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Clinical Sonography & Telecytology
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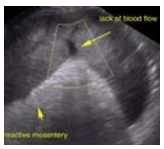
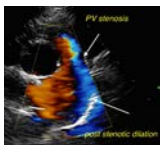
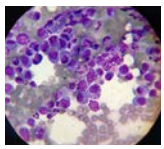
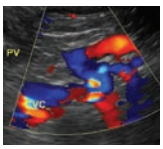





SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Dolly Bartell

SPECIES

Canine

BREED

Chihuahua

SEX

Spayed Female

AGE

7 Years

WEIGHT

10 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Nicole Gotfredson

HOSPITAL NAME

Buffalo Vet Center

REFERRING VET

Dr. Garry Gotfredson

INVOICE

39522

DATE

7/14/22

PRESENTING CLINICAL SIGNS

Referral case, history of pancreatitis

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. 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 (3.4 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 XXcm 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

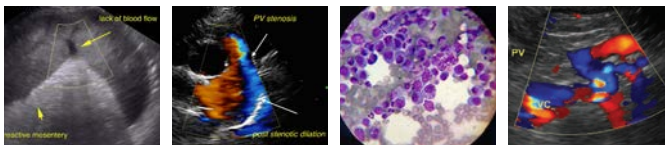
The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

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 contains a large amount of fluid. 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 minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall



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layering maintaining the typical 1:3 muscularis:mucosa layer ratio. Duodenum wall measured 0.28 cm. Jejunum wall measure 0.21 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

- Severely fluid distended gastric lumen – correlate with feeding history and abdominal radiographs. If the patient was adequately fasted, consider such differentials as delayed gastric emptying or an outflow tract obstruction (none clearly visualized).
- Large, heterogeneous liver – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The stomach is severely dilated with fluid. Some areas of the outflow tract are visualized, but I cannot see a clear transition into duodenum. There is minimal duodenal fluid distention, so if an obstruction is present, it would likely be distal pylorus. Correlate these findings with abdominal radiographs. Recommend either gastric decompression via nasogastric tube, or promotility medications with continued monitoring to look for gastric emptying. If dilation persists, consider evaluation for an outflow tract obstruction (endoscopic surgery, etc.).

The distended stomach hinders evaluation of some of the cranial abdominal structures. There is no evidence of an inflamed pancreas visualized, although the degree of clinical signs does not always correlate with the severity of pancreatic inflammation visualized on ultrasound. Correlate with PLI level and recommend medical therapy for acute gastroenteritis/pancreatitis. Serial imaging should be performed every 12-24 hours, or as clinically needed until improvement is noted.

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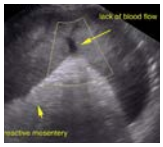
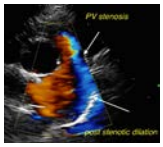
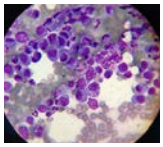
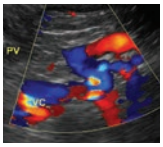

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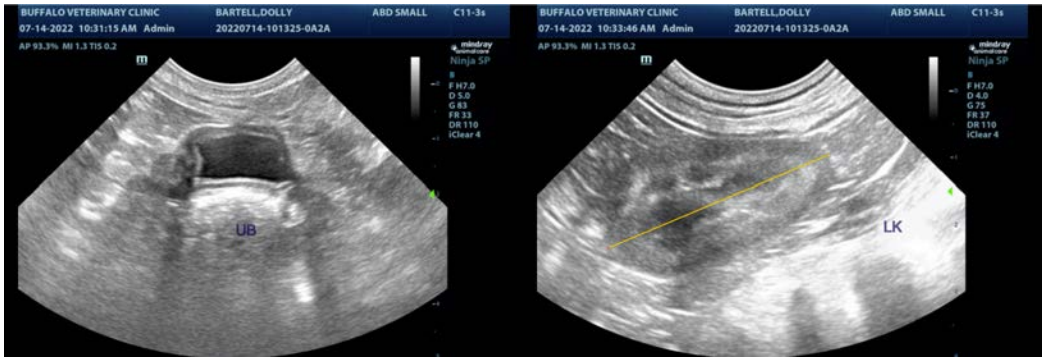

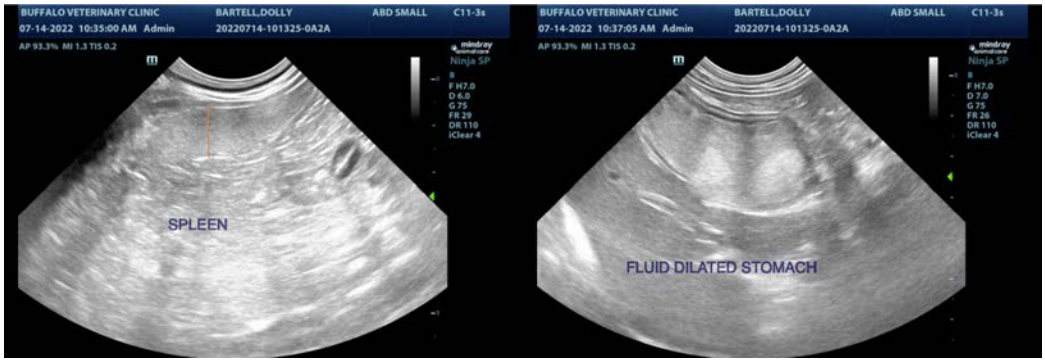

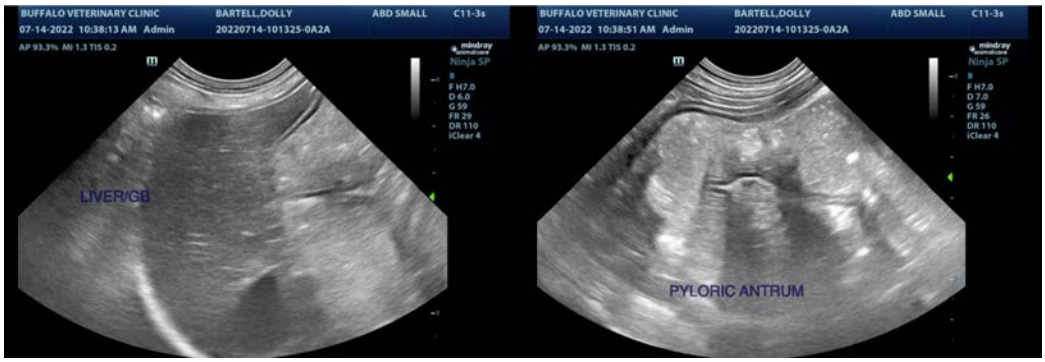

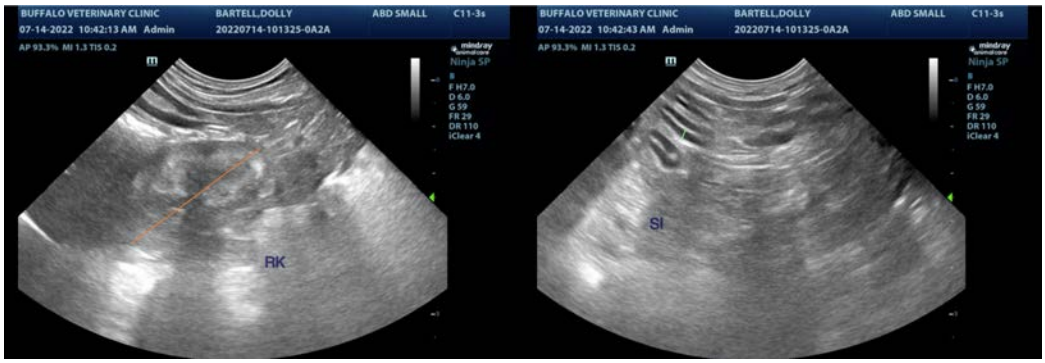

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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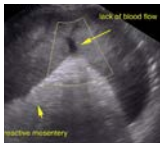
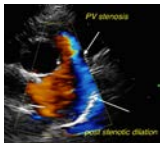
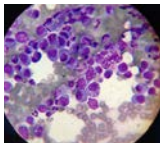
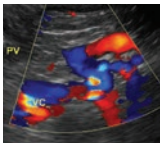

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Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

Eric Lindquist, DMV, DABVP, Cert. IVUSS, CEO of SonoPath.com

info@SonoPath.com