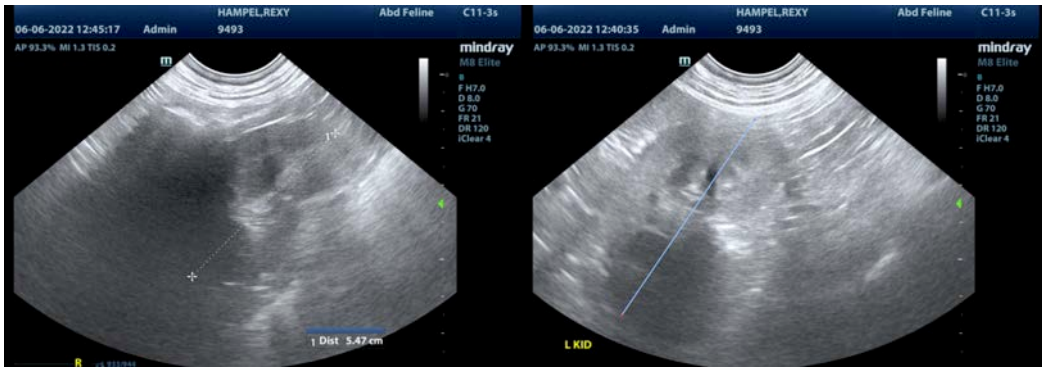

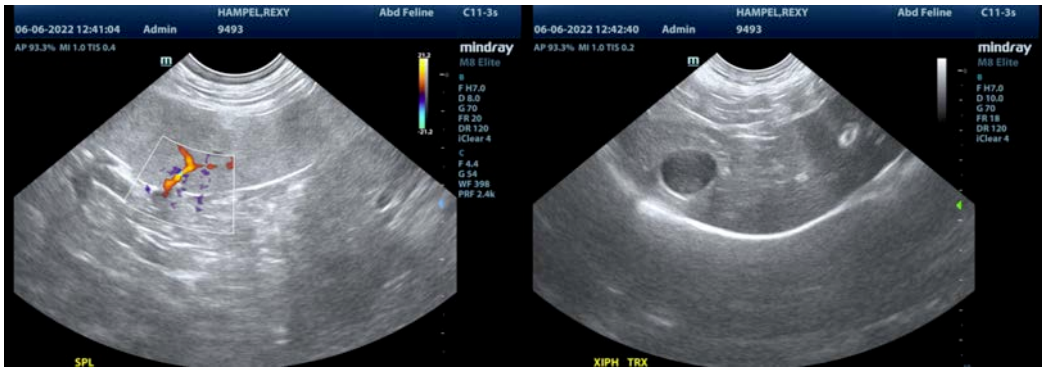

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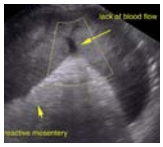
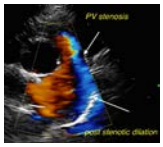
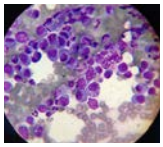
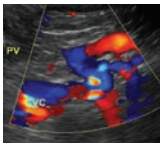

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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