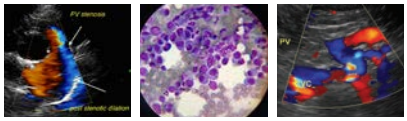
IMAGING PERFORMED BY

IntraPet.com



SonoPath
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DATE

8/15/23

PATIENT

Lolli McCraw

SPECIES

Canine

BREED

French Bulldog

SEX

Spayed Female

AGE

8/8/21

WEIGHT

23 Pounds

INTERPRETED BY

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

HOSPITAL NAME

Animal Emergency Hospital

REFERRING VET

Dr. Martinoli

INVOICE

44656

PRESENTING CLINICAL SIGNS

Previously visited on the 5th Vomiting more over the 24 hours yellow, phlegm and constant Owner concerned not fully recovered from her UTI and does not want to force the pills on her empty stomach and being lethargic ate for 2 days when she left here - small amount of wet dog food and regular food stopped eating- ate a few carrots vomiting started Saturday and was all day. Monday - Friday no vomiting but decreasing appetite. Owner gave chicken for one day and only liked it for one day. tried to give it again and she was not interested. Owner is concerned about the cough. Started before the vomiting. Coughing is new and concerned it could be viral. Eating/drinking: drinking normal, not eating Very lethargic
Feces: Owner has not seen her poop for days. Before coming previously had diarrhea

Current Medications: Unasyn, Ondansetron.
Lab Results: CBC/Chemistry/Urinalysis – NSF.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
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 left kidney has a normal shape and size (4.87 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal 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 (5.12 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal 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 m 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 0.57 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 mild and 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 to mild 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. Duodenum wall measures 0.49 cm. Jejunum wall measures 0.32 cm. Visualized peristalsis appears appropriate. The duodenum is slightly prominent with mild fluid distention.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized and appear mostly empty with some gas shadowing distally. The distal portion of the colon wall appears slightly thickened with intact wall layering, measuring 0.35 cm.

Pancreas
The right limb of the pancreas is prominent and mottled compared to the surrounding isoechoic 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. There are prominent lymph nodes visualized. There is a sublumbar lymph node near the colon measuring 1.26 cm x 0.68 cm. Additionally, there are lymph nodes at the mesenteric root. One such lymph node measures 1.08 cm x 1.03 cm. The omentum is generally of normal echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Prominent, mottled right limb of the pancreas with a mildly fluid distended duodenum – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation. The changes in the duodenum are likely secondary to mild duodenitis.

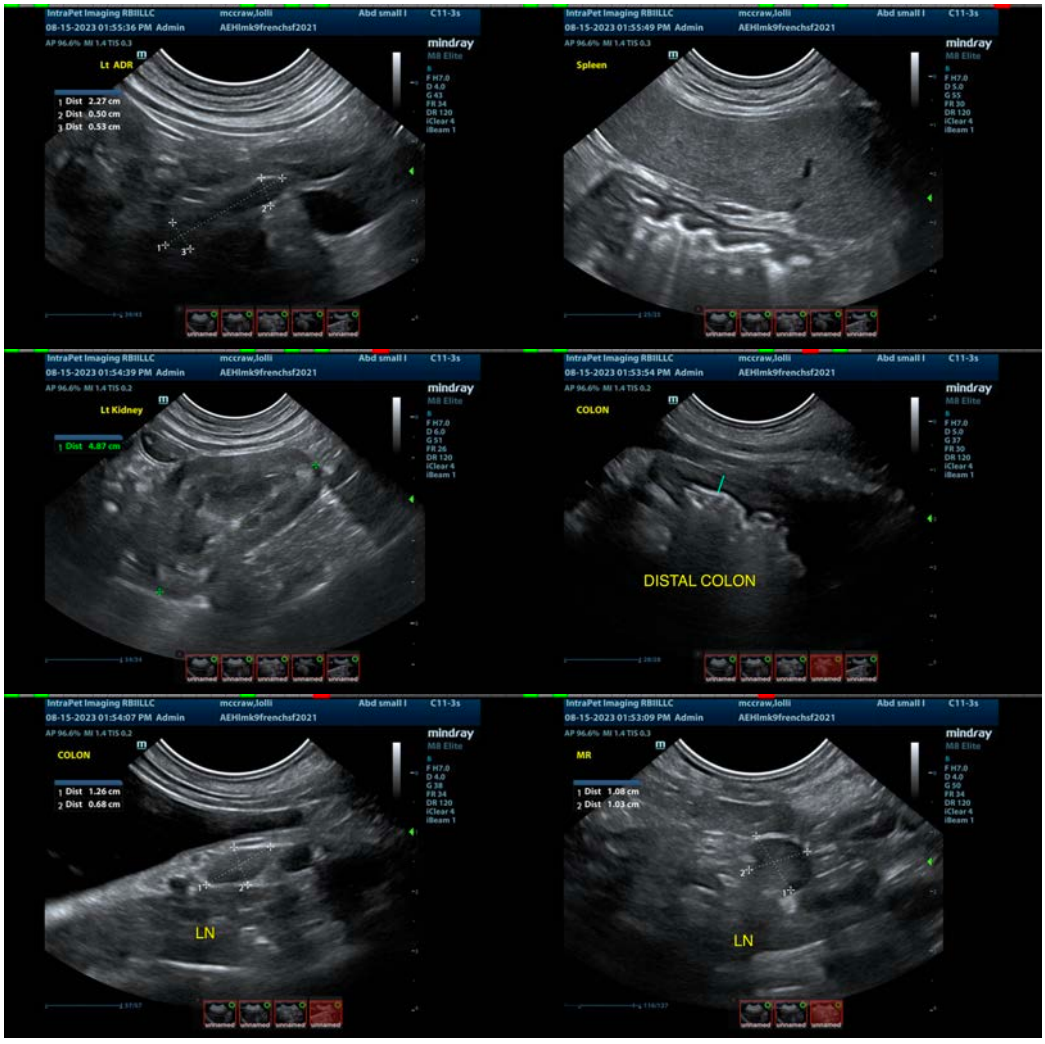
- Thickening of the distal colon wall with intact wall layering – Findings are most consistent with inflammation. Infiltrative disease is thought less likely.

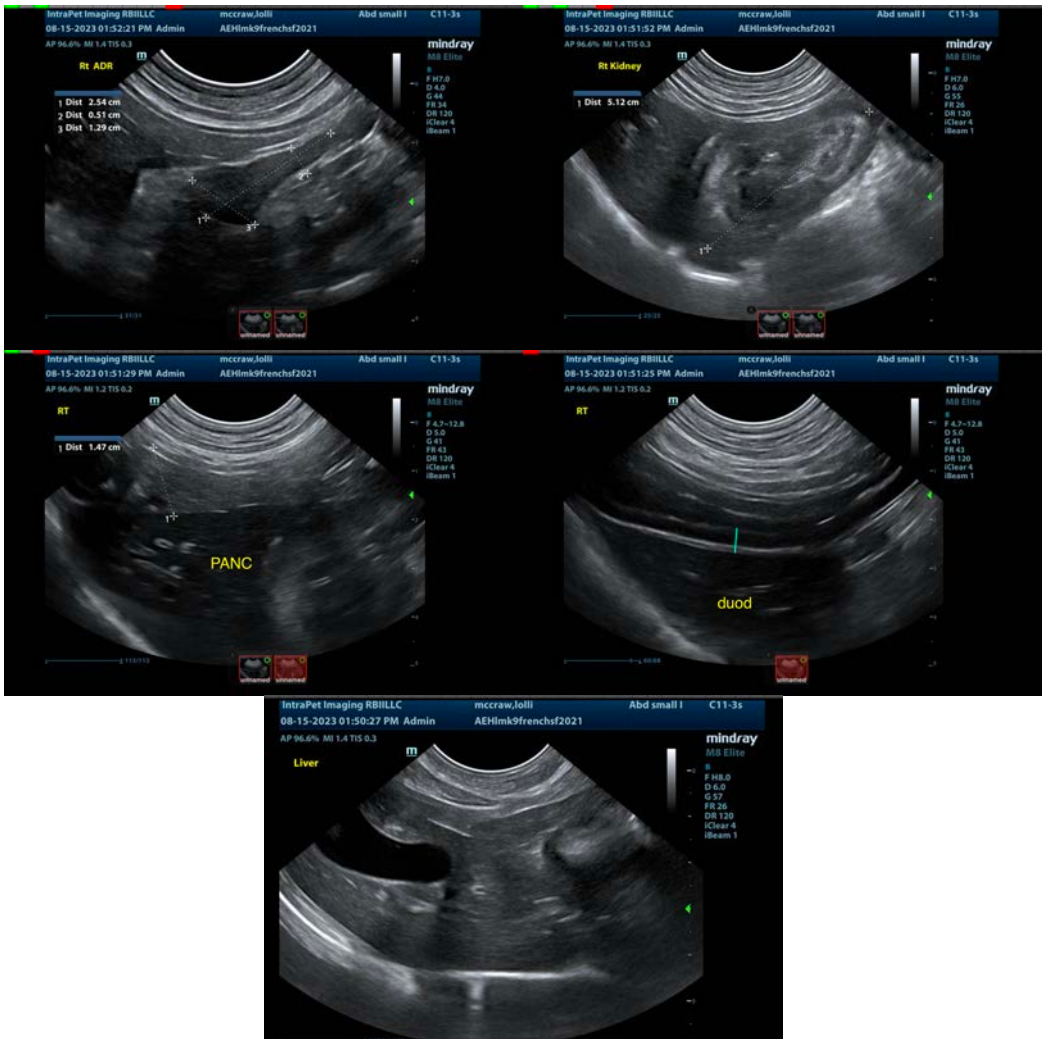
- Prominent sublumbar and mesenteric lymph nodes – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal lesions are visualized associated with the gastrointestinal tract to explain the GI signs reported, although there is some evidence of generalized inflammation, gastroenterocolitis, etc. Possible differentials would include dietary indiscretion, pancreatitis, GI parasitism, food allergy, dysbiosis, less likely IBD or intestinal neoplasia. Given the history of oral antibiotics, dysbiosis could be considered. Additionally, I would correlate findings with a quantitative cPLI level, as the pancreas is somewhat prominent.

Recommend empirical treatment for gastroenterocolitis/pancreatitis. Additionally, consider 3-view thoracic radiographs (if not already done) to evaluate the cough reported. If symptoms are persistent, consider serial imaging (radiographs +/- ultrasound). Additionally, upper GI endoscopy could be helpful.





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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