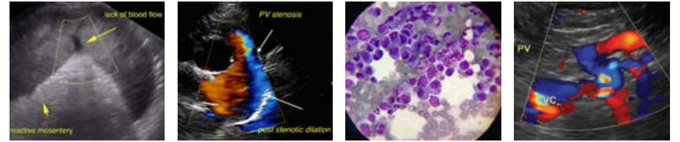
SonoPath
Clinical Sonography & Telecytology

EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Lola Joseph

SPECIES
Canine

BREED
Catahoula

SEX
Spayed Female

AGE
2 Years

WEIGHT
57 Pounds

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

IMAGING PERFORMED BY
Dr. James Hornbuckle

HOSPITAL NAME
Golden Isles AH

REFERRING VET
Dr. James Hornbuckle

INVOICE
39711

DATE
7/20/22

PRESENTING CLINICAL SIGNS

Lola presented for acute vomiting and nausea of 1 days duration. She has a h/o chewing on non food items, but none in recent noted hx. AUS was ordered to further explore the possibility of a FB
Abnormal PE/Chem/CBC/UA Results: Normal PE

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 (5.1 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 (5.7 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 0.46 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 0.50 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.

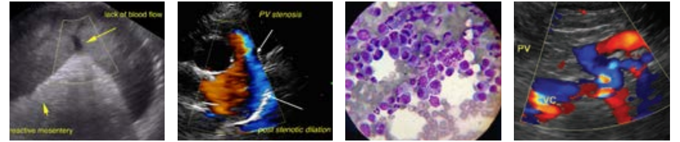
Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is mildly heterogenous in echotexture with subtle, indistinct focal mottling. 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 dilated with a lage amount of 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



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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.

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. Jejunum wall measured 0.40 cm. Visualized peristalsis appears appropriate. There is no evidence of a diffuse obstructive pattern, although there is mild fluid dilation of the proximal small intestine.

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 area of 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

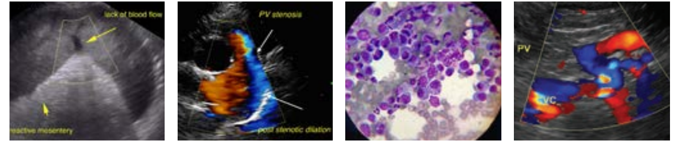
- Distended gastric lumen with ingesta and shadowing material - Correlate with feedings history and abdominal radiographs. If adequately fasted then consider such differentials as delayed gastric emptying or a partial outflow tract obstruction (none visualized).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is no evidence of a severe diffuse obstructive pattern in the small intestine, but the stomach is significantly dilated with ingested material, gas, etc. This material is shadowing and makes full evaluation of the stomach and pyloric region difficult. Correlate these findings with feeding history. If this patient was adequately fasted, correlate with abdominal radiographs, and consider such differentials as ingested foreign material with a partial obstruction, delayed gastric emptying, etc. If a suspicion for ingested foreign material is high, and radiographs support this finding, you could consider exploratory. If an obstruction is not identified, then recommend obtaining GI biopsies.

Additionally, both adrenal glands are somewhat “flat” in appearance. Consider a baseline cortisol or ACTH stimulation test to rule out Addison’s disease.

The significance of the mildly heterogeneous liver is unclear. Correlate with bloodwork results. If liver enzyme values are normal, this is likely incidental. If there are elevations present, consider testing for Leptospirosis. Consider a liver function test and fine needle aspirate.



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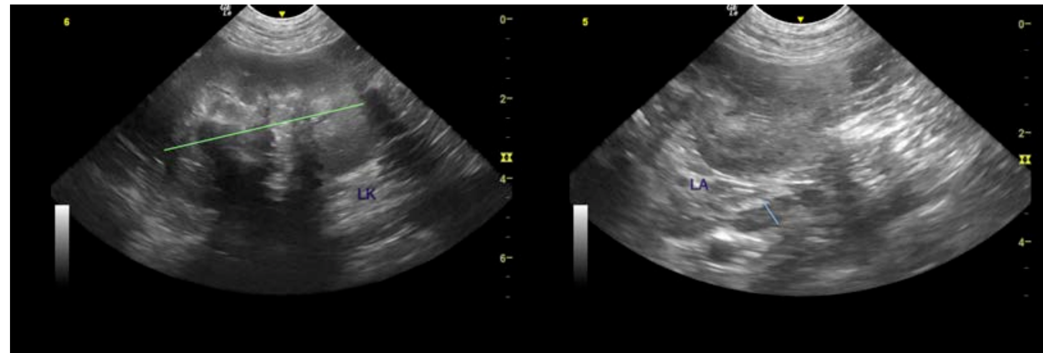

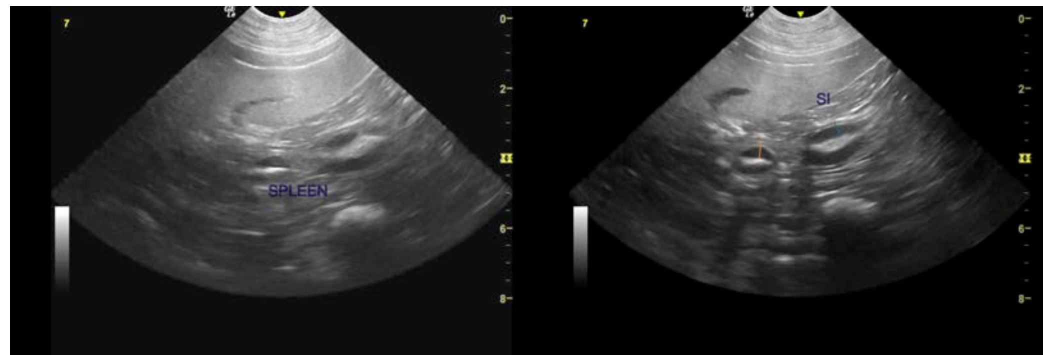

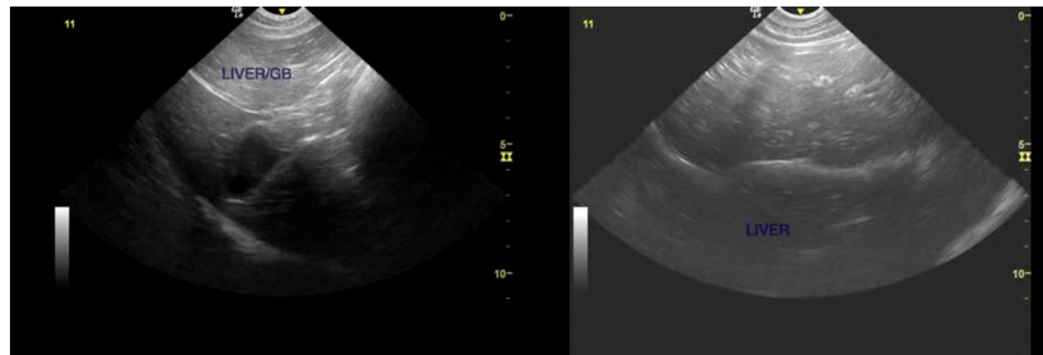

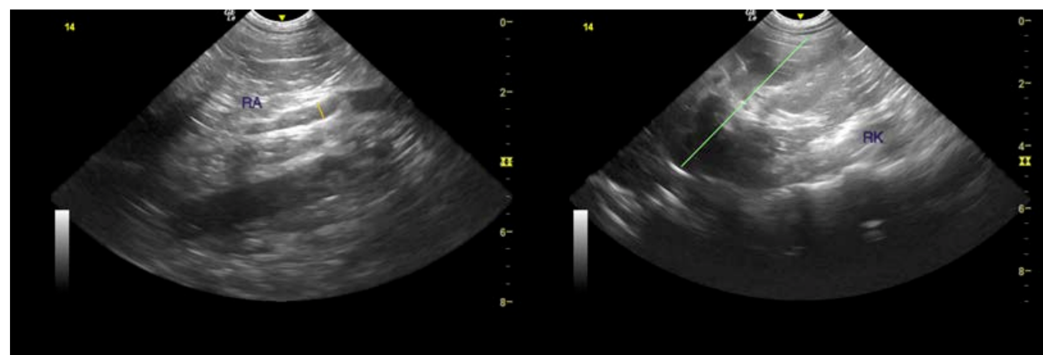

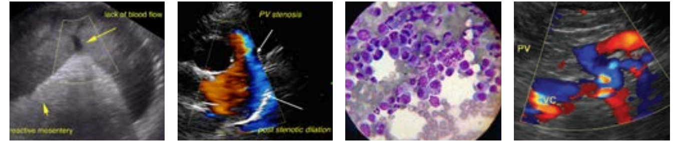

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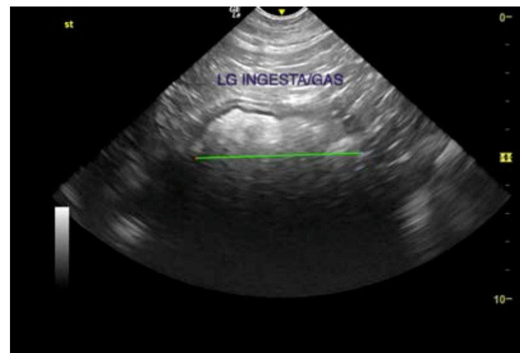

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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