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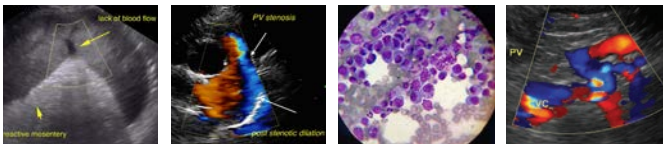

PATIENT

Chloe Seidner

SPECIES

Canine

BREED

Labradoodle

SEX

Spayed Female

AGE

8 Years

WEIGHT

13.2 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Scott

HOSPITAL NAME

Ho Ho Kus VH

REFERRING VET

Dr. Scott

INVOICE

24999

DATE

8/27/21

PRESENTING CLINICAL SIGNS

Hx of addison's disease- is on pred and florinef. Had pyoderma that a diff vet treated with a cephalosporin --> towards the end of the course she started to have GI signs- vomiting/anorexia/diarrhea --> went to AERA they checked BW (normal) and did antinausea --> Went home and she was breathing heavy that night --> back to AERA and poss of asp pneumonia or artifact on xray --> did better the next day then declined again that night --> came here yesterday recheck rads WNL no evidence of pneumonia at all, gave fluids cerenia, pepcid- ate chicken well last night but then this morning had GI sounds and was lethargy again and wheezy breathing
Abnormal PE/Chem/CBC/UA Results: Vetscan WNL on the 25th. recheck bw pending now chest rads WNL Normal PE besides diarrhea

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 (3.9 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 (4.16 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 region of left adrenal (Cranial to left renal artery) is unremarkable but the adrenal is not distinctly visualized. 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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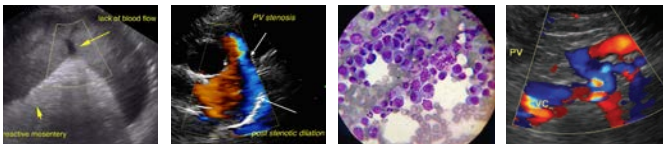

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Gastrointestinal

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. Jejunum wall measured 0.30 cm. Visualized peristalsis appears appropriate. No focal bowel lesions are observed, but there are areas where the small intestine appears somewhat bunched and corrugated, and the mesentery around the small intestine appears very inflamed. No bowel dilation is 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 prominent and hypoechoic as 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, 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 generally of increased echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Hypoechoic pancreas surrounded by hyperechoic mesentery – could be consistent with pancreatic inflammation, but subjectively the inflammation visualized in the bowel does not appear localized around the pancreas. This could be either primary pancreatitis or pancreatic inflammation secondary to the inflamed surrounding tissues.

- Hyperechoic omentum – the mesentery in the abdomen appears very inflamed. A source of this inflammation is not readily apparent.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No specific lesion is observed, which explains the symptoms described. The mesentery appears very inflamed and hyperechoic. This could be due to pancreatic inflammation, but subjectively the inflammation does not appear centered around the pancreas. Correlate with abdominal radiographs to look for evidence of foreign material or an obstructive pattern. Some of the bowel loops appeared somewhat corrugated and inflamed, but a clear obstruction was not visualized.

When I think of difficulty breathing and a normal chest radiograph, consider upper airway sources, a pulmonary embolism, or acid based derangements. Additionally, some breathing patterns can be due to pain, etc.

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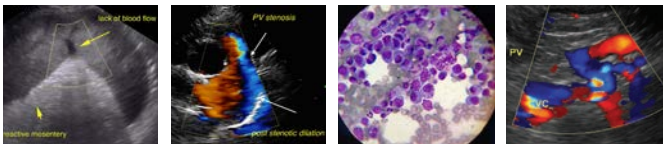

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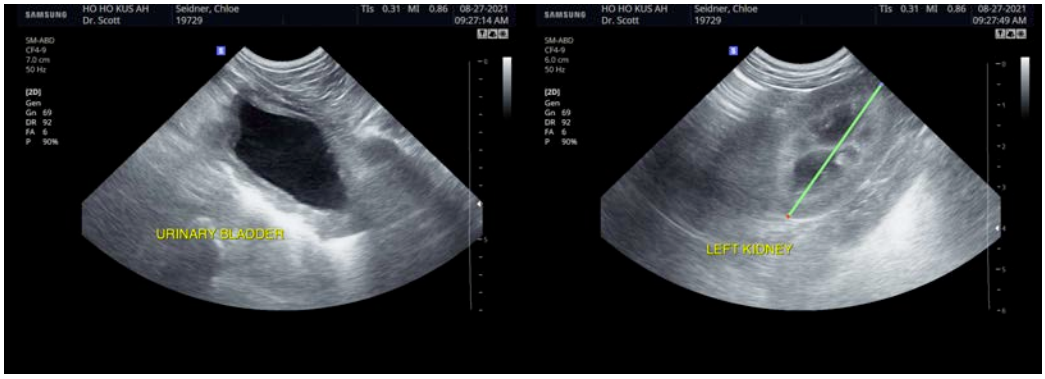

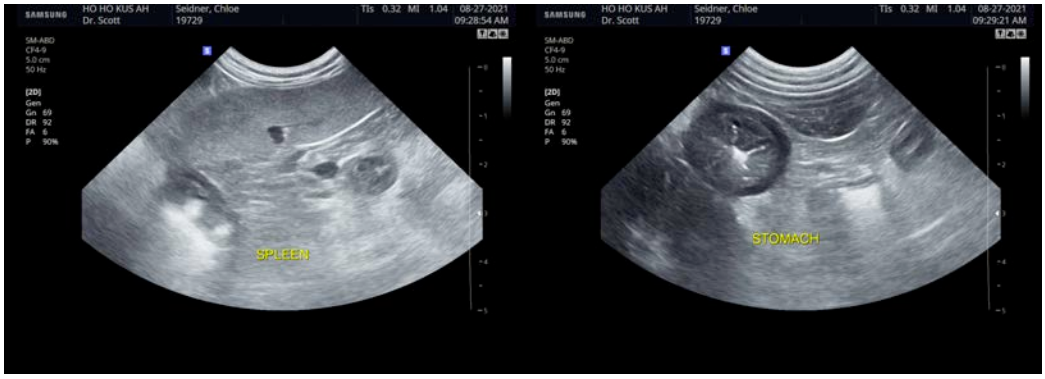

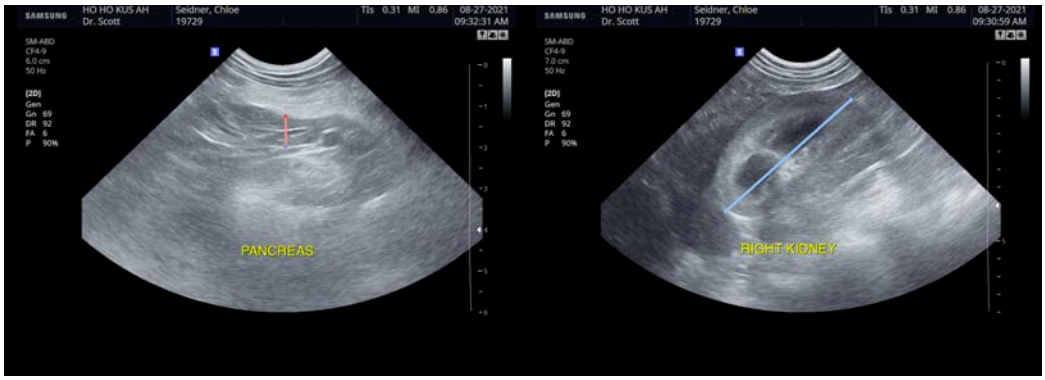

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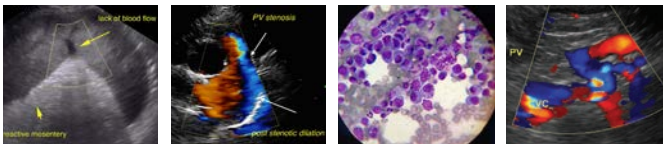

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
kathleen.sennello@sonopath.com