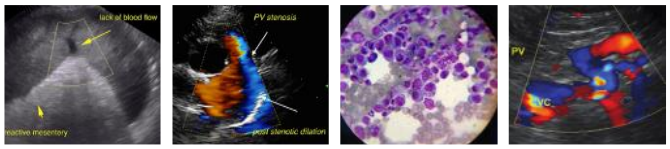
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Isla Igyarto

SPECIES
Canine

BREED
Boxer Mix

SEX
FS

AGE
6yr

WEIGHT
98.6

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

IMAGING PERFORMED BY
Mavis McCormick

HOSPITAL NAME
Lanier Animal Hospital

REFERRING VET
Dr. Joncas

INVOICE
11851ag

DATE
10/14/2022

PRESENTING CLINICAL SIGNS

Patient has had a significantly decreased appetite for about 1 month and vomits anytime she does eat. It was confirmed to be vomiting from a video the owner showed and her description of an abdominal buildup to the vomit. She is being fed from raised bowls, and the owner has tried offering different dog and human foods. She seems to be weak in the legs and lethargic. She is still drinking a normal amount of water and urinating/defecating normally. She presented to another vet 2 weeks ago for these symptoms where rads and bloodwork were performed. There were no significant findings. She was started on Omeprazole, Gabapentin, and Metoclopramide, and Pantoprazole. There has been no improvement since starting these medications. She presented this week for re-evaluation. Bloodwork was repeated and there were mild changes from 2 weeks ago. She was given Cerenia, SQ fluids, and Entyce. There was no change 24 hours after presentation.

Abnormal PE/Chem/CBC/UA Results: BW 9/27: Elevated total protein (8.1), globulin (4.1), cholesterol (>450), ALP (274); decreased BUN (6.5), Na (140), Cl (101); CBC WNL BW 10/11: mild anemia (HCT 32.9%, RBC 5.5, HGB 12.3), leukocytosis (WBC 18.55), neutrophilia (14.78), monocytosis (2.33); elevated ALP (273)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder was subnormal in size owing to lack of urine distension which prohibited full evaluation of the urinary bladder walls. The 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.

Overtly normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. Mild indistinct corticomedullary border demarcation was present bilaterally with mild pyelectasia. The left kidney measured 6.4 cm in length. The right kidney measured 7.3 cm in length.

The area of the aortic trifurcation was free of pathology.

The area of the iliac trifurcation was free of pathology including no evidence of medial, iliac or sublumbar lymphadenopathy.

Adrenal Glands

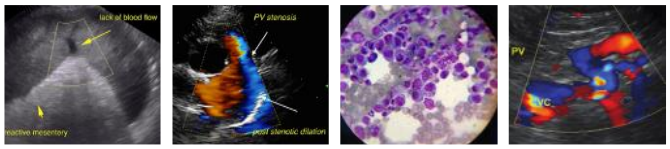
The area of the left adrenal gland was indistinctly visualized. Potential for caudal to generalized left adrenomegaly possible. The left adrenal gland possibly measured 1.7 cm width at the caudal pole. Potential for regional or overlaying lymph node is possible. The right adrenal gland was not visualized.

Spleen

The spleen exhibited subnormal size potentially indicative of volume contraction, primarily maintained a symmetrical capsule contour with generalized mild parenchyma heterogeneity. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to

Liver

The liver was subjectively mildly enlarged in size with normal structure and contour. The liver parenchyma exhibited generalized non-uniform echogenicity. The hepatic and portal vasculature were normal in appearance without signs of congestion.



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The gallbladder and common bile duct were not definitively visualized.

Gastrointestinal

The stomach presented mild variable wall thickening with indistinct gastric wall layer detail. The lumen of the stomach contained mild to moderate progressive to strongly shadowing non-specific ingesta with no signs of ileus or obstruction.

The ventral gastric body wall measured 0.8 cm in width.

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.

Pancreas

The pancreas was not definitively visualized.

Free Abdomen

Regional to generalized non-uniform mildly hyperechoic mesentery in the ventral and cranial abdomen was present. Small pockets of scant free fluid were present with multiple variably sized hypoechoic swollen mesenteric lymph nodes, an example measuring 2.4 cm in diameter. A mid abdominal probable mesenteric root lymph node measured 4.3 cm x 1.8 cm.

ULTRASONOGRAPHIC FINDINGS

- Hepatopathy with mild nonuniform parenchyma
- Bilateral pyelectasia
- Mild to variably thickened stomach exhibiting indistinct gastric wall layering, mild to moderate progressive to strongly shadowing gastric ingesta
- Multifocal hypoechoic swollen mesenteric lymphadenopathy, regional to generalized non uniform hyperechoic mesentery and scant to mild peritoneal free fluid
- Possible left adrenomegaly

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The pyelectasia may be owing to chronic renal changes, potential pelvic scarring possibly owing to previous calculi passage, IV fluid therapy (if applicable). Urine C/S and protein: creatinine ratio on sterile urine sample is recommended.

Although sampling is required for further assessment, primary concern for intra-abdominal possibly multicentric neoplasia i.e. lymphoma or other is warranted given this presentation. Assuming normal clotting status and using a 25g needle, a mesenteric LN and hepatic FNA for screening cytology is warranted for further assessment.

The shadowing gastric ingesta is nonspecific and may correlate with recent meal ingestion or food. The possibility of gastric foreign material cannot be definitively excluded.

Referral for further assessment recommended if possible.

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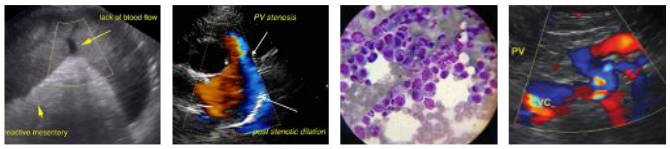

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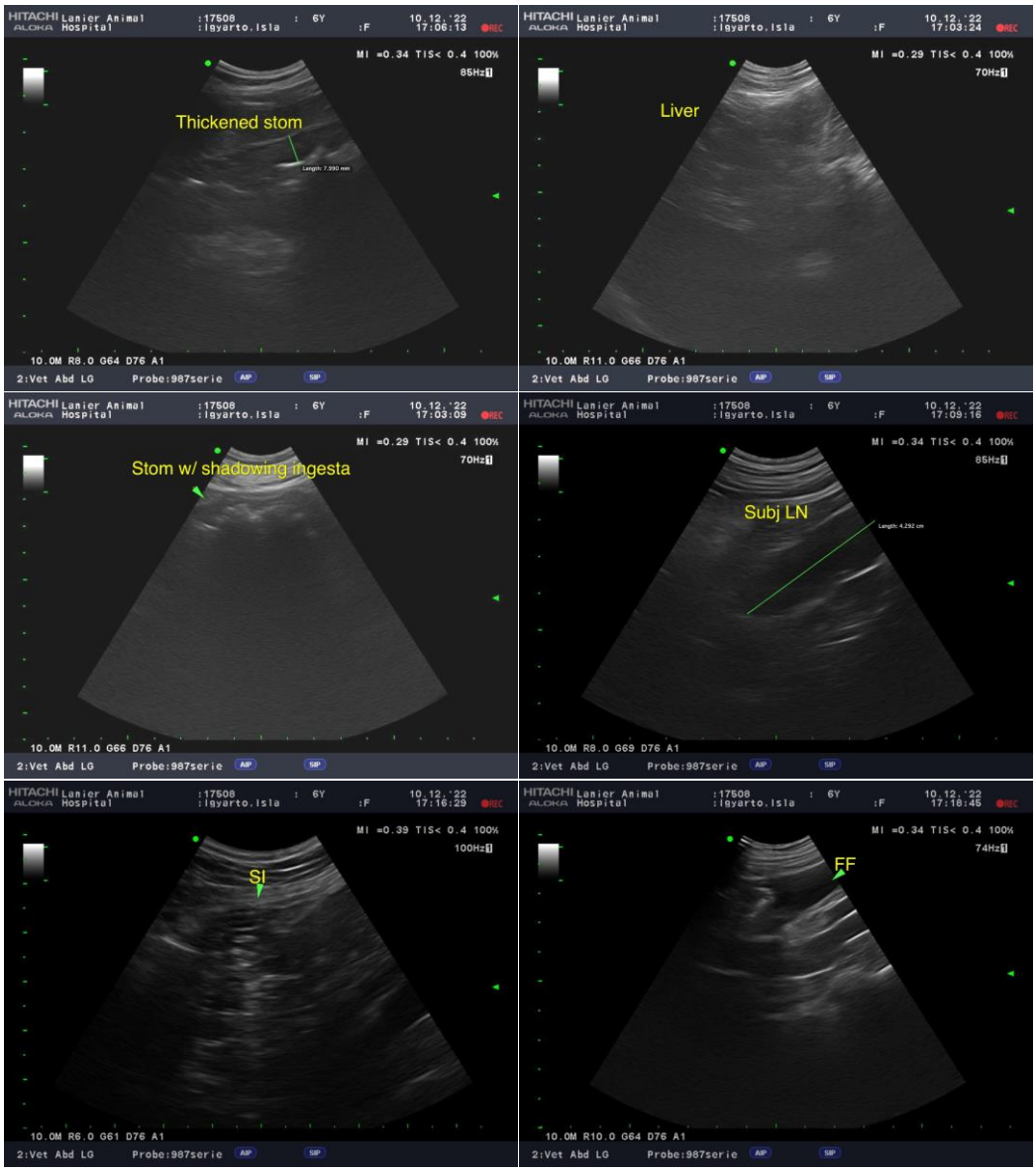

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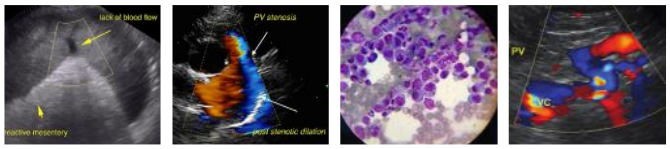

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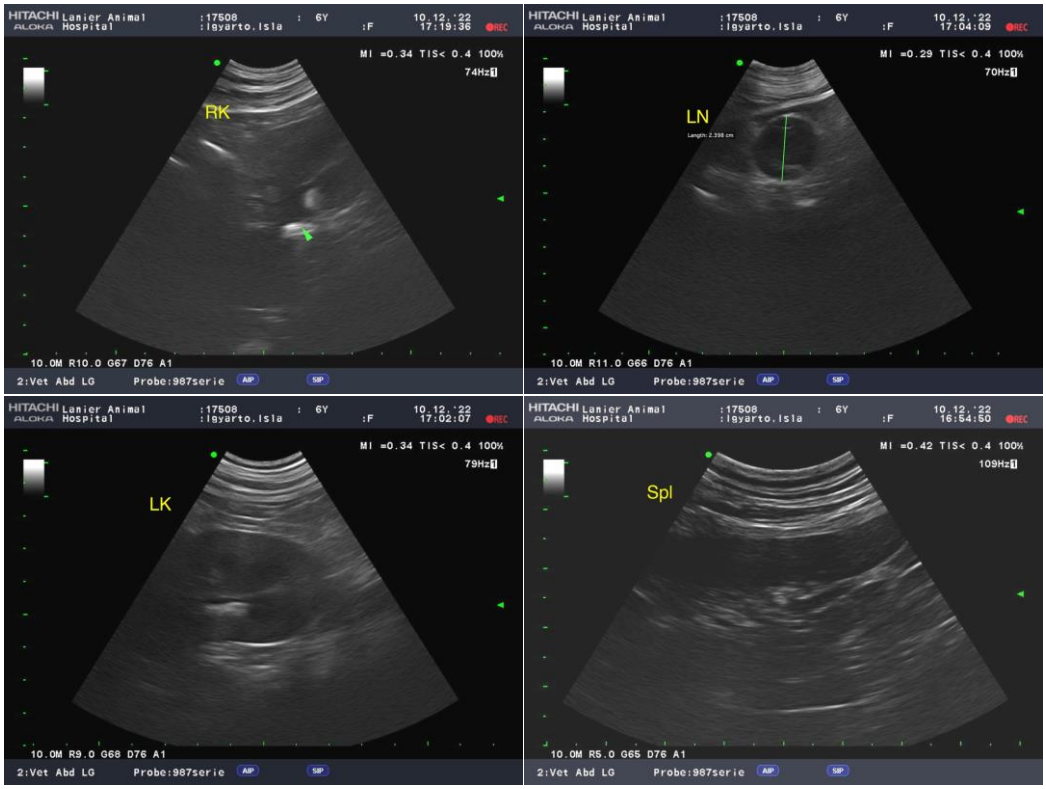

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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