**PATIENT**

Lincoln Yentrapati

**SPECIES**

Canine

**BREED**

German Shepherd

**SEX**

MN

**AGE**

9yr

**WEIGHT**

68lb

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

Rachel Runnells RVT

**HOSPITAL NAME**

SVS Imaging KC

**REFERRING VET**

Dr. Lyle

**INVOICE**

12226ag

**DATE**

11/21/2022

**PRESENTING CLINICAL SIGNS**

First came in 10/7/22: Not eating last 4 days, drinking water, playful. Losing weight. Hx per O of occasional diarrhea and vomiting, but not doing that now. Had tarry stool after getting Galliprant.

Was on carafate, cefalexin, metronidazole, and gabapentin. RX amoxicillin, cerenia, pro pectalin,

Initially responded well, and even gained weight up to 84.4 lb, but recheck 10/31 was down to 77 lb. Had regurgitated some food. 11/21: weight down to 68#, not eating much, whimpered when picked up under belly.

Abnormal PE/Chem/CBC/UA Results: 10/7: looks like has lost significant weight, losing muscle mass. BW - all normal except ALB 2.6 (2.7-4.4). 10/31: weight loss, abd palp NSF, mm pk/moist. AG empty. No active fistula, but does have a scar. 11/21: more weight loss.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN****Urinary System**

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra exhibited normal thickness and tone. Anechoic urine was present in the lumen with minor dependent mineral. 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 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 7.9 cm in length. The right kidney measured 8.7 cm in length.

The area of the aortic trifurcation was free of pathology.

The area of the residual prostate appeared normal and free of pathology.

**Adrenal Glands**

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.62 cm width at the caudal pole and 0.67 cm width at the cranial pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.60 cm width at the caudal pole and 0.69 cm width at the cranial pole.

**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 presented enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion.

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The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content with non-dependent mildly echogenic non-organized debris. No evidence of gallbladder or peripheral gallbladder inflammation was present. The cystic and common bile ducts were normal.

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**Gastrointestinal**

The stomach presented intact wall layering with a normal wall layer ratio. Marked gastric distention with retained mildly echogenic fluid and non-shadowing chyme with no signs of ileus, obstruction or foreign material.

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The small intestine presented segmental variable distention with retained non-shadowing chyme. Focal to possible multiple coalescing strongly shadowing intestinal luminal echoes were present in the subjective mid abdomen, an example measuring 5-6 cm in length. Concurrent intact mildly prominent segmental intestinal wall layering was present with ill-defined focal to segmental non-homogeneous mural hypertrophy exhibiting loss of wall layering potentially measuring ~ 4.0 cm x 3.0 cm. Segmental of empty small intestine likely distal exhibiting intact wall layering was present to the level of the ileocolic junction.

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Normal visible colon wall layers were present with apparent semi 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.

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**Free Abdomen**

No overt lymphadenopathy was present.

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Small pockets of scant peri intestinal to peritoneal free fluid was present.

**ULTRASONOGRAPHIC FINDINGS**

- Strongly shadowing segmental small intestinal ingesta/echoes with mechanical/metabolic ileus to obstructive pattern proximal
- Suspect ill-defined focal to segmental intestinal mass/lesion
- Segments of empty small intestine without ileus likely distal

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**Secondary**

- Mild dependent urinary bladder mineral
- Mild gallbladder debris (non-mucocele)
- Mild hepatic parenchymal remodeling-subjectively benign

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Segmental upper to mid obstructive gastrointestinal pattern was present which may potentially be secondary to obstructive intestinal foreign material, intestinal mural mass or a combination. Some of the intestinal segments exhibiting distention with retained fluid exhibited intact to mild prominent wall layer which may suggest inflammatory changes although a more diffuse infiltrative intestinal neoplastic process cannot be definitively excluded.

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Exploratory laparotomy for gross inspection of the full GI tract, potential resection/anastomosis of the ill-defined intestinal mass, enterotomy if confirmed foreign material secondary to pica as well as full



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thickness intestinal biopsies based on gross inspection of the intestinal tract is recommended. A guarded prognosis is indicated.

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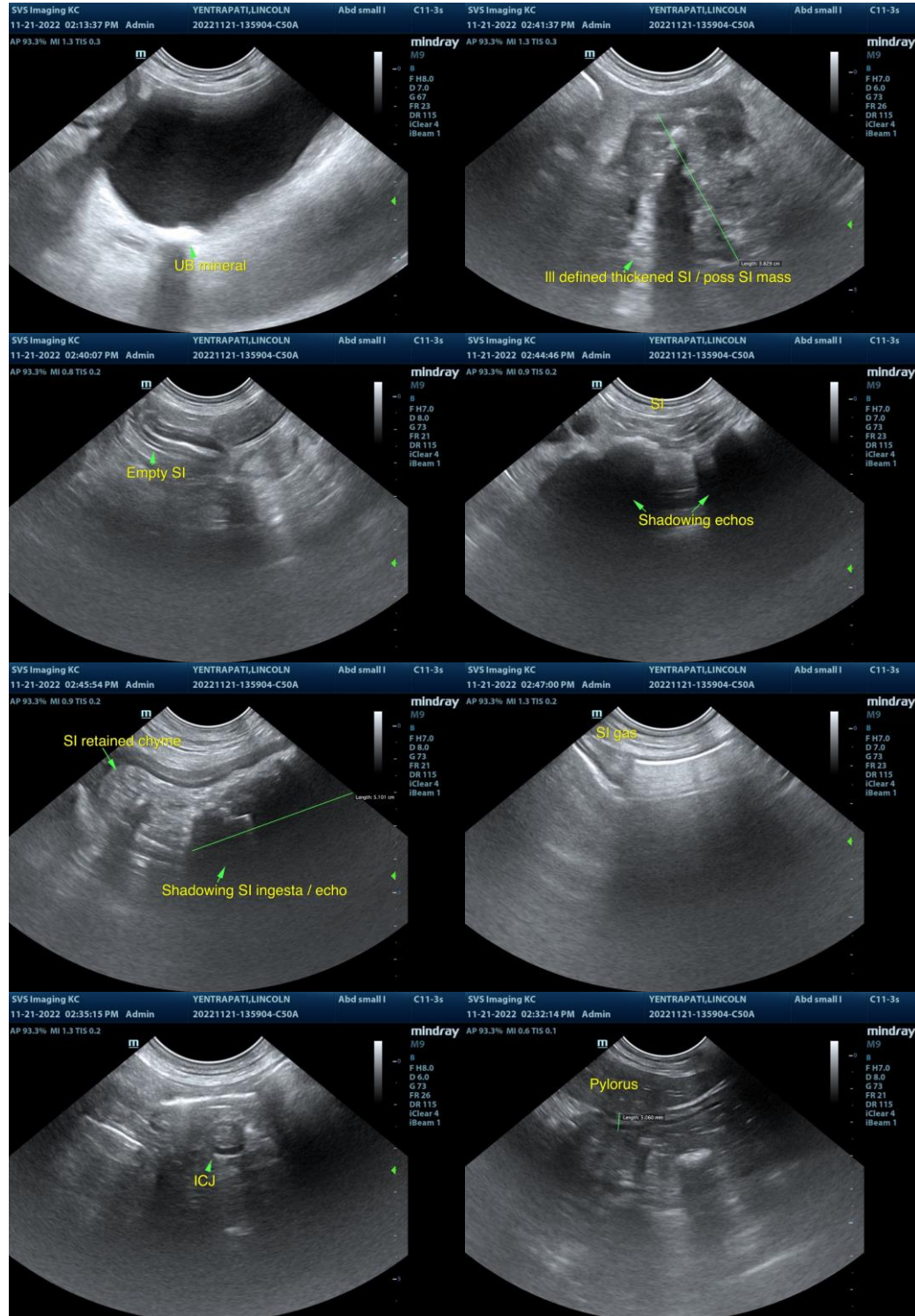
Dr. Lyle

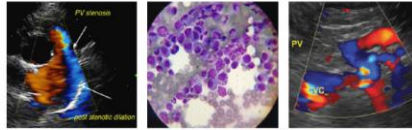
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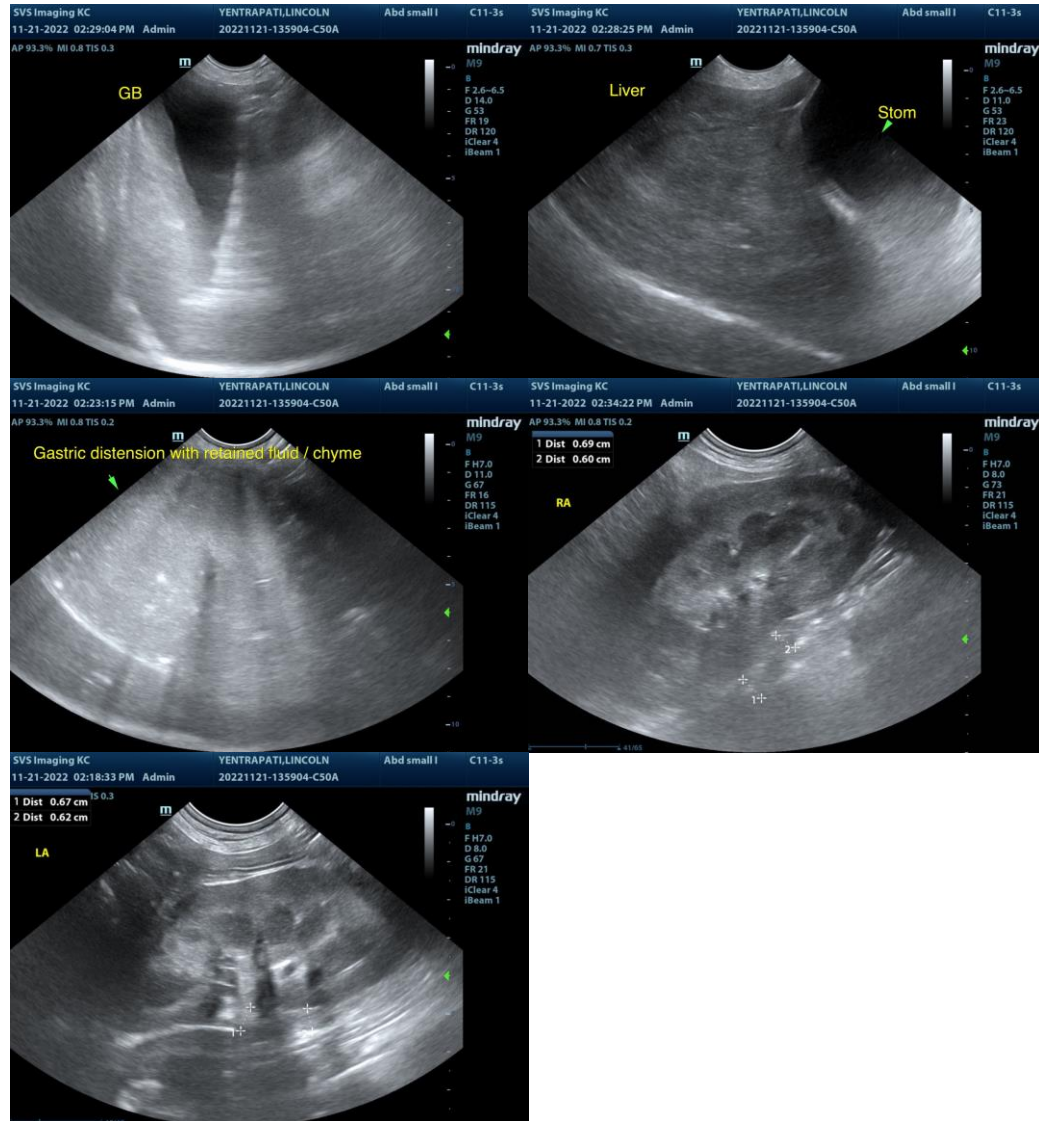
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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