



<b>PATIENT</b>	<b>PRESENTING CLINICAL SIGNS</b>
Sophie Denarde	Chronic vomiting for 1-2 months, was eating OK up until yesterday, now not eating. mildly tense abdomen when palpated currently on: Tramadol, Sucralfate, Metronidazole
<b>SPECIES</b>	Abnormal PE/Chem/CBC/UA Results: BW-WNL Rads: CONCLUSIONS: Gastroenteritis/pancreatitis could be a possibility for the vomiting. A definitive foreign body or obstructive lesion is not appreciated. This does not completely rule out the potential for a nonidentified pyloric outflow disorder but this is felt less likely. Urinary bladder calculus. RECOMMENDATIONS: A definitive surgical lesion is not confirmed. The further evaluate the GI an ultrasound exam could be considered. If the patient is stable and a more conservative approach is preferred, medical management for the vomiting could be initiated follow-up radiographs to monitor the appearance of the GI.
Canine	
<b>BREED</b>	
Cairn Terrier	
	<b>ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN</b>
<b>SEX</b>	<i>Urinary System</i>
FS	The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal thickness and tone. Mild to moderate dependent mineralized sand to microcalculi present. Additional focal areas of mineral to nonobstructive small calculi noted in the proximal urethral lumen. Anechoic urine was present in the lumen. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.
<b>AGE</b>	No evidence of pathology in the area of the aortic trifurcation.
12 Years	
<b>WEIGHT</b>	Normal size and margination was 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. Focal areas of nonobstructive medullary mineral was present in both kidneys. No evidence of pyelectasia. The left kidney measured 4.1 cm in length. The right kidney measured 4.6 cm in length.
8.43kg	
<b>INTERPRETED BY</b>	<i>Adrenal Glands</i>
R. McKenzie Daniel, DVM, DABVP	The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 1.9 cm length x 0.55 cm width at the caudal pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 1.6 cm length x 0.52 cm width at the caudal pole.
<b>IMAGING PERFORMED BY</b>	<i>Spleen</i>
Kelly Reshny, RVT	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.
<b>HOSPITAL NAME</b>	<i>Liver</i>
Beattie Pet Hosp Stoney Creek	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 thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.
<b>REFERRING VET</b>	<i>Gastrointestinal</i>
Salib	The stomach presented intact wall layering with a normal wall layer ratio. The stomach exhibited moderate distension with retained echogenic fluid and chyme. The echogenic fluid and chyme extended
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48122	
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11-1-21	



<b>PATIENT</b>	into the segmental small intestine, likely upper duodenum and jejunum, with variable yet moderate upper small intestinal obstructive ileus pattern.
Sophie Denarde	
<b>SPECIES</b>	A focal small intestinal mural lesion, likely jejunal in location measuring approximately 2.2 cm length x 1.5 cm width, was present. This mural lesion contained subjectively intact yet altered wall layering with some loss of wall layer detail. Primarily empty small intestine noted distal to the focal mural lesion with minor segmental chyme extending to the level of the colon.
Canine	
<b>BREED</b>	Normal visible colon wall layers were present with apparent formed feces in lumen.
Cairn Terrier	
<b>SEX</b>	<b><i>Pancreas</i></b>
FS	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 pancreatic inflammation or neoplastic disease was evident.
<b>AGE</b>	<b><i>Free Abdomen</i></b>
12 Years	Subtle peri-intestinal reactive mesentery noted around the intestinal mural lesion and without evidence of free fluid or overt peritonitis.
<b>WEIGHT</b>	No evidence of significant lymphadenopathy was present.
8.43kg	
<b>INTERPRETED BY</b>	<b>ULTRASONOGRAPHIC FINDINGS</b>
R. McKenzie Daniel, DVM, DABVP	<ul style="list-style-type: none"><li>• Focal small intestinal (likely jejunal) mural lesion with proximal gastrointestinal obstructive pattern.</li><li>• Mild urinary bladder nonobstructive proximal urethral mineral.</li><li>• Bilateral chronic renal changes with nonobstructive medullary mineralization.</li></ul>
<b>IMAGING PERFORMED BY</b>	<b><u>INTERPRETATION OF THE FINDINGS &amp; FURTHER RECOMMENDATIONS</u></b>
Kelly Reshny, RVT	A cause of the patient's clinical signs consistent with focal small intestinal mural lesion with at least partial obstruction in the upper gastrointestinal tract noted. Considerations for the focal mural lesion may include inflammatory neoplastic or granulomatous etiologies. Subjectively, this focal small intestinal mural lesion appears to be amendable to surgical resection. Exploratory laparotomy for gross assessment of the lesion as well as resection and anastomosis +/- gastrointestinal biopsies if clinically indicated would be appropriate. Cystotomy with urinary bladder and proximal urethral flush recommended if surgery is elected. Urine culture and sensitivity on a sterile urine sample also suggested.
<b>HOSPITAL NAME</b>	
Beattie Pet Hosp Stoney Creek	
<b>REFERRING VET</b>	
Salib	
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**PATIENT**

Sophie Denarde

**SPECIES**

Canine

**BREED**

Cairn Terrier

**SEX**

FS

**AGE**

12 Years

**WEIGHT**

8.43kg

**INTERPRETED BY**

R. McKenzie Daniel,  
DVM, DABVP

**IMAGING  
PERFORMED BY**

Kelly Reshny, RVT

**HOSPITAL NAME**

Beattie Pet Hosp  
Stoney Creek

**REFERRING VET**

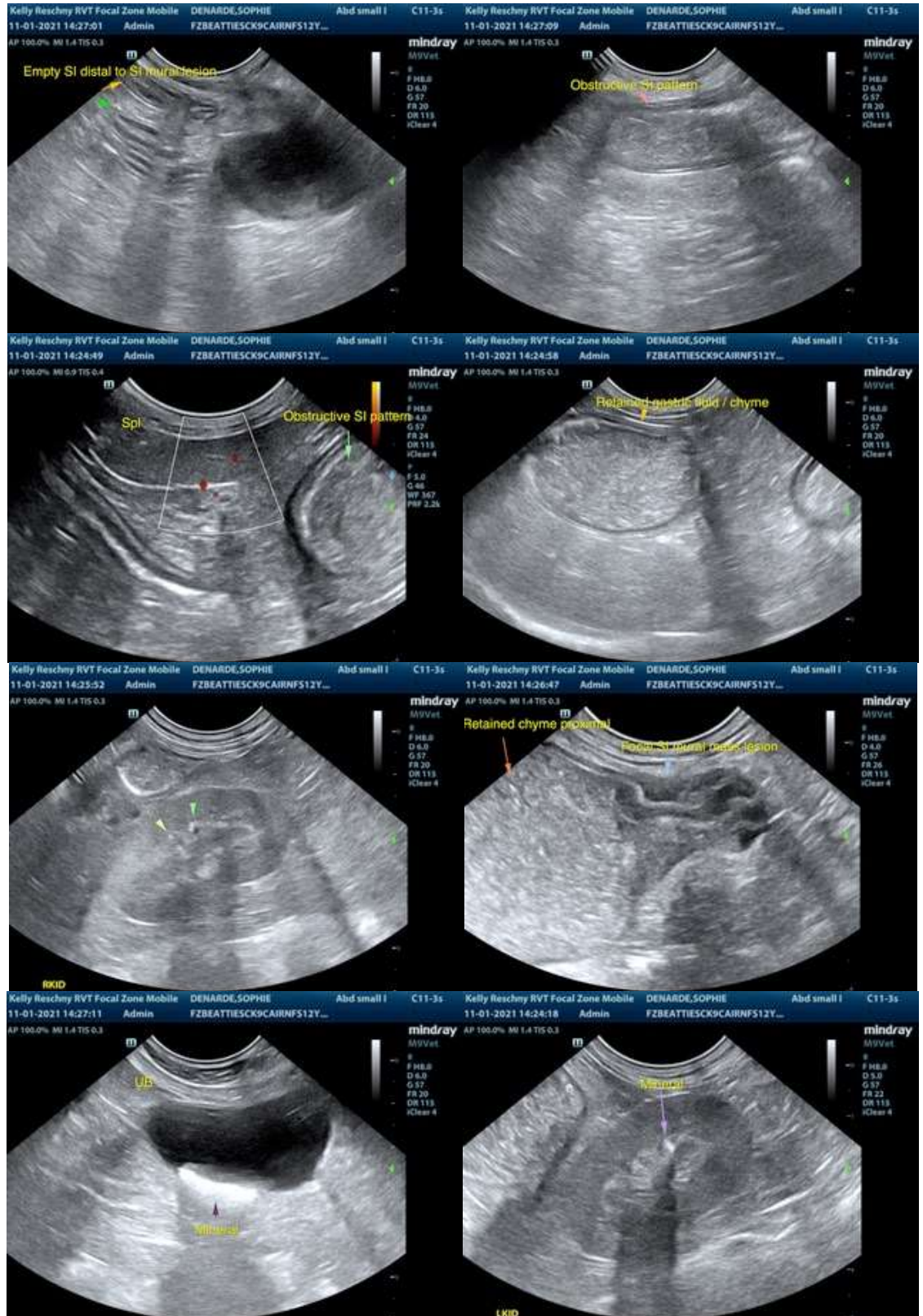
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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