



PATIENT

Apollo Mager

SPECIES

Canine

BREED

Boxer

SEX

Neutered Male

AGE

6 Years

WEIGHT

69 Pounds

INTERPRETED BY

Eric Lindquist, DMV

DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Tam Mengine

HOSPITAL NAME

Stoney Creek VH

REFERRING VET

Dr. Tam Mengine

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DATE

6/9/22

PRESENTING CLINICAL SIGNS

Many year history of vomiting and regurgitating after rapidly eating or drinking. Lateral thoracic rad shows no evidence of megaesophagus. Only occurs a few times a month. Stools have recently been soft (last 3 days), and has lost 3 pounds in last 3 months. No improvement with hydrolyzed diet trial, or prilosec. Most recent lab work was 2/22, and showed creat of 2.0, otherwise unremarkable, no U/A performed. Fecal O&P pending

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 normal in size and shape for this neutered male dog. The parenchyma is homogenous and the external margins are smooth. The prostatic urethra appears normal with no evidence of irregularity, invasion, mass effect or calculi.

The left kidney has a normal shape and size (7.08 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 (7.14 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 0.59 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 0.69 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 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.



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Gastrointestinal

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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 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.

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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 measured 0.50 cm. Jejunum wall measured 0.31 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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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

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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

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Evaluation of the peritoneal cavity did not reveal any evidence of effusion. Occasional mesenteric lymph nodes are visualized, one measures 0.45 cm. The omentum is of normal echogenicity.

ULTRASONOGRAPHIC FINDINGS

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- Moderate ingesta/fluid within the gastric lumen – Correlate with feeding history and abdominal radiographs. If the patient was adequately fasted, then this could indicate delayed gastric emptying or partial outflow tract obstruction (none observed).

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- Visible/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

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Today's scan is relatively normal. No large focal lesions are observed. Unfortunately, there are many causes for diarrhea and weight loss that cannot be definitively diagnosed by ultrasound alone. Initial workup makes a metabolic disease less likely. You could consider screening for Addison's disease and obtaining 3-view thoracic radiographs. If primary gastrointestinal disease is thought most likely, then consider the following:

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- Consider a GI panel to Texas A&M for a qualitative PLI, TLI, cobalamin and folate to obtain more information regarding a possible B12 deficiency, exocrine pancreatic insufficiency, etc.

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- Consider chronic probiotic therapy.

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- Consider parasite testing and empirical therapy (if not already done). If there is no response to dietary management and general therapy, then consider obtaining GI biopsies.



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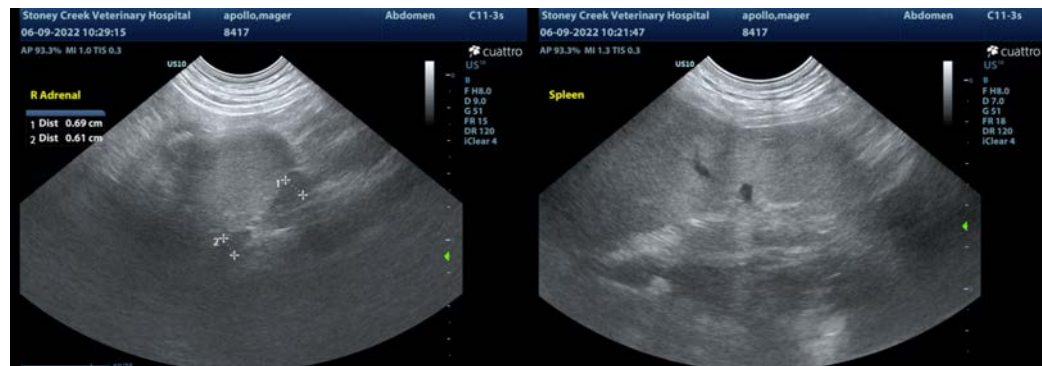
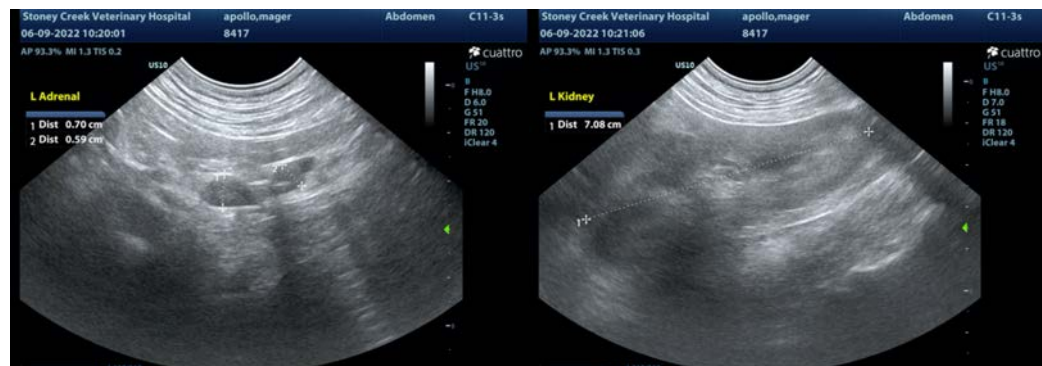
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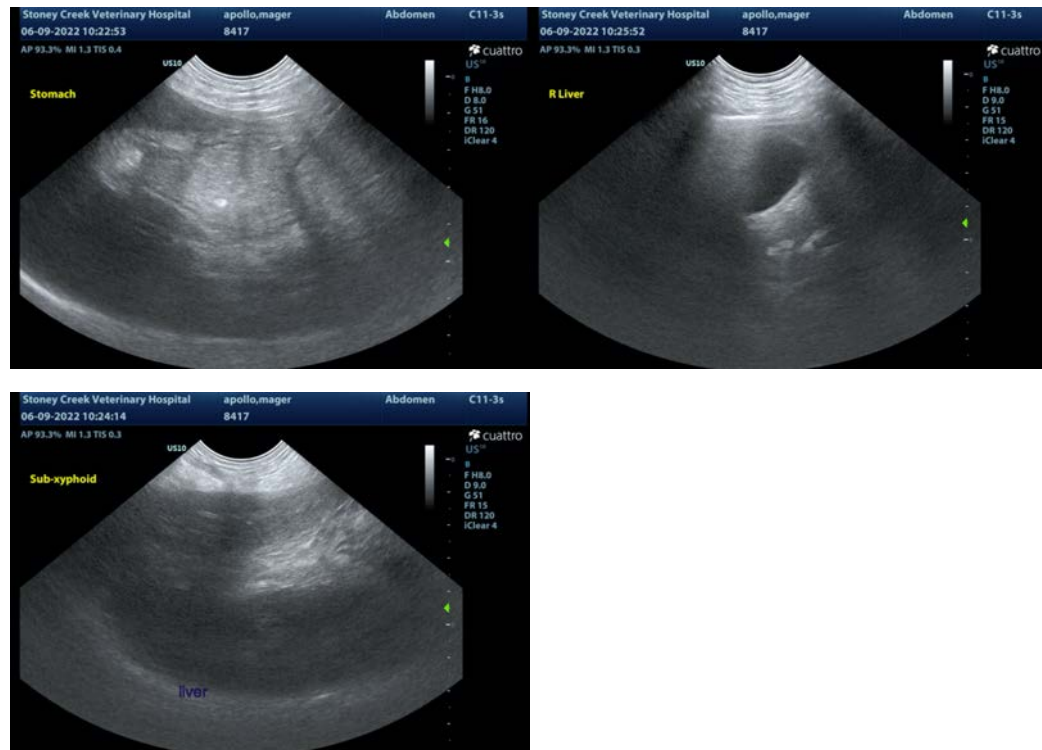
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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