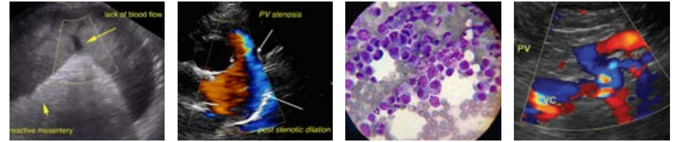
SonoPath

Clinical Sonography & Telecytology

EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Bradley Nicholas

SPECIES

Canine

BREED

Kelpie

SEX

Neutered Male

AGE

6 Years

WEIGHT

51.2 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Saum Hadi

HOSPITAL NAME

Bethany Family PC

REFERRING VET

Dr. Saum Hadi

INVOICE

39227

DATE

7/6/22

PRESENTING CLINICAL SIGNS

P presents for an acute onset of diarrhea (2-3 days) and vomiting (1-2 days). P has maintained a good appetite and has not vomited in the last 24 hours. Diarrhea is more consistent with large intestinal in origin (frequent episodes, small amounts, scant hematochezia, straining). P BAR, did not have breakfast this morning. P has a history of idiopathic epilepsy, managed on KBr. Fecal O&P + Giardia snap + Resting cortisol pending.
Abnormal PE/Chem/CBC/UA Results: Fecal O&P + Giardia snap

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly distended with anechoic urine. The Bladder wall appears mildly irregular diffusely, and measures at a thickness of 0.38 cm. The area of the trigone, ureteral papillae and proximal urethra appear normal with no obvious evidence of mass lesion or calculi. Findings are most consistent with cystitis or lack of urine distention.

The prostate is not clearly seen.

The left kidney has a normal shape and size (4.8 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 (5.2 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 0.44 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.

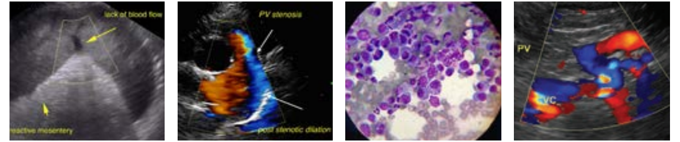
Spleen

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.



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Gastrointestinal

The stomach contains moderate shadowing material. 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 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

There is no free fluid. There is a prominent sublumbar lymph node visualized measuring 0.71 cm in diameter. The omentum is of normal echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Slightly irregular urinary bladder mucosa – The bladder mucosal changes could be consistent with cystitis or artifactual due to lack of adequate luminal distension. Bladder neoplasia cannot be ruled out but is considered unlikely in this patient.

- Shadowing material visualized within the gastric lumen – Correlate with feeding history. If the patient was adequately fasted, then correlate with abdominal radiographs, as this could represent ingested foreign material.

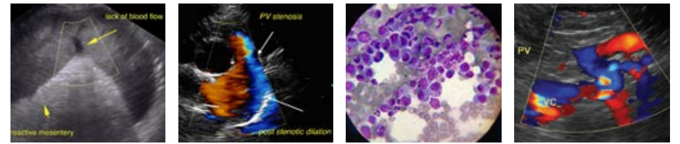
- Mild sublumbar lymphadenopathy – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is some focal shadowing material visualized within the gastric lumen. If this patient was adequately fasted (including medications, etc.), this could represent ingested foreign material. Correlate with abdominal radiographs. There is no evidence of a complete obstruction at this time, and there is no obstructive pattern in the distal bowel. If a foreign object is strongly suspected, and gastrotomy is performed, then recommend obtaining GI biopsies at the time of surgery, regardless if foreign material is identified.

Recommend urinalysis and culture to evaluate the irregular urinary bladder wall.

If diarrhea persists, consider reevaluation of the sublumbar lymph node. This likely a reactive lymph node, but underlying neoplasia cannot be excluded as a possibility.



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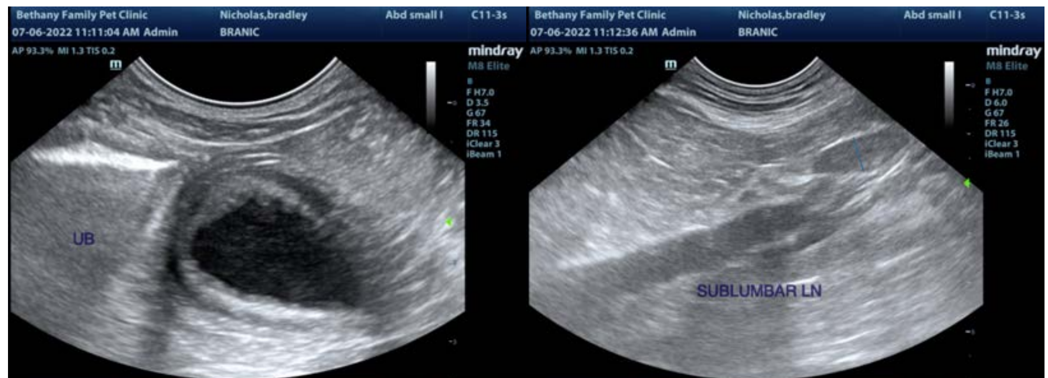

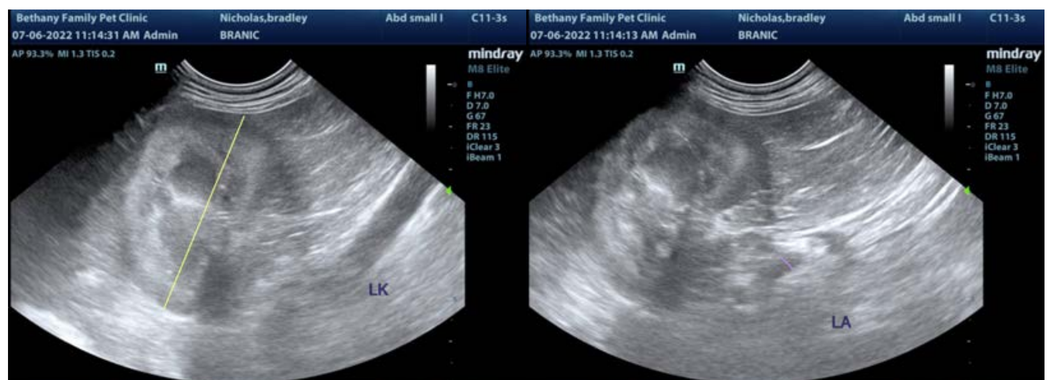

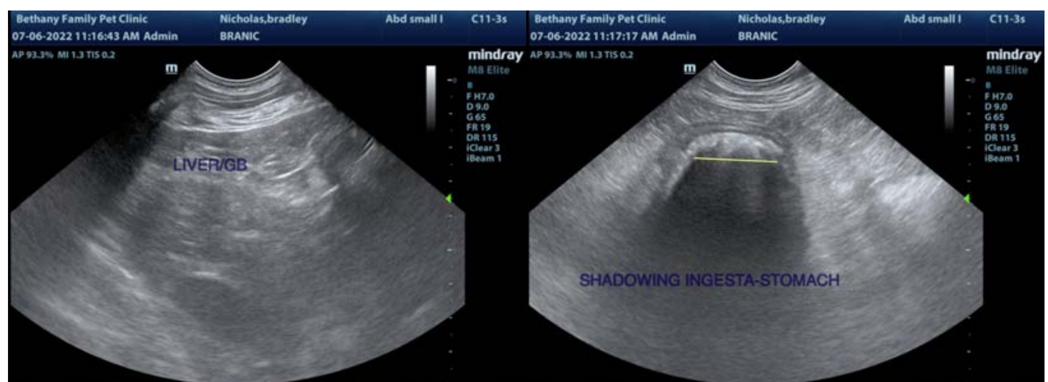

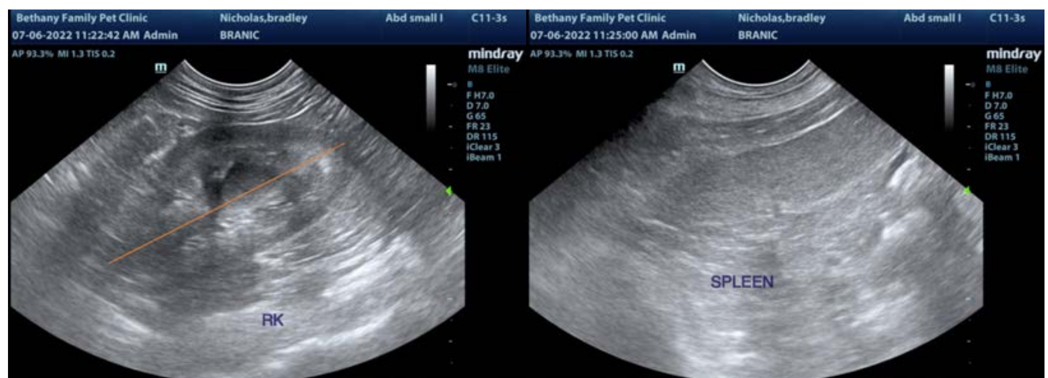

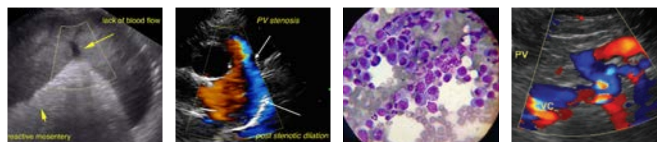

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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