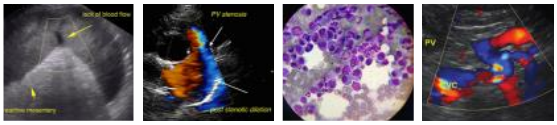


PATIENT
Penny Stover

SPECIES
Canine

BREED
Labradoodle

SEX
FS

AGE
8yr

WEIGHT
18lb

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

IMAGING PERFORMED BY
Jenna Walsh CVT

HOSPITAL NAME
Willakenzie Animal Clinic

REFERRING VET
Dr. Popuette

INVOICE
12243ag

DATE
11/25/2022

PRESENTING CLINICAL SIGNS

presented 11/21 for vomited twice, inappetance, straining to defecate rads done, no obvious indications of obstruction, bloodwork alt slightly elevated rest wnl presented 11/25 for continued inappetance, is drinking water now and keeping it down, continues to strain to defecate repeat rad today, 2 areas of gas in si, apparent normal stool in colon, rectal exam empty, anals easily expressed Current Medications cerenia, metronidazole Radiographic Findings gas in stomach, 2 areas of gas in si Primary Question/Differential to Be Answered in This Exam cause of inappetance, could have eaten stuffing from a toy, is she obstructed???

Abnormal PE/Chem/CBC/UA Results: alt slightly elevated

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 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 4.9 cm in length. The right kidney measured 4.6 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

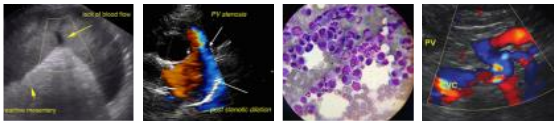
The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.55 cm width at the caudal pole and 2.0 cm length. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.50 cm width at the caudal pole and 1.5 cm length.

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 primarily anechoic luminal content. 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 retained primarily anechoic fluid was present in the mid gastric body, antrum and pylorus.

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 strongly shadowing formed feces in lumen.

Pancreas

The pancreas was mildly enlarged exhibiting subtle asymmetrical contour and non-homogeneous to hypoechoic parenchyma compared to the adjacent omental fat.

Free Abdomen

Perilymphatic to peripancreatic generalized mild hyperechoic mesentery was present with mild volume anechoic peritoneal free fluid.

Focally enlarged mid to cranial abdominal mesenteric lymph nodes were present. These lymph nodes were homogenous, mildly hypoechoic and smoothly marginated. A normal width: length ratio was maintained (<0.5). Evidence of perilymphatic inflammation was evident. An example of lymph node size was 4.0 cm x 1.4 cm.

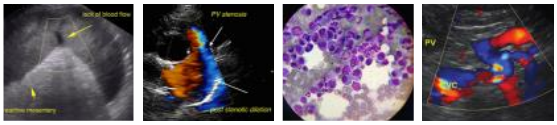
ULTRASONOGRAPHIC FINDINGS

- Mild gastritis/gastroenteritis pattern with mild gastric hypomotility-no overt evidence of GI obstructive pattern or definitive foreign material
- Sonographically unremarkable colon containing strongly shadowing fecal matter
- Pancreatitis
- Mild subjective acute hepatopathy
- Variably enlarged to hypoechoic mesenteric lymphadenopathy-hyperplasia, reactive lymphadenitis potentially secondary to inflammatory bowel episode, early neoplastic lymphadenopathy possible
- Generalized perilymphatic to peripancreatic hyperechoic mesentery and mild volume peritoneal free fluid

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The potential for small amounts of passing or passed foreign material now residing in the colon could be possible. Given the lack of definitive GI obstructive criteria, no indication for immediate surgical intervention. Assessment for evidence of cranial abdominal or subxiphoid discomfort palpation in the area of the pancreas is recommended. Correlation with a spec cPL is recommended. Assuming normal clotting status and using a 25g needle, a lymph node FNA for screening cytology is warranted for further assessment +/- effusion analysis cytospin cytology or C/S if evidence of inflammatory cells.

Empirically hospitalization with therapy for pancreatitis, as needed GI and hepatic support with monitoring of ALT levels and clinical response would be reasonable. A recheck sonogram is



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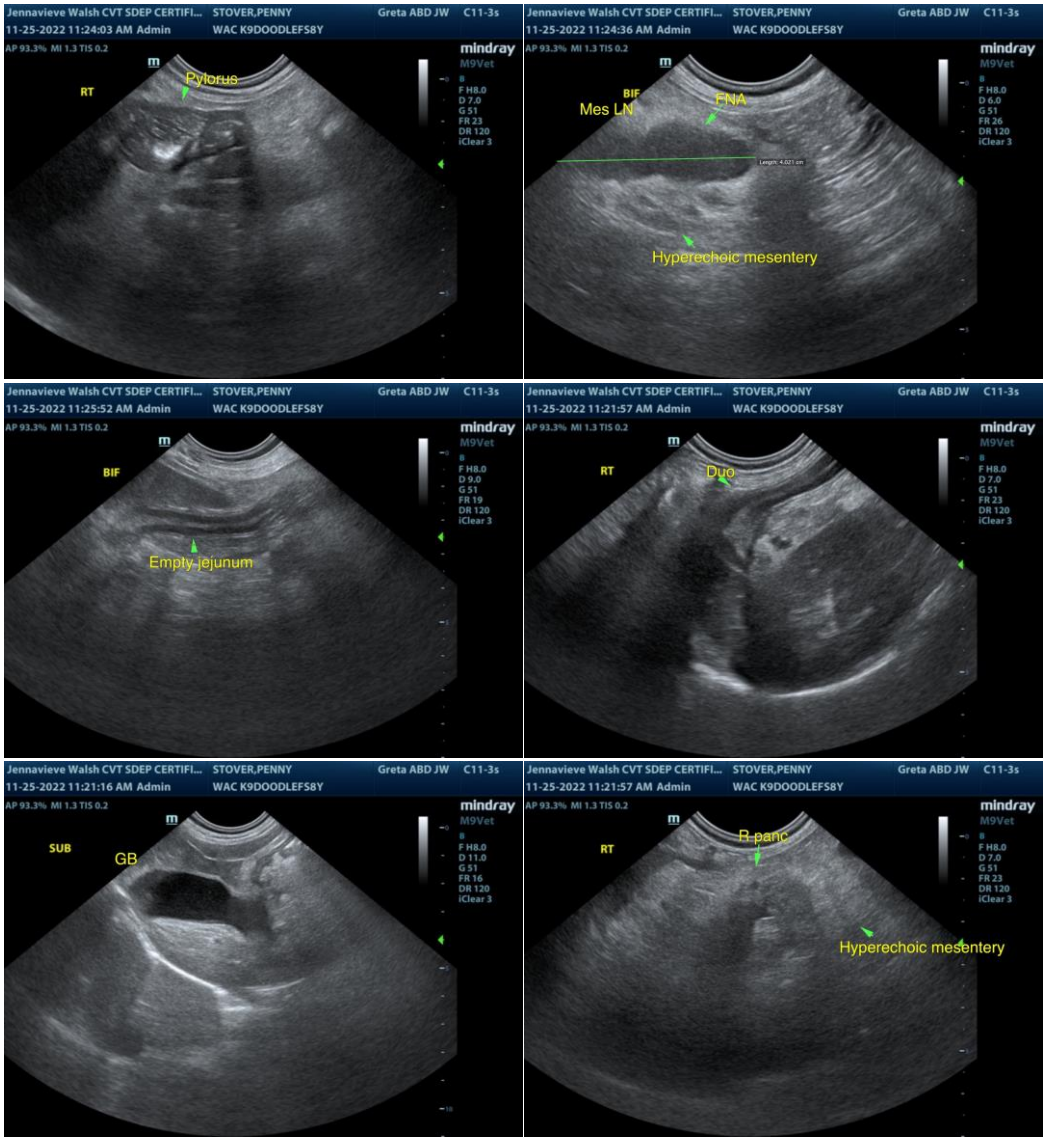
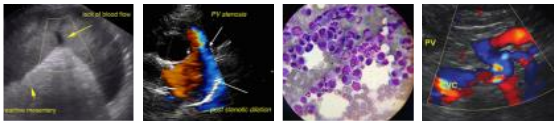
recommended if persistent/progressive GI signs, increasing hepatic enzyme elevations or progressive peritoneal effusion.





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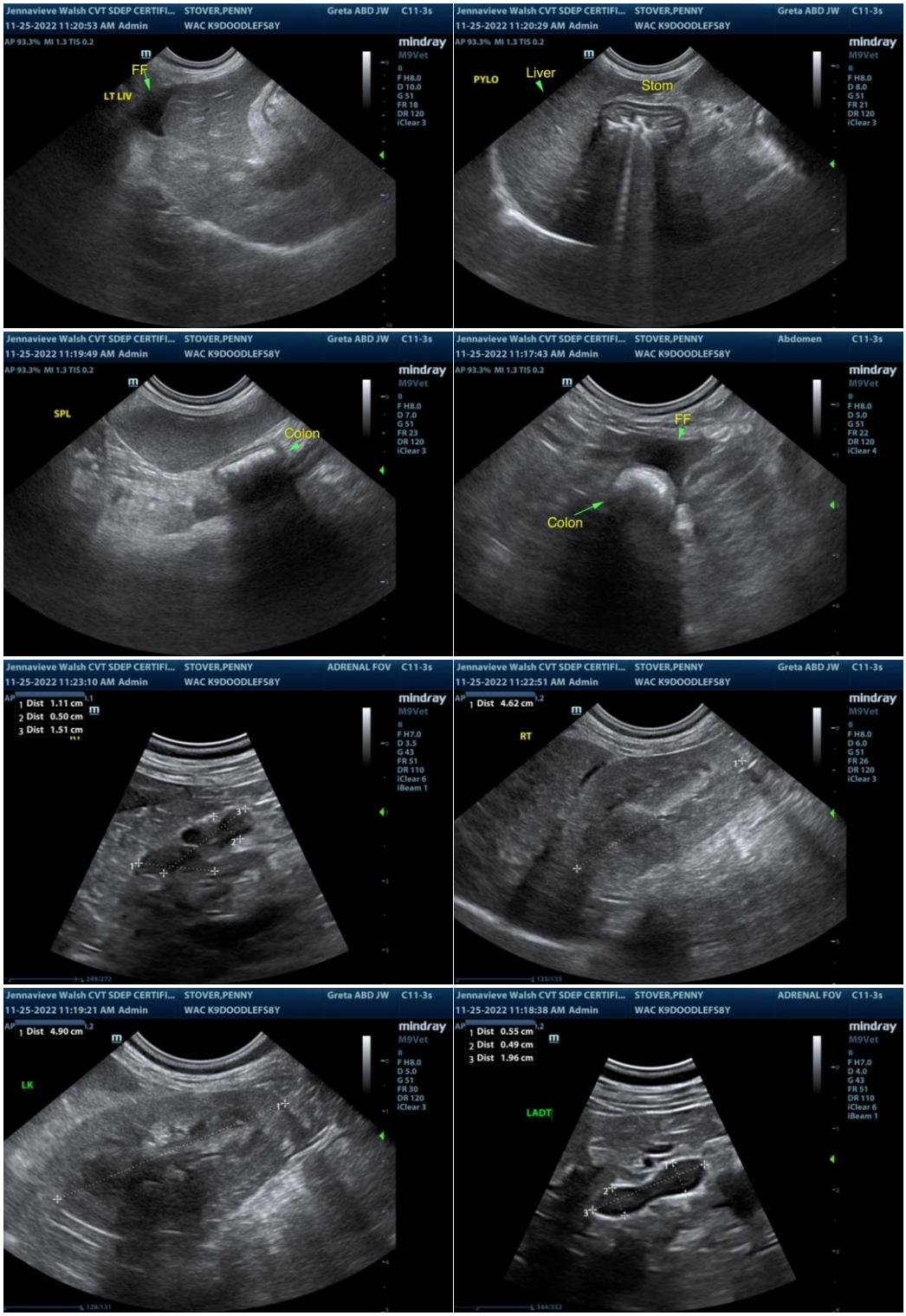
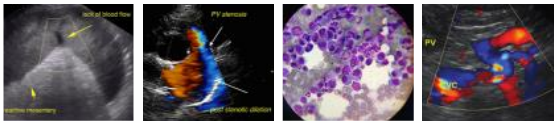


The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not



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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