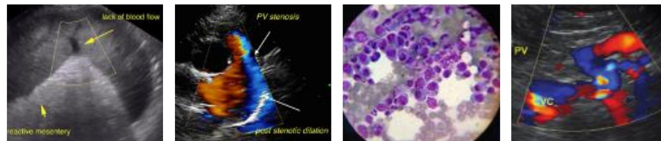

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1-800-838-4268 info@sonopath.com

PATIENT

Jesse Brennan

SPECIES

Canine

BREED

Golden Retriever

SEX

Spayed Female

AGE

10 Years

WEIGHT

81.6 Lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

John Bucha, VMD

HOSPITAL NAME

Harveys Lake VC

REFERRING VET

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INVOICE

13480

DATE

1/18/22

PRESENTING CLINICAL SIGNS

History: Brennan, "Jesse" 10-year-old, FS, Golden Retriever. Presented for vomiting and not eating. This started on December 20, 2021. Currently only drinking water and eating ice. If she eats anything else she will vomit. Not our regular patient, we only performed an ultrasound. Treated with Metronidazole and Cerenia pills by regular veterinarian (RV). Has been seen by multiple veterinarians. Completed lab work appeared relatively normal (done by RV). Jesse is still alert and active; she lost 10# within the last few weeks. 1-14-22 83#, 1 month ago: approx low 90's lb as per owner. Thank you, John Bucha VMD

Abnormal PE/Chem/CBC/UA Results: Abnormal bloodwork RDW 23.7 (13.6-21.7%) RETIC-HGB 18.7 (22.3-29.6 pg) MPV 14.2 (8.7 - 13.2 fl) all other bloodwork - Within normal limits

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of – cm exhibited normal thickness and tone. Mild asymmetrical luminal surface to micropolypoid changes were present likely associated with age related mural changes, primarily in the ventral apical to dorsal apical urinary bladder wall. An example measured 0.7 cm in diameter. Very minor particulate nondependent sediment was present and primarily anechoic urine. No calculi were noted. 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 loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 6.5 cm in length. The right kidney measured 6.4 cm in length.

Adrenal Glands

The left and right adrenal glands were not definitively visualized.

Spleen

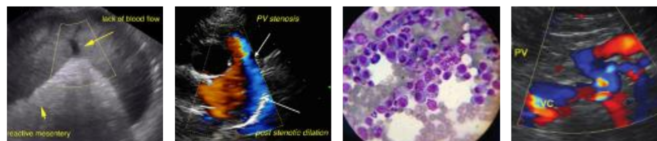
The spleen exhibited primarily finely textured parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Mild generalized parenchyma heterogeneity was present without evidence of nodular changes. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. The parenchymal heterogeneity is likely consistent with benign changes such as extramedullary hematopoiesis or age-related remodeling with minor potential for inflammatory or neoplastic disease.

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 thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal



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The stomach exhibited intact and sonographically unremarkable wall layering with moderate gastric distention secondary to retained anechoic to mildly echogenic fluid. Fluid distention continued into the likely upper to mid small intestine.

Focal intussusception was present in the nonspecific small intestinal segment with jejunal location considered most probable. Empty and sonographically unremarkable small intestine was noted likely distal to the intussusception without concurrent evidence of mechanical/metabolic ileus.

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

Pancreas

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

Free Abdomen

Subtle evidence of mild periintestinal omental reactivity noted around the intussusception. No evidence of lymphadenopathy, peritonitis or peritoneal free fluid.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Intussusception with secondary proximal gastrointestinal obstructive pattern

Secondary Findings

- Potential mild to focal apical cystitis with minor polypoid component
- Mild chronic renal changes
- Mild hepatic parenchymal remodeling

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The cause of the patient’s clinical signs appear to be secondary to likely jejunal intussusception with secondary proximal obstructive pattern. Potential for underlying neoplastic etiology associated with the intussusception cannot be definitively excluded. Likewise, the possibility of intestinal foreign material, although considered unlikely, cannot be excluded.

Three-view chest radiographs recommended to rule out occult thoracic pathology. If no evidence of thoracic pathology, laparotomy for gross inspection of the intussusception with potential for resection and anastomosis would be warranted.

Potential for emerging neoplastic urinary bladder disease is considered a less likely differential diagnosis. Screening BRAF assay could be considered. Alternatively, urinary bladder biopsies could be considered at the time of surgery.

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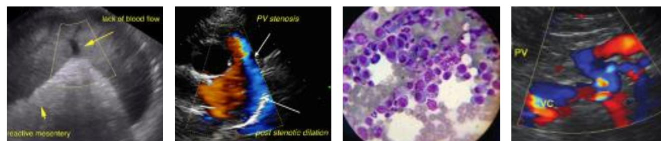

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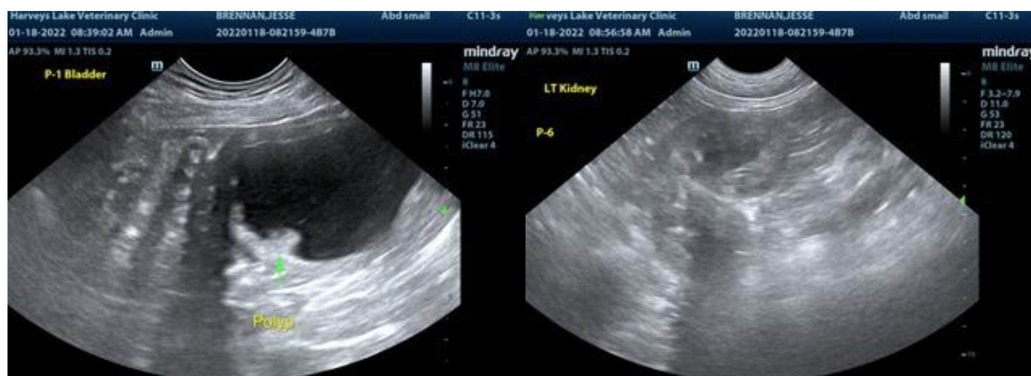

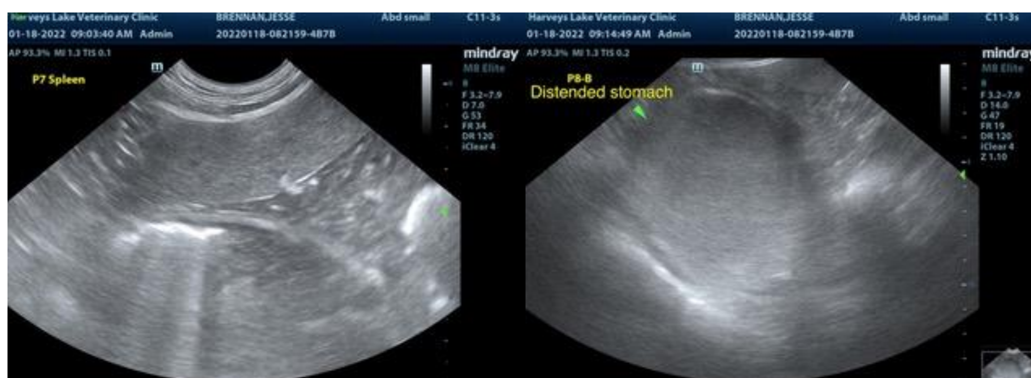

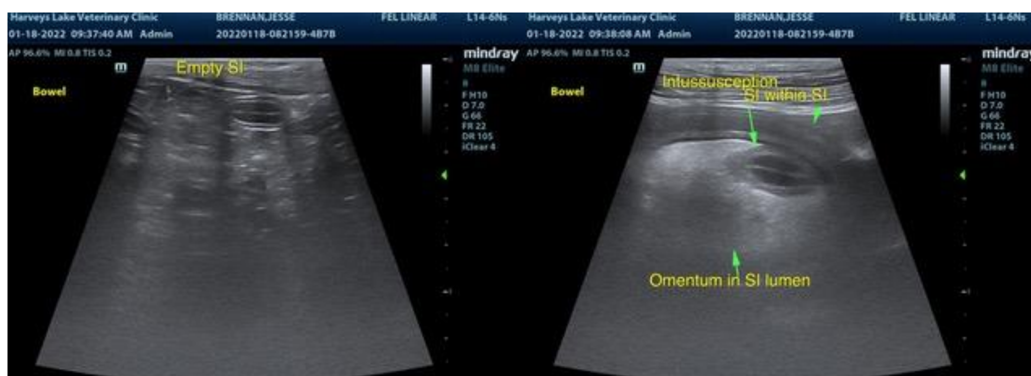

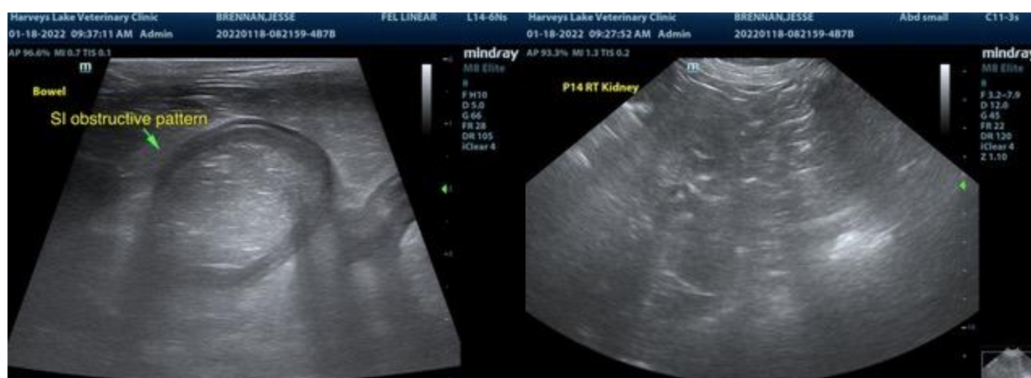

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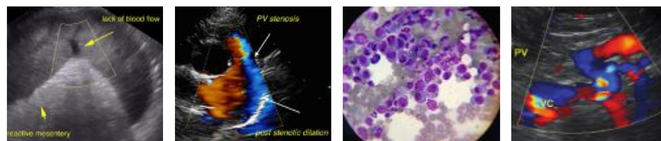

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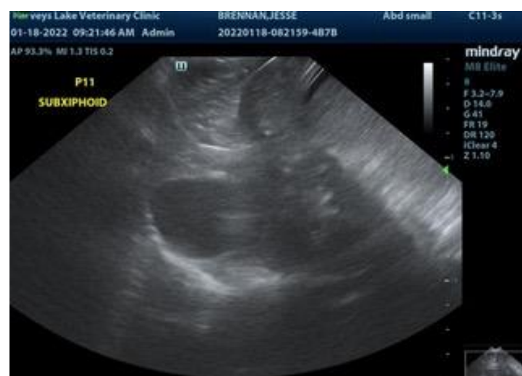

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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