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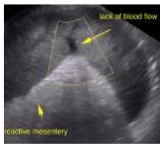
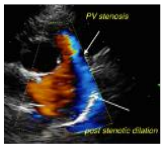
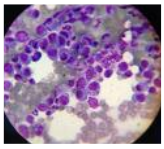
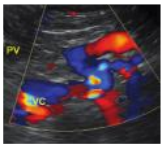

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1-800-838-4268 info@sonopath.com

PATIENT

Lilly Montoya

SPECIES

Canine

BREED

Dachshund

SEX

Spayed Female

AGE

13 Years

WEIGHT

4.2 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Jenna Walsh, CVT

HOSPITAL NAME

Wilvet of Salem

REFERRING VET

Dr. Menzen

INVOICE

17689

DATE

10/14/22

PRESENTING CLINICAL SIGNS

History: Vomiting diarrhea hyporexia
Abnormal PE/Chem/CBC/UA Results: cbc - HCT 62.8%*, WBC 10.15, mono 1.26*, bands suspected, PLT 395 chem10 - Glu 96, Creat 0.9, BUN 11, TP 6.1, ALB 2.5, Glob 3.6, ALT 72, ALP 28 AFAST - no abd FF, a few loops of liquid filled bowel

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 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.

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. Pinpoint medullary mineral was present. The left kidney measured 3.9 cm in length.

Adrenal Glands

The left adrenal gland was mildly enlarged in size with subtle nonhomogeneous yet nonmineralized parenchyma. The left adrenal gland measured 2.0 cm in length x 0.70 cm at the caudal pole in width.

A mild to moderately sized, well-defined, hyperechoic nodule was present in the cranial right adrenal gland with mild associated symmetrical capsule expansion. The nodule did not exhibit signs of mineralization or vascular invasion. The nodule measured 1.7 cm x 1.4 cm, resulting in distortion of the associated right adrenal capsule yet without evidence of parenchymal escape or vascular invasion. The overall right adrenal gland measured 2.5 cm in length x 1.6 cm at the cranial pole in width and 0.54 cm at the caudal pole in width.

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 normal in appearance without signs of congestion.

The gallbladder was non distended in size with mild hyperechoic nonorganized debris. No evidence of gallbladder or peripheral gallbladder inflammatory criteria. The cystic duct and common bile ducts were normal without evidence of dilation.

Gastrointestinal

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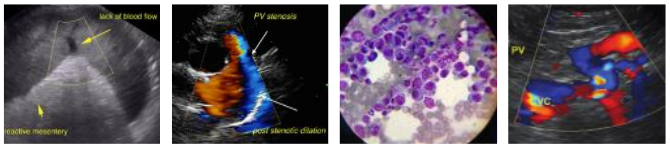

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The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained moderate echogenic, nonshadowing ingesta with secondary gastric distention primarily in the area of the gastric body and fundus. No evidence of mechanical pyloric outflow obstruction. The visualized gastric walls were sonographically normal. The pylorus wall measured 0.42 cm.

The small intestine presented intact wall layering and maintained 1:3 muscularis/mucosa ratio. Segmental propensity for mildly prominent mucosa layer. The lumen of the small intestine was empty with no evidence of mechanical obstructive pattern or foreign material, as well as no evidence of loss of intestinal wall layering.

The colon walls presented intact yet prominent wall layering with mild thickened to echogenic submucosa. The colon was primarily empty.

Pancreas

The right limb and base of the pancreas presented hypoechoic to heterogeneous echogenicity compared to adjacent omental fat. Mild asymmetrical capsule margination was present with mild variable parenchymal swelling and mild peripancreatic reactivity / inflammation. No overt evidence of neoplasia.

Free Abdomen

Generalized hyperechoic mesentery was present. Intermittent benign/reactive mesenteric lymph nodes consistent with probable mesenteric hyperplasia or reactive lymphadenitis secondary to inflammatory bowel episode. No free fluid or omental masses noted.

ULTRASONOGRAPHIC FINDINGS

- Distended stomach with ingesta- no evidence of mechanical pyloric outflow obstruction
- Enterocolitis pattern- subjectively acute
- Mildly enlarged to irregular left adrenal gland with concurrent right adrenal nodule
- Mild chronic renal changes
- Prominent to mildly hypoechoic pancreas- suggestive of concurrent subjectively mild pancreatitis

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Aggressive therapy for acute gastroenterocolitis/acute hemorrhagic diarrhea syndrome, if evidence of hematochezia, as well as concurrent low-grade pancreatitis is warranted. No overt evidence of gastrointestinal or pancreatic neoplastic criteria. Spec CPL or a GI panel to include PLI/TLI/Cobalamin/Folate levels may be considered for further assessment.

The adrenal presentation is nonspecific and may indicate right adrenal functional versus nonfunctional adenoma, unilateral or bilateral hyperplasia (potentially owing to stress) or benign hyperplasia. Potential for neoplastic criteria, specifically in the right adrenal gland, i.e., pheochromocytoma, adenocarcinoma or other cannot be excluded. Screening blood pressure to assess for evidence of hypertension, which may allude to a right adrenal pheochromocytoma is recommended. Ideally, sonographic monitoring of the bilateral adrenal glands for evidence of progressive changes or enlargement with initial recheck in 4-6 weeks is advised.

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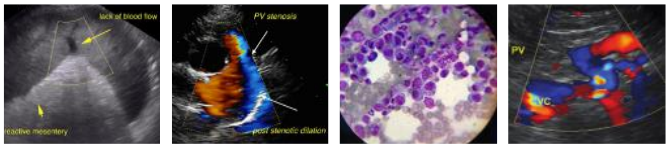

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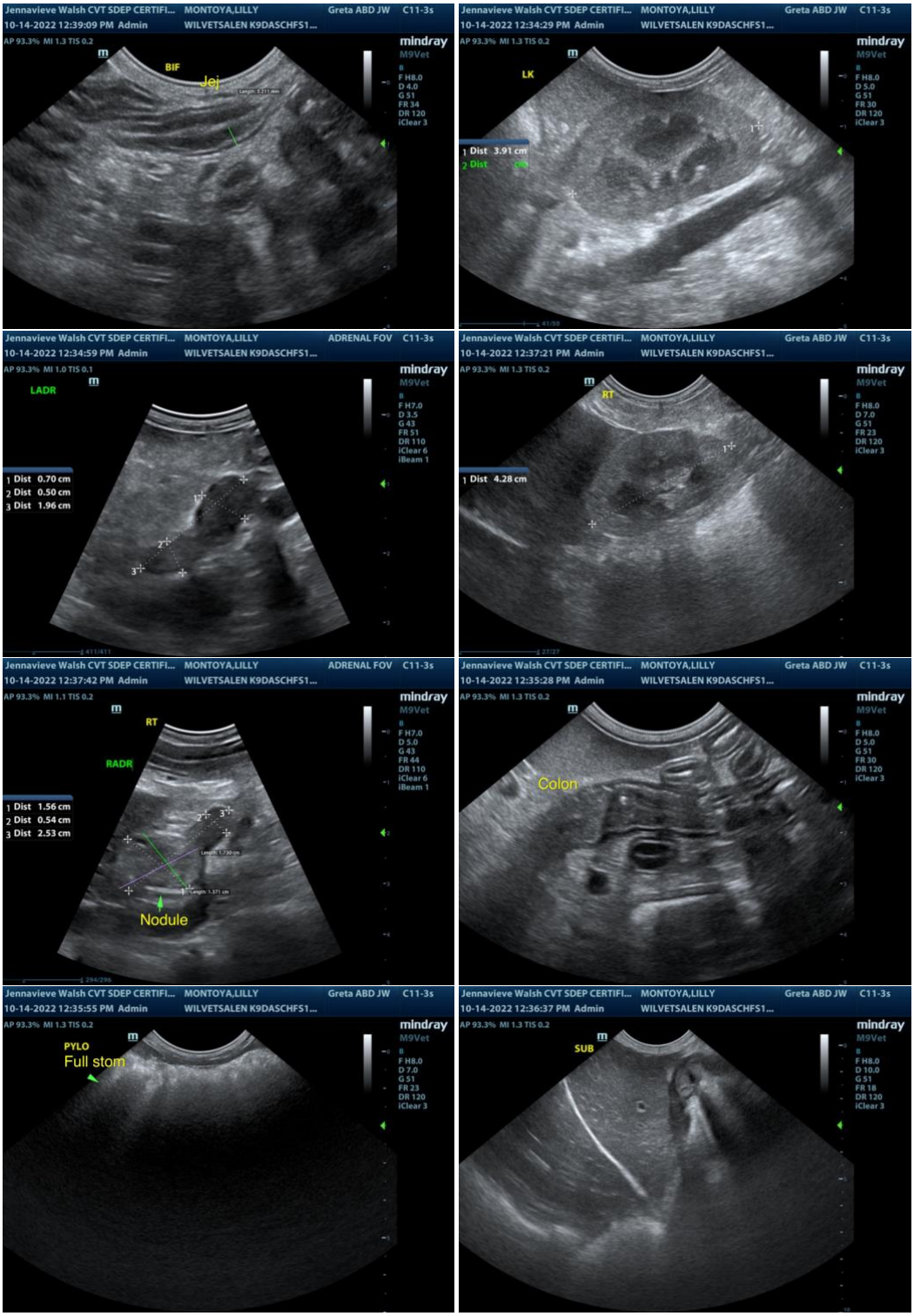

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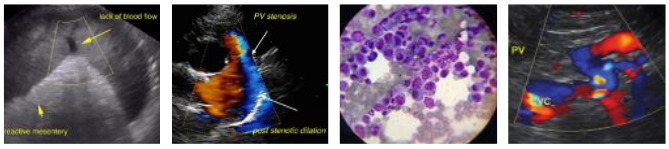

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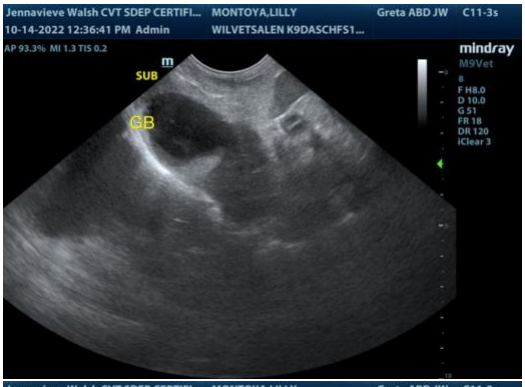

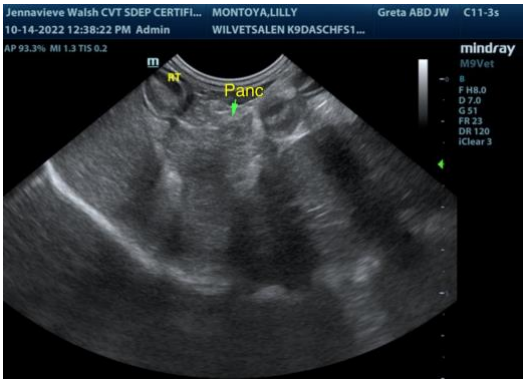

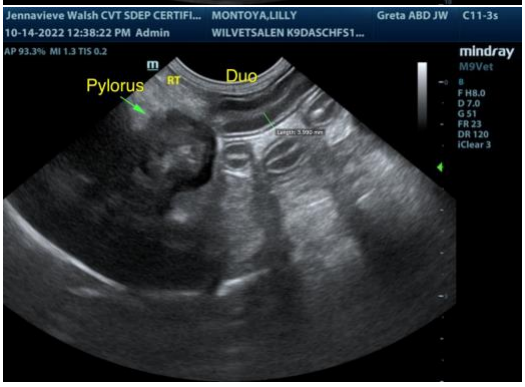

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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