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Clinical Sonography & Telecytology
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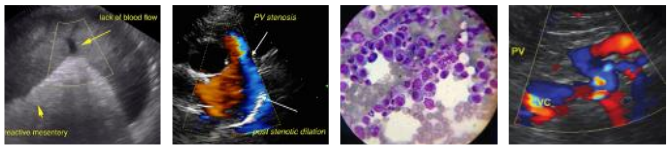

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Sissy Hendrickson

SPECIES

Canine

BREED

Tibetan Terrier

SEX

FS

AGE

11yr

WEIGHT

55.40lb

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Evoniuk

HOSPITAL NAME

State Avenue Vet Clinic

REFERRING VET

Dr. Evoniuk

INVOICE

11127ag

DATE

11/22/2022

PRESENTING CLINICAL SIGNS

History: lump on right rear hip has gotten bigger has a skin tag on anal area cyst on top of head that o feels p reacts to more than usual when touched last couple of weeks has not been acting herself o feeds people food to p, but p has not shown interest in it has occasional diarrhea, but that is her norm, depending on what she is fed no vomiting has been wheezy, even when at rest--does do some coughing no meds/supplements changed food from regular dog chow to a higher protein dog chow about 3-4 weeks ago p thinks gums are very pale lr Physical Exam: General Appearance: Quiet, alert and responsive, apprehensive but friendly Hydration: Hydration appears normal Eyes: Corneas clear, pupils normal size, symmetrical, sclera white, no ocular discharge Ears: No exudate observed, no redness present Oral Cavity: Tartar moderate Nasal Cavity: No obvious abnormalities observed Cardiovascular: Regular rhythm; no murmur detected Respiratory: Lungs auscultate clear bilaterally; trachea clear Abdomen: Abnormal: very tense, difficult to perform deeper palpation Rectal: Normal rectal exam Musculoskeletal: Normal ambulation Integument: Normal amount of shedding; skin looks normal; hair coat in good condition Lymph Nodes: Lymph nodes are all normal in size Focal firm swelling of the R hip region, smooth. Assessment: Anemia- RO chronic disease, bleeding (Ro splenic mass, other), consumptive, immune mediated other (no overt saline agglutination) Plan: Spoke with O as update and recommend US .O consented. Plan CBC with retics and path review. Pending US review. jme

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 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. The left kidney measured 6.2 cm in length. The right kidney measured 6.5 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 left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.57 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 0.63 cm width at the caudal pole and 0.66 cm width at the cranial pole.

Spleen

The spleen exhibited normal size, areas of medial capsule asymmetry and subtle generalized parenchymal heterogeneity with focal to intermittent non-disruptive hypoechoic nodules, an example measuring 0.67 cm. The nodules did not distort the splenic capsule. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis.

Liver

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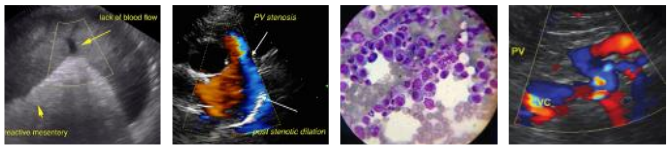

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The liver presented enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with primarily anechoic luminal content and mild non-dependent echogenic non-organized debris. No evidence of gallbladder or peripheral gallbladder inflammation was present. No evidence of gallbladder or peripheral gallbladder inflammation was present. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented mild wall thickening secondary to echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. Mild gastric distension with mild retained primarily anechoic fluid was present.

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 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, overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Mild age-related renal changes
- Mild gallbladder debris (non-mucocele)-likely incidental assuming no evidence of cholestasis
- Mild gastritis pattern with possible minor gastric hypomotility
- Sonographically unremarkable small bowel

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Overall, there is no overt evidence of significant abdominal visceral pathology as a definitive cause of the patient's clinical signs. No evidence of intra-abdominal neoplasia was observed. AS needed Gi support and empirical therapy for mild gastritis should prove beneficial. No overt evidence of gastric ulceration.

Although considered unlikely a resting cortisol level to rule out occult Addison's disease given the patient's inappetence as well as anemia may be considered.

Correlation with pending CBC path review is suggested.

Three view chest radiographs are recommended if not done to assess for occult thoracic pathology as a contributing factor.

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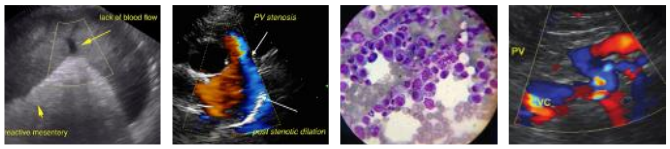

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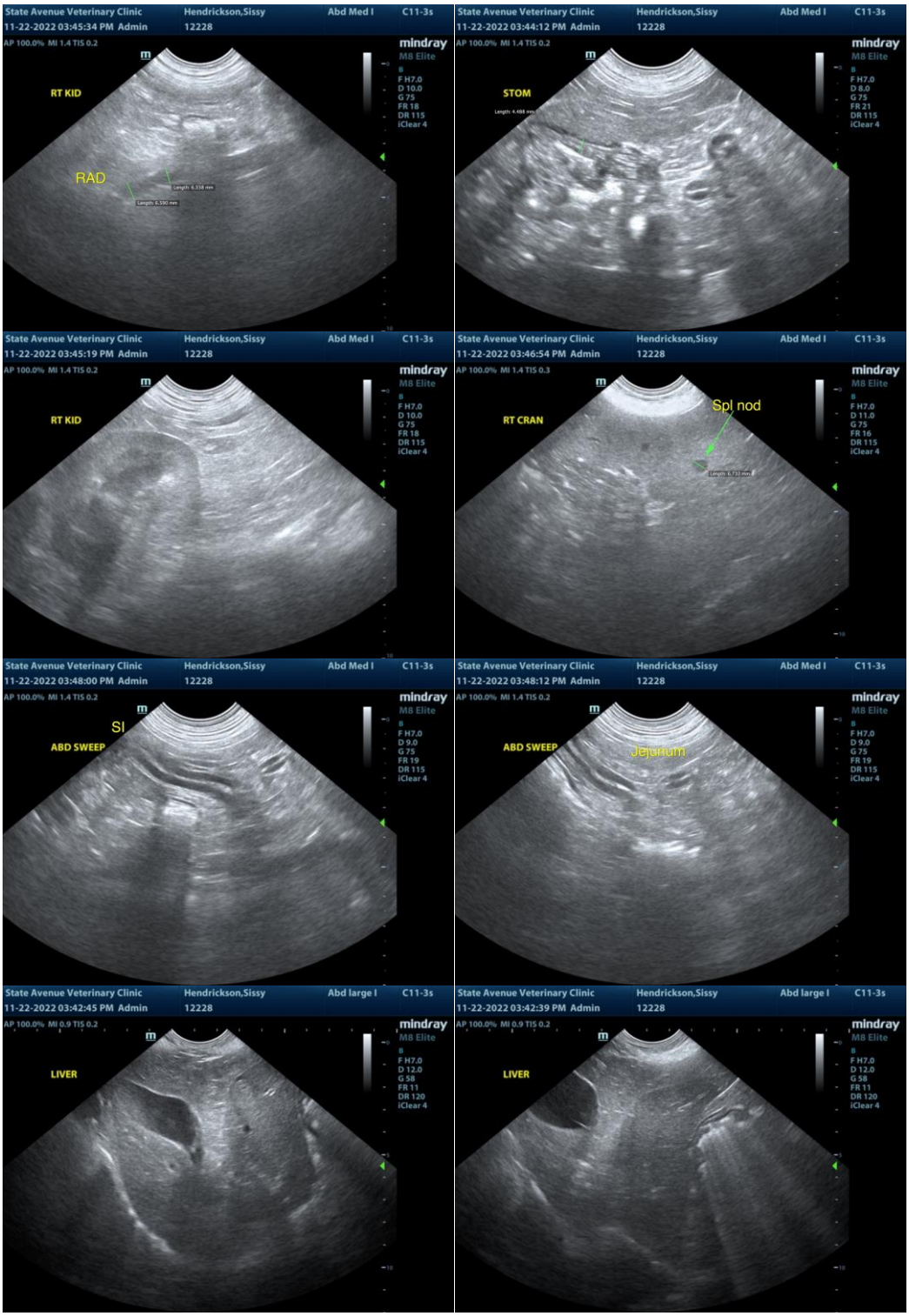

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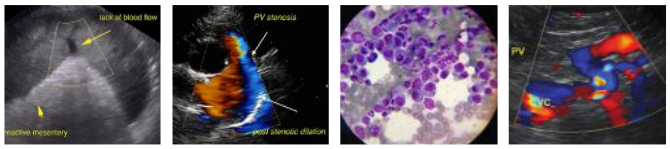

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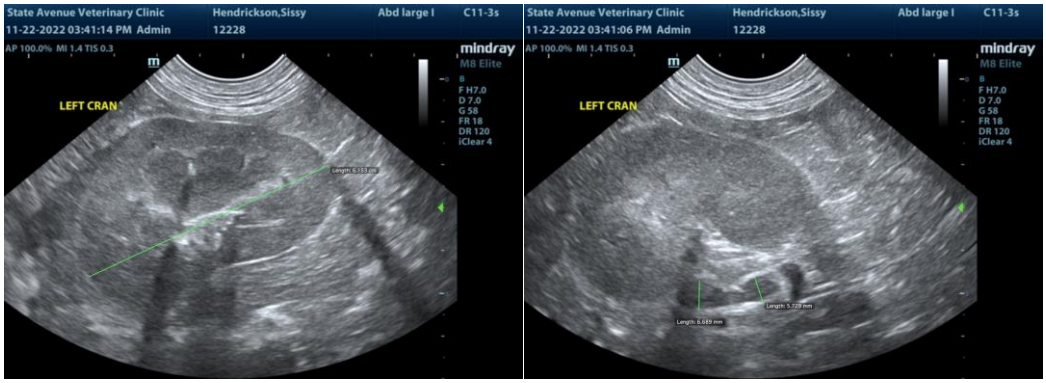

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
mac.daniel@sonopath.com