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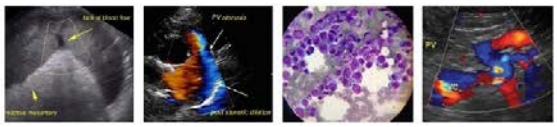

THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Abbie Osmond

SPECIES

Canine

BREED

Cockapoo

SEX

Spayed Female

AGE

7 Years

WEIGHT

8.0 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Haldimand AH

REFERRING VET

Dr. Rode

INVOICE

39474

DATE

7/13/22

PRESENTING CLINICAL SIGNS

History of chronic, intermittent diarrhea since Dec 2021. Has had off and on vomiting episodes as well. Was being fed Gastro Low Fat diet but last few days owner offering anything she will eat. Abdomen feels gassy and uncomfortable, has lost weight. Was started on Metronidazole, Gabapentin and Sulcrate.

Abnormal PE/Chem/CBC/UA Results: Please see attached radiographs. Rads showed loss of detail cranial abdomen. Retics high (207.3) Platelets high 625, CBC comments said polychromasia, platelet and WBC morphology normal. ALP high 229, Spec cPL normal, Fecal negative, 4dx negative

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly 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 (4.01 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 (4.09 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 0.50 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 0.53 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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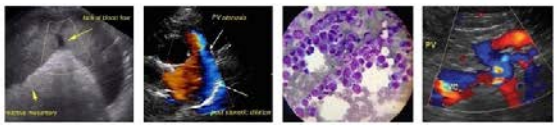

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Gastrointestinal

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 relatively uniform diameter with mild to moderate fluid distension. More distal bowel segments are dilated with echogenic fluid resembling chyme. Wall thickness generally appears mildly increased at 0.28 cm. Bowel loops follow a typical curvilinear path. Some areas have mildly reduced detail of wall layering. Jejunum wall measured 0.28 cm. Duodenum wall measured 0.38 cm. Visualized progressive peristalsis appears reduced in some more dilated areas of bowel. 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 significant fluid dilation with gas and nonformed fecal material. There is no observed focal 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

- Diffuse mild/moderate fluid dilation of the small intestine with subjective thickening and very questionable loss of layering in some areas. Findings are suggestive of generalized ileus and small intestinal disease. Differentials include inflammation, infection, or less likely neoplastic infiltration.
- Diffusely dilated/fluid filled colon – consistent with the diarrhea reported.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The overall impression of the GI tract is that of fluid dilation and possibly a lack of progressive motility/generalized ileus. No obvious obstructions are visualized, but this cannot be 100% ruled out. Correlate these findings with abdominal radiographs. Recommend workup for primary gastrointestinal disease.

- Recommend a GI panel to Texas A&M with a qualitative PLI, TLI, cobalamin and folate to look for further information regarding pancreatic and small intestinal disease.
- Recommend chronic probiotic therapy.
- Recommend a novel protein/hydrolyzed protein prescription diet.
- Strongly consider biopsies of the large and small bowel, particularly if there is no response to dietary management.
- Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.

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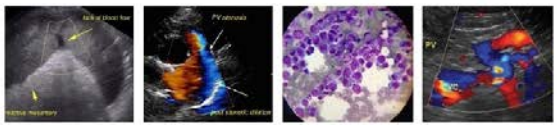

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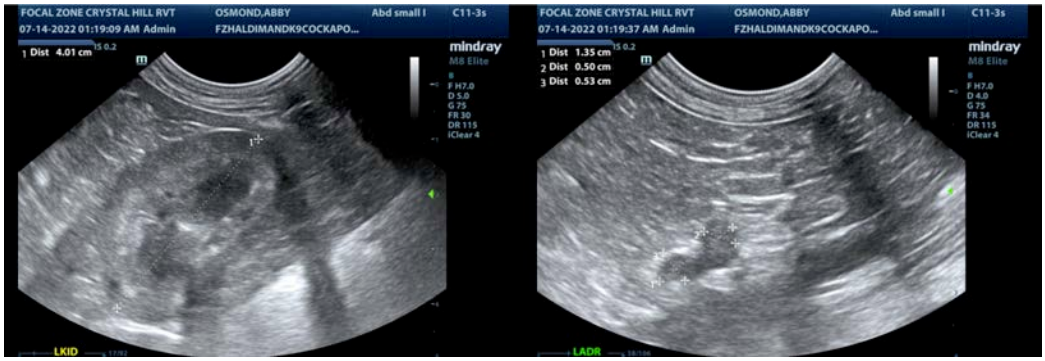

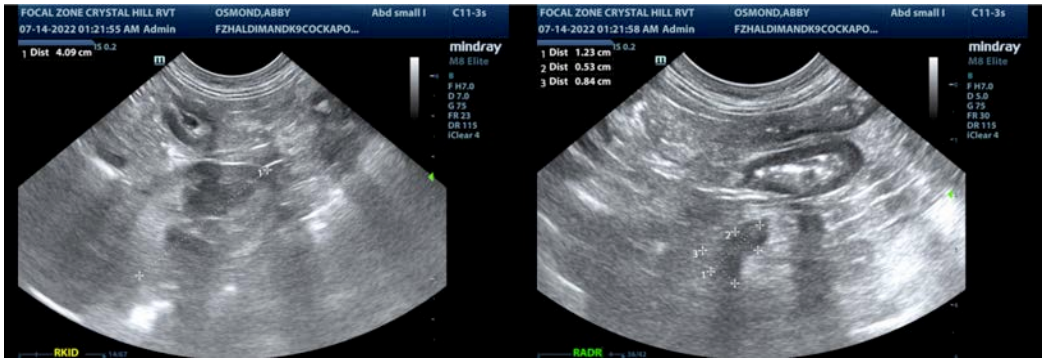

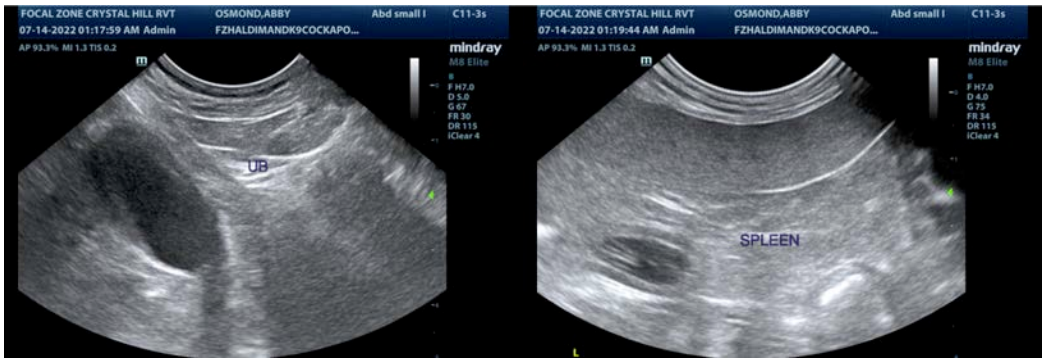

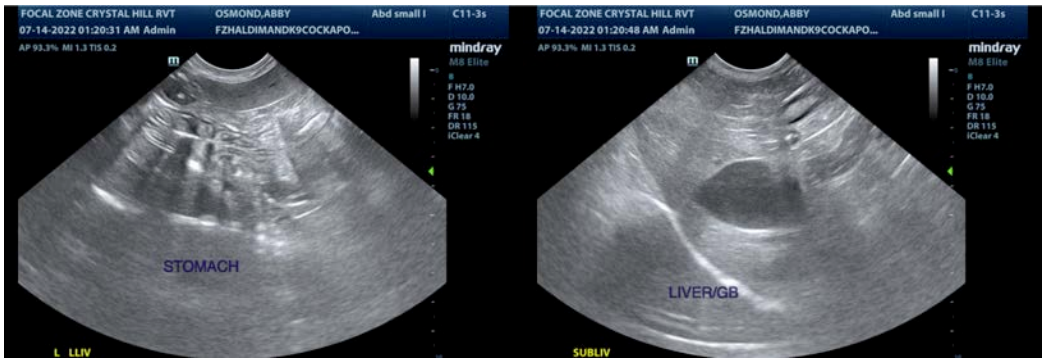

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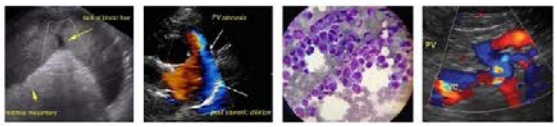

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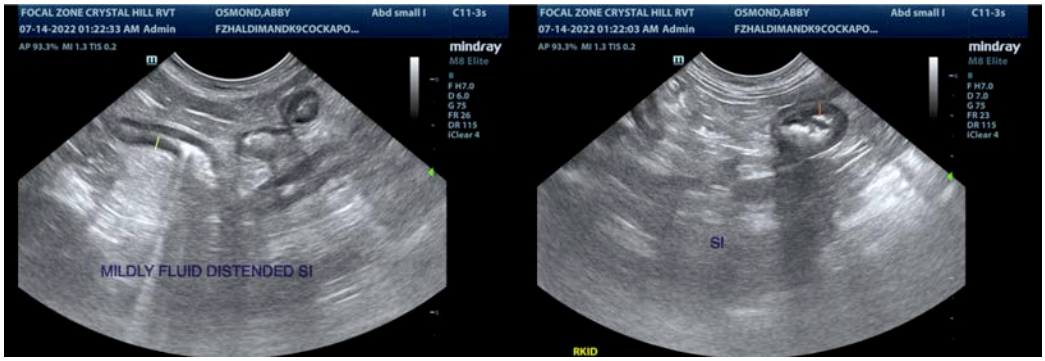

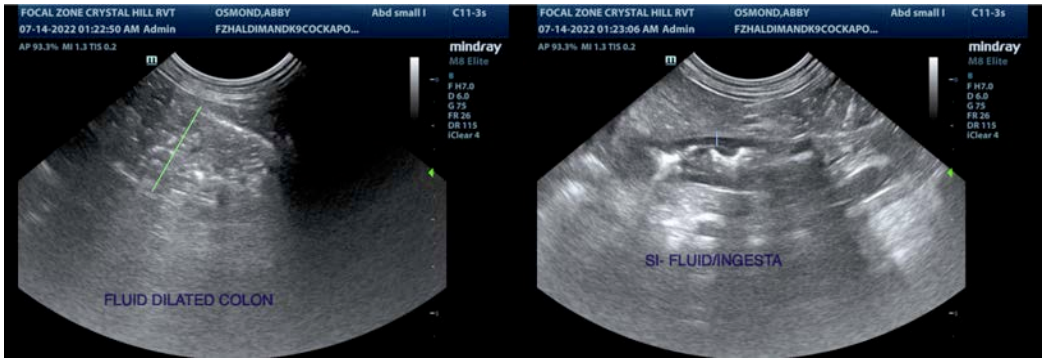

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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