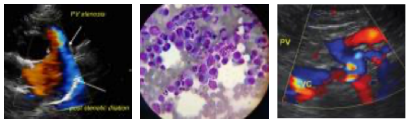
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
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DATE

7.6.2023

PATIENT

Dempsey Black

SPECIES

Canine

BREED

Golden Retriever

SEX

Neutered Male

AGE

5/8/2017

WEIGHT

80.4 lbs

INTERPRETED BY

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

HOSPITAL NAME

Animal Care Center

REFERRING VET

Dr. Beavers

INVOICE

13596

PRESENTING CLINICAL SIGNS

Saw pet in May for coughing, poor appetite, vomiting, abdominal pain. rads and BW performed. rx'd cerenia, gaba, antibiotics; went to ER 6/16 for pain, lethargy, panting. NSF on workup. rx'd pain meds saw again 7/5 tense/painful abdomen, lethargy, intermittent coughing, sent out CBC/T4/chem

Current Medications: was previously on gaba 300mg 1 capsule every 8-12hrs and carprofen 75mg 1 tab BID
Lab Results: inc. WBC; waiting on sent out labwork (CBC, chem, T4)
Radiographs: Prominent spleen.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: IV: Dexdomitor.
Stat Report: Not requested.
Imaging Performed By: Rachel Brilhart, RDMS.

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 (1.10 cm) 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 (6.96 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 (6.48 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 / borderline “flat” at 0.39 cm. 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 / borderline “flat” at 0.51 cm. 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 gall bladder 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 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 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 (0.22 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 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. ‘

Other

The right auricle and pericaridum were visualized and were unremarkable. No obvious pathology is visualized. If cardiac function evaluation is desired a full echocardiogram is warranted.
There is no evidence of any pleural effusion or thoracic mass lesions visualized.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Borderline “flat” adrenals – Recommended screening for Addison’s disease.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No significant lesions were visualized on today’s exam to explain the symptoms reported. If not already done, recommended three-view thoracic radiographs and screening for Addison’s disease. Unfortunately, there are many causes for underlying GI signs, which cannot be definitive diagnosed by ultrasound alone.

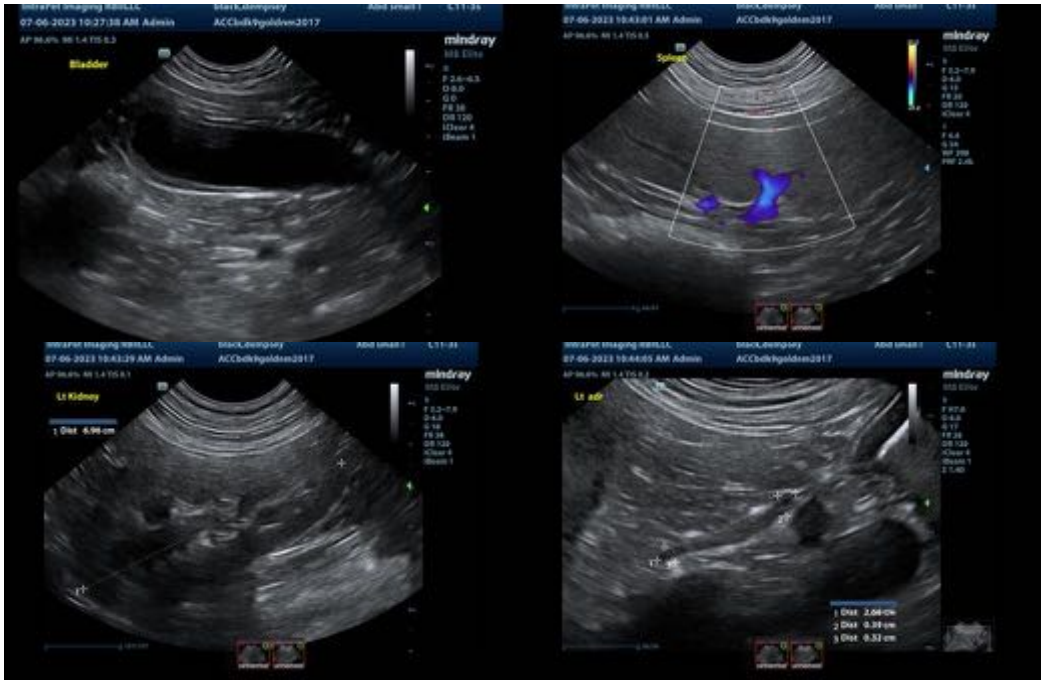
- Consider such differentials as food allergy/dietary intolerance, GI parasitism, pancreatitis, dysbiosis, recurrent dietary indiscretion, IBD and less likely neoplasia, etc.

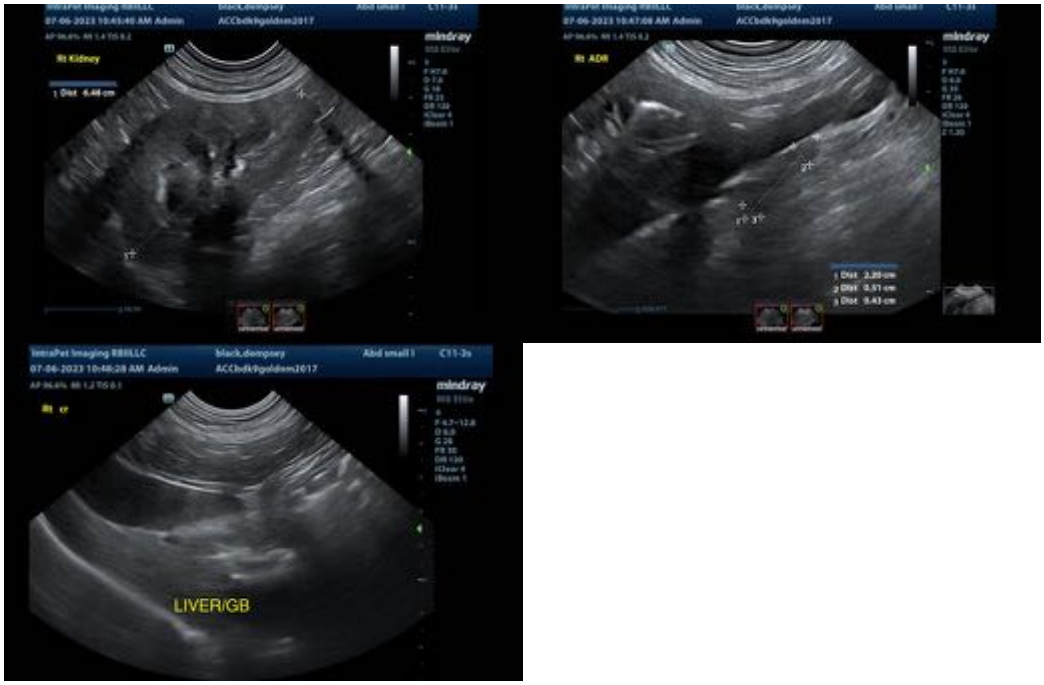
- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks).

- A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

- Recommended chronic probiotic therapy.
- If symptoms are persistent, and primary gastrointestinal disease is strongly suspected, you could consider upper GI endoscopy.

The coughing history is questionable (could this be aspiration pneumonia?). Sometimes this can be hard to diagnose on radiographs if it is subtle. Also, consider the possibility of esophageal disease, etc.





The information and recommendations provided are based on the images presented by the referring veterinarian. 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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