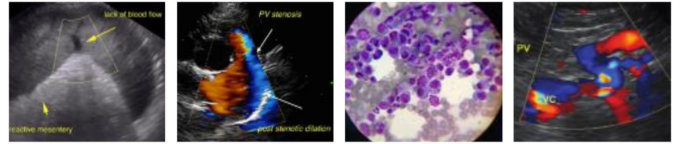
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Rosebud Griffin

SPECIES

Canine

BREED

Doxen

SEX

Spayed Female

AGE

4.5 Years

WEIGHT

11.3 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Robyn Lantz

HOSPITAL NAME

Eastgate VC

REFERRING VET

Robyn Lantz

INVOICE

20409

DATE

1/6/23

PRESENTING CLINICAL SIGNS

History: Yesterday morning: O states that pt v+ yesterday a large amount around 4pm first the old food then the new food as well, d+ this morning unusual amount appearing to be yellowish and water consistence. E/d normal until yesterday. PT had a hard time getting comfortable last night and struggled throughout the night. Sleeping for a few minutes then moving again. Prior to this pt was doing very well and was back to normal behaviors. O ran out of regular food but ran out, so O gave pt different food. Meds: Methocarbamol 500mg, Prednisolone 5mg tapering now at EOD dosing for suspected recent IVDD (recovering well), recently off gabapentin. This AM - no more vomiting or diarrhea. NPO. Given Cerenia and SQ fluids, stopped Prednisolone. Based on radiology report, radiologist concerned about possible GI FB, did move overnight, but still concerned GI FB present. (Palpated possible abdominal mass or enlarged spleen/lymph node 1-2 weeks ago and then again yesterday on exam. Patient has also chronic reducible umbilical hernia

Abnormal PE/Chem/CBC/UA Results: I palpated something semi-firm in mid-cranial abdomen on last two examinations. Concerned about mass or enlarged abdominal organ in abdomen. Patient also has separate long term reducible umbilical hernia as well. Radiologist yesterday concerned about possible pyloric FB. P was fasted overnight to compare radiographs from yesterday and this AM if any movement or change in intestinal tract. Abnormal lab results: POTASSIUM 3.1MEQ/L NA/K RATIO 45 CHLORIDE 83MEQ/L PrecisionPSL 263U/L Lymphocytes 576 /UL HGB 21.8G/DL HCT 61%

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 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. Aortic trifurcation was normal.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. The left kidney measured 3.8 cm in length. The right kidney measured 4.0 cm in length.

Adrenal Glands

The left adrenal gland was indistinctly visualized, exhibiting potential for nonspecific subnormal size, measuring 0.22 cm at the caudal pole.

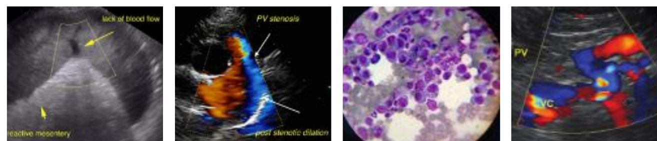
The right adrenal gland was not definitively visualized.

Spleen

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 uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were



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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

The stomach presented wall thickening secondary to echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. The stomach contained a mild amount of nonshadowing to variably echogenic ingesta/chyme. No evidence of mechanical pyloric outflow construction, overt gastric foreign material or obstructive pyloric mural pathology. This is a mild change.

The small intestine presented intact wall layering with primarily maintained 1:3 muscularis/mucosa ratio. Segments of jejunum exhibited prominent intact yet indistinct wall layer detail with minor segmental jejunal nonobstructive ileus pattern. Mildly prominent jejunal wall measured up to 0.34 cm. By comparison, normal appearing jejunum wall measured 0.28 cm. The duodenum wall measured 0.35 cm.

Normal visible colon wall layers were present with subjective semi-formed to possible soft fecal matter.

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

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

ULTRASONOGRAPHIC FINDINGS

- Generalized gastroenteritis pattern with mild gastric and segmental jejunal nonobstructive stasis, suspect mild to moderate segmental jejunitis
- Sonographically unremarkable colon, with subjective semi-formed/soft fecal matter
- Sonographically normal pancreas

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No evidence of gastrointestinal obstructive pattern or overt gastrointestinal foreign material. Technically, the possibility of a small amount of passing nonobstructive foreign material cannot be definitively excluded yet considered less likely. Dietary intolerance/food hypersensitivity, occult gastroenterocolic episode, emerging inflammatory bowel disease, occult parasitism, less likely occult Addisons disease or low-grade pancreatitis are all potentials.

No indication for immediate surgical intervention given this presentation. Supportive care for acute gastroenterocolitis should prove beneficial. If persistent or recurrent gastrointestinal signs, A GI panel to include PLI/TLI/Cobalamin/Folate +/- resting cortisol level to rule out occult Addisons disease is suggested. No evidence of intraabdominal neoplastic criteria, masses or significant lymphadenopathy.

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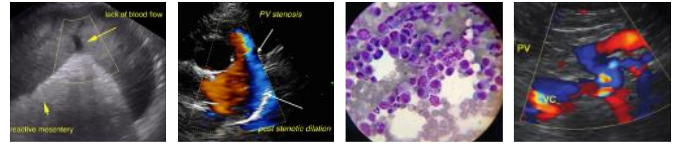

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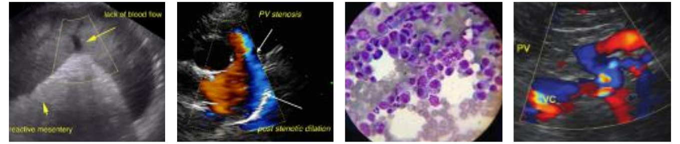

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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