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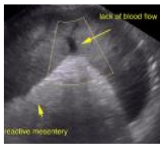
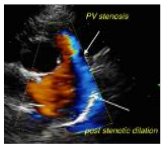
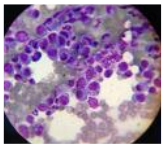
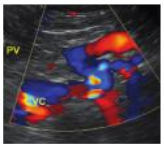

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1-800-838-4268 info@sonopath.com

PATIENT

Hershey Vargas

SPECIES

Canine

BREED

Pomeranian/Mixed

SEX

Male

AGE

15 Years

WEIGHT

3.5

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY

Dr. Kim

HOSPITAL NAME

Ridgefield Park AH

REFERRING VET

Dr. Kim

INVOICE

20537

DATE

1/13/23

PRESENTING CLINICAL SIGNS

History: Patient presents to the hospital due to vomiting or regurgitating, inappetence and urinary incontinence that started on Wednesday. Patient is still drinking water normally but not acting himself. He passed a hard stool during PE. Severe muscle wasting and weight loss noticed (lost 1lb within the past month)

*The submitted study contained 25 still images and 8 videos for review.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone and cystourethral junction exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted. No overt evidence of medial iliac or sublumbar lymphadenopathy.

The prostate exhibited subjective mild enlargement (1.3 cm in diameter) with mild irregular prostatic capsule contour and nonhomogenous parenchyma. No obvious evidence of prostatic abscess or parenchymal mineralization.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. Focal areas of nonobstructive medullary mineral were noted. The left kidney measured 2.6 cm in length. The right kidney measured 2.8 cm in length.

Adrenal Glands

The bilateral adrenal glands were overtly normal in size. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The left adrenal gland measured 0.34 cm. The right adrenal gland measured 0.38 cm.

Spleen

The spleen was subnormal in size, consistent with volume contraction. The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to benign parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion.

The gallbladder was non-distended in size with anechoic content and moderate congealed yet nonorganized echogenic gallbladder debris without evidence of gallbladder or peripheral gallbladder inflammatory criteria. No evidence of posthepatic obstructive criteria. The cystic and common bile ducts were normal.

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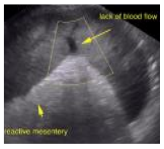
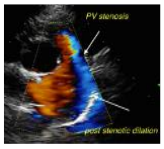
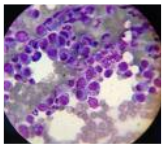
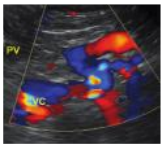

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Gastrointestinal

The stomach presented wall thickening secondary to echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. The stomach contained moderate retained primarily anechoic fluid and nonshadowing variably echogenic ingesta/chyme. No overt evidence of mechanical pyloric outflow obstruction.

The intestinal walls demonstrated intact wall layering and maintained 1:3 muscularis / mucosa ratio. The mucosa exhibited mild decreased echogenicity with occasional mucosal speckling. A minor segmental small intestinal ileus pattern with segmental duodenojejunal corrugation, which may indicate segmental hypermotile or dysfunctional bowel.

Normal visible colon wall layers were present with apparent formed feces in lumen.

Pancreas

The pancreas was normal in size and contour with heterogeneous isoechoic parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

Free Abdomen

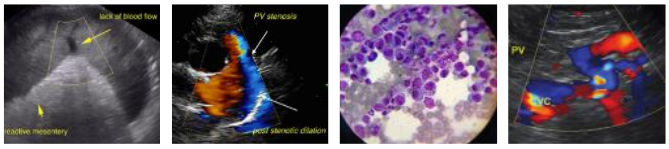
No evidence of omental masses, significant lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Nonspecific mild prostatomegaly- benign prostatic hyperplasia, prostatitis, potential for prostatic neoplastic criteria possible. Further assessment of the prostate would require sampling, i.e., ultrasound guided FNA cytology or prostatic wash for cytology +/- culture and sensitivity.
- Bilateral chronic renal changes with nonobstructive medullary mineral
- Hepatic parenchymal remodeling with moderate congealed nonorganized gallbladder debris (non-mucocele)
- Subjective acute gastroenteritis pattern with gastric hypomotility and segmental small intestinal corrugation
- Mild heterogenous pancreas- no sonographic evidence of significant pancreatitis/pancreatic neoplastic criteria. Potential for chronic pancreatitis is possible.
- Volume contracted spleen

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The hypomotile stomach is suspected to be secondary to metabolic or inflammatory criteria and secondary stasis, although the possibility of non-visualized upper intestinal mechanical obstruction cannot be definitively excluded. Likewise, the possibility of more significant or possible infiltrative gastrointestinal disease or neoplasia, given the weight loss in this patient, is possible. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. Empirically, hospitalization with rehydration protocol, electrolyte supplementation (if clinically indicated), as needed gastrointestinal support with assessment of clinical response and sonographic monitoring for evidence of resolving or persistent gastric stasis. Three-view chest radiographs are suggested to rule out concurrent thoracic or



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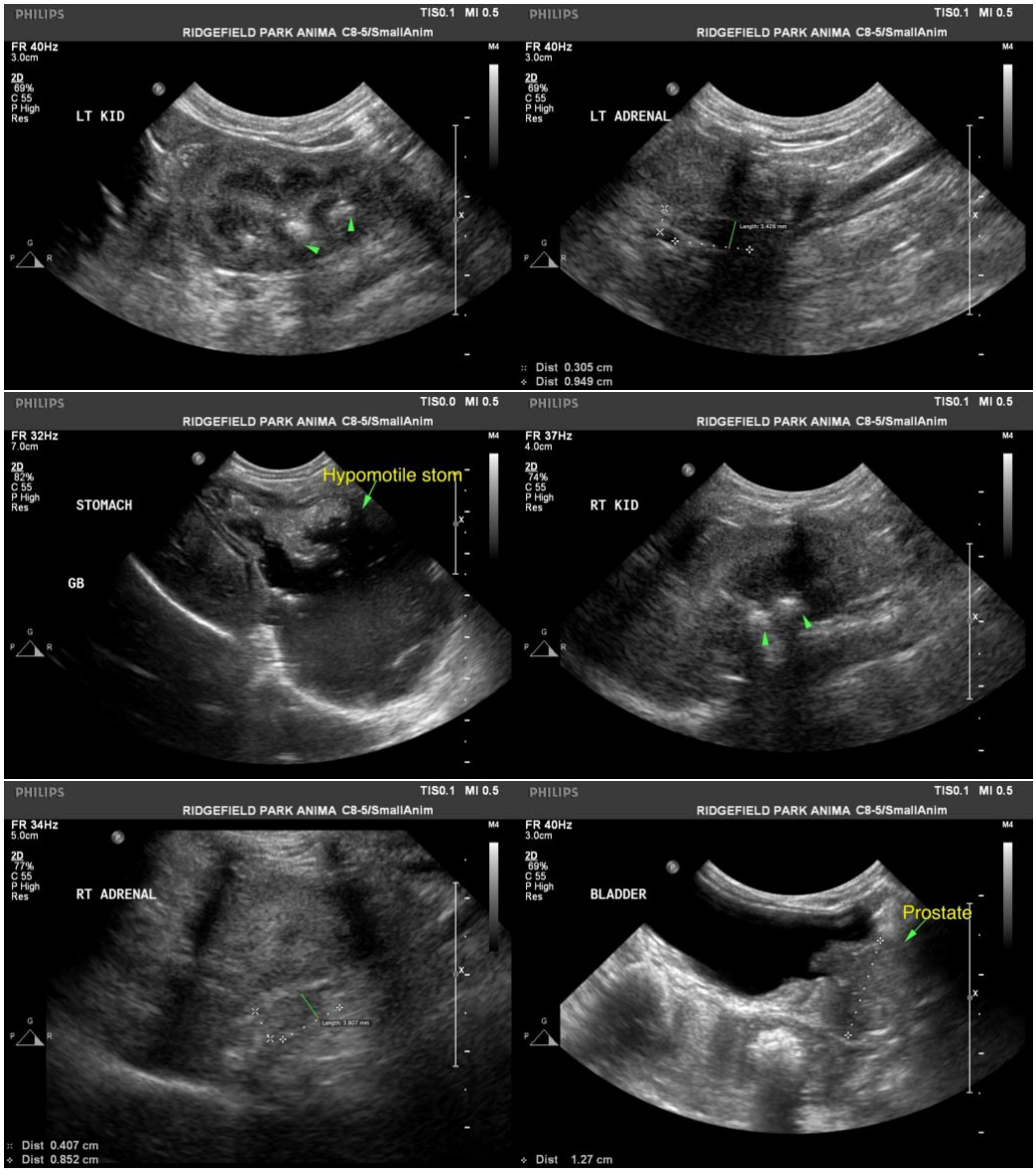
esophageal pathology as a contributing factor to the weight loss. Correlation with full CBC chemistry panel and urinalysis is suggested.



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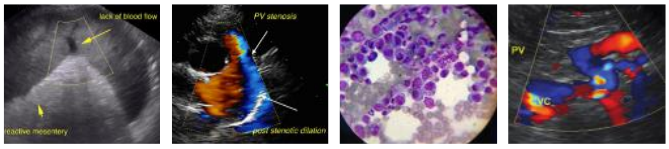

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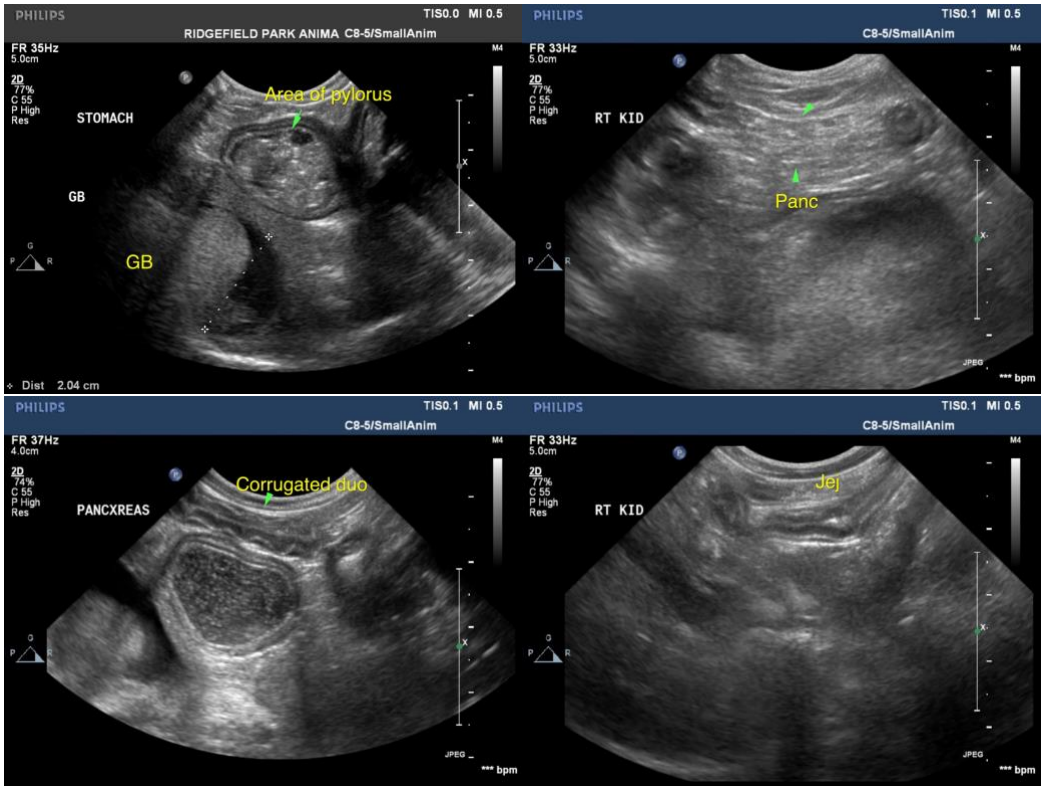

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)
info@SonoPath.com