



PATIENT

Jackson Martin

SPECIES

Canine

BREED

Schipperke

SEX

MN

AGE

13yr

WEIGHT

14.4

INTERPRETED BY

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

IMAGING PERFORMED BY

Carly Pate

HOSPITAL NAME

VCA McKenzie
Animal Hospital

REFERRING VET

Dr. Wayland

INVOICE

12718ag

DATE

01/16/2023

PRESENTING CLINICAL SIGNS

Pet vomited 4 times this morning, bright yellow foamy bile, has been posturing his neck oddly, not eating or drinking, and more lethargic

Abnormal PE/Chem/CBC/UA Results: IH cPL was strong positive, CBC unremarkable, Chemistry Amylase was over 1200, ALP 576, ALB 4.7

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2 cm 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.

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 to moderate loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. Pinpoint areas of medullary mineral were present. The left kidney measured 4.5 cm in length. The right kidney measured 4.0 cm in length.

The area of the aortic trifurcation was free of pathology.

The area of the residual prostate appeared normal and free of pathology.

Adrenal Glands

Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The left adrenal gland measured 0.54 cm width in the cranial pole and 0.65 cm width in the caudal pole. The right adrenal gland measured 0.72 cm width in the cranial pole and 0.42 cm width in the caudal pole.

Spleen

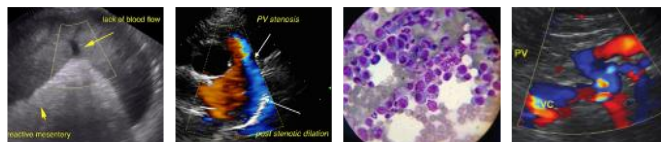
The spleen exhibited areas of capsule asymmetry with generalized mild parenchyma heterogeneity. Previously noted static non-disruptive hypoechoic splenic nodules were present, an example measuring 0.73 cm in diameter. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis.

Liver/Gallbladder

The liver exhibited generalized enlargement, symmetrical capsule contour and mild non-homogenous parenchyma. Evidence of parenchyma remodeling was present. Intermittent variably echogenic non-disruptive nodules were present, an example in the mid ventral liver measured 2.4 cm in diameter. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content with mild non-organized echogenic debris and possible polyps. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented mild to moderate wall thickening secondary to echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. Mild gastric distension with moderate retained primarily anechoic fluid was present.



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The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material.

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

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Pancreas

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

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Free Abdomen

No omental masses, overt lymphadenopathy or peritoneal effusion was present.

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ULTRASONOGRAPHIC FINDINGS

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- Borderline prominent left adrenal gland-suspect benign
- Mild to moderate chronic renal changes with medullary mineral
- Non-specific subjectively static splenic nodules-hyperplasia, hematopoiesis, focal splenitis, small hematoma or similar suspected, potential for emerging neoplastic criteria thought less likely yet cannot be definitively excluded
- Hepatomegaly exhibiting parenchymal remodeling, previously noted variably echogenic nodules
- Mild gallbladder debris-potential for gallbladder polyps-subjectively static
- Heterogenous right pancreatic limb with minor pancreatic duct dilation
- Hypomotile gastritis pattern-overtly normal small bowel

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The strong positive cPL may be reactive owing to primary gastric or upper GI inflammation. Empirical therapy for acute hypomotile gastritis +/- low-grade pancreatitis with assessment of clinical response would be reasonable. No overt evidence of upper GI obstructive criteria. Sonographic reassessment of the stomach and upper GI tract is suggested if persistent/progressive signs of hypomotile gastritis despite empirical therapy.

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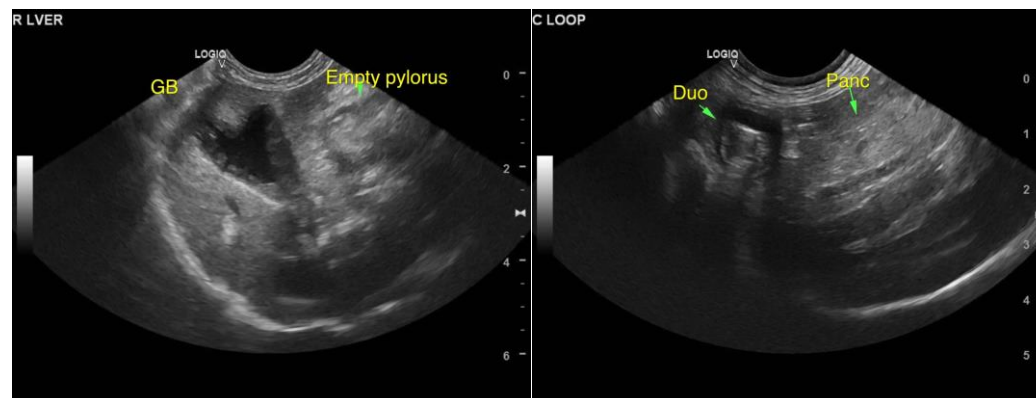
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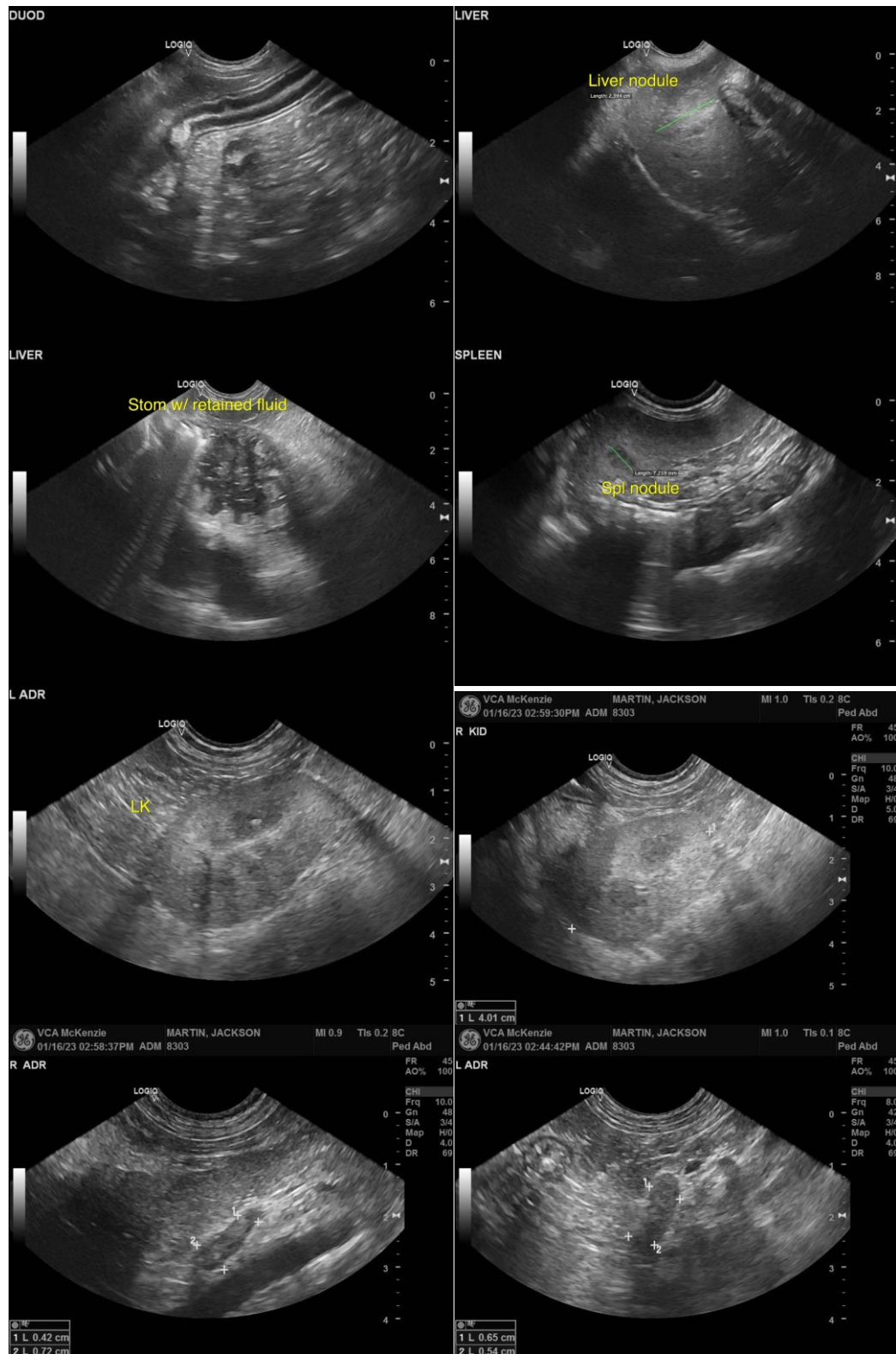
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not



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visible in the image/video clips provided.

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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.

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mac.daniel@sonopath.com

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