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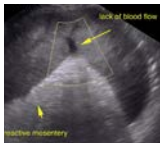
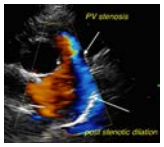
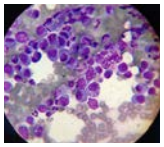
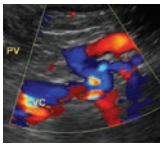

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1-800-838-4268 info@sonopath.com

PATIENT

Huckleberry Smith

SPECIES

Canine

BREED

Goldendoodle

SEX

Neutered Male

AGE

5 Years

WEIGHT

28.8 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Patti Mayfield, DVM

HOSPITAL NAME

Patti Mayfield

REFERRING VET

Patti Mayfield, DVM

INVOICE

42576

DATE

11/7/22

PRESENTING CLINICAL SIGNS

Patient presented to EVH on 11/6/2022 at ~ 12 am for the following Hx: -- vomiting noted several times daily since Thursday. -- lethargic. -- no diarrhe anoted. -- signs have been worsening at home. -- p ate normally this evening (approx 7 pm), last vomiting noted at 1:30 pm -- otherwise healthy per o. -- p is known to "rip things up" but no known ingestion. Current treatments include: - Cerenia 1 mg/kg IV q 24 hours - Norm R @ 87 mL/hr Patient ate ~ 1 jar baby food ~ 6 hours prior to AUS, then was anorexic Sedated with Dexdomitor/Torb (mixed) IV for AUS

Abnormal PE/Chem/CBC/UA Results: PE: -- ~ 5% dehydration, soft abdomen, otherwise unremarkable. 3 view abd rad on presentation: -- moderate amt ingesta in stomach. moderate amt gas in intestines with bunching noted. no obstructive pattern, no apparent foreign material. CBC: -- Mild neutrophilia, 12,222/uL (2950-11,640) CHEM: -- Mild hyperlipasemia, 2081 U/L (200-1800) Repeat 3-view abdominal rads (~ 12 hours after IVF): -- Stomach is empty with resolution of mild gas/soft tissue density and no obvious gastric foreign material/obstruction. A soft tissue density substance is present potentially in the colon, vs SI, with no significant gas distention or plication in the vicinity. A separate, slightly "bunched" region of SI is noted with mild gas appreciated, with no obvious foreign material.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of – 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 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 right kidney measures 7.2 cm. The left kidney measures 6.2 cm.

Adrenal Glands

The adrenal glands were uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 2.3 cm length x 0.58 cm at the caudal pole. The left adrenal gland measured 2.9 cm length x 0.59 cm at the caudal pole.

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. A focal area of mild isoechoic medial parenchymal expansion/isoechoic nodule noted in the caudal medial spleen measuring 1.1 cm diameter, resulting in focal asymmetrical medial capsule contour. No evidence of regional inflammation. This isoechoic nodule to focal parenchymal expansion is not considered pathological, and likely a patient variant. 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 thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

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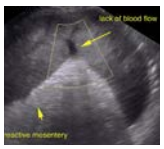
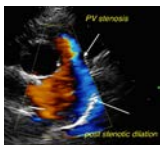
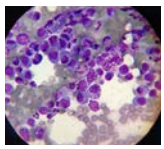
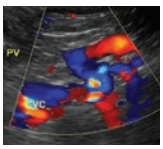

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Gastrointestinal

The stomach presented wall thickening secondary to echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. Mild retained anechoic fluid noted. No evidence of mechanical pyloric outflow obstruction.

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. No evidence of intestinal corrugation/plication. Minor segmental luminal gas present.

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

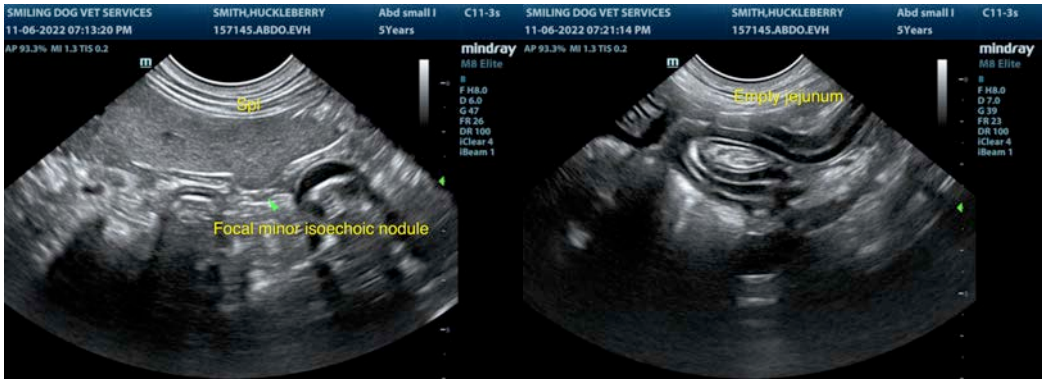
No evidence of significant lymphadenopathy. No omental masses or peritoneal free fluid.

ULTRASONOGRAPHIC FINDINGS

- Gastritis pattern with mild retained gastric fluid
- Sonographically unremarkable small bowel with mild segmental gas pattern

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Sonographically, the appearance of the stomach is suggestive of gastritis and potential mild gastric stasis. Technically the possibility of a small amount of passing or passed foreign material, given the patient history, cannot be definitively excluded, yet no indication for surgical intervention without evidence of gastrointestinal obstructive pattern or definitive foreign material. Supportive care for gastritis/gastroenteritis is recommended. Spec cPL could be considered to assess for evidence of low-grade to chronic pancreatitis, which may present sonographically normal. Although considered unlikely given normal adrenal presentation, resting cortisol to rule out occult Addison's disease may be considered. Sonographic reassessment suggested to assess for evidence of progressive inflammatory gastric or gastrointestinal mural changes if clinical signs persist despite supportive care.



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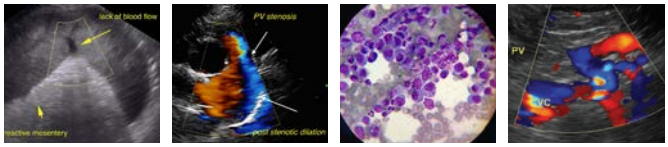

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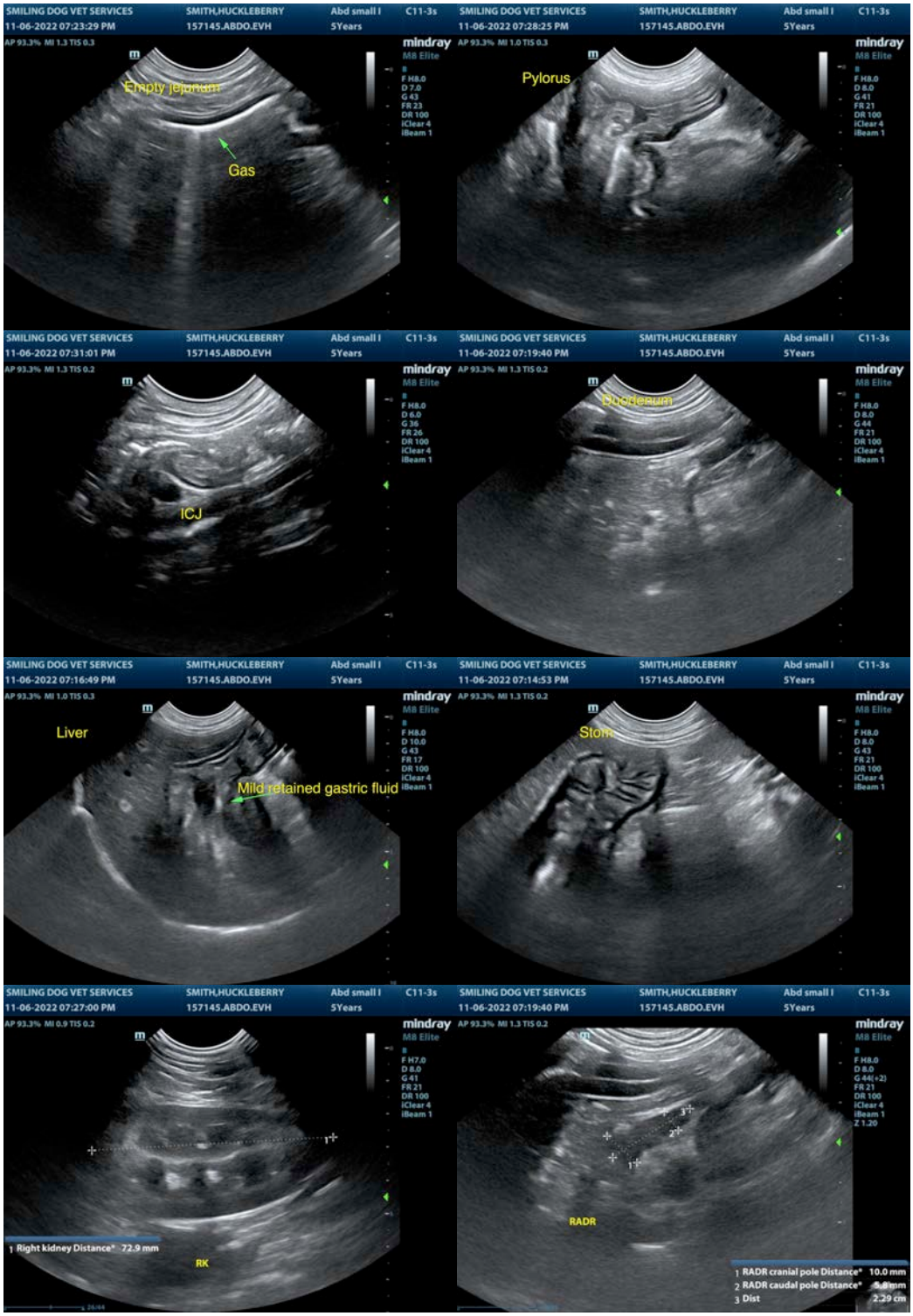

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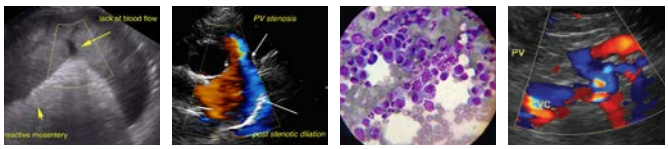

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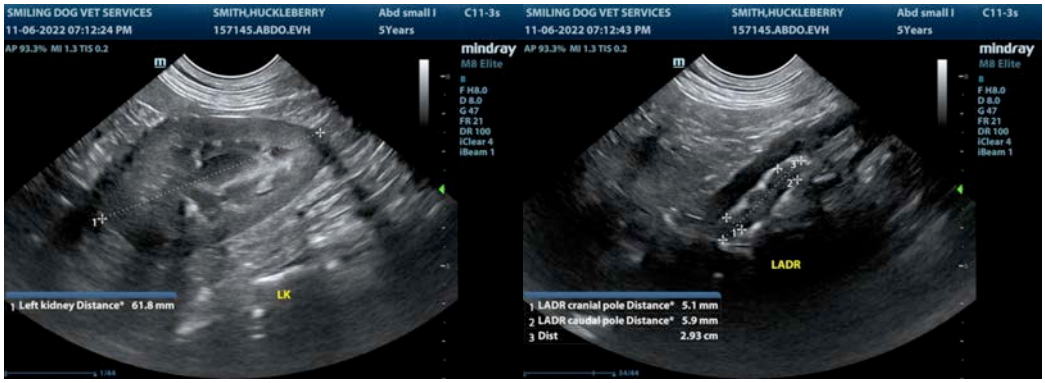

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@SonoPath.com