

**PATIENT**Zookini Reppen
30353C**SPECIES**

Canine

BREED

Beagle

SEX

Neutered Male

AGE

7 Years

WEIGHT

14 kg

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

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VETDr. Keller- Madison
VS**INVOICE**

20076

DATE**PRESENTING CLINICAL SIGNS**

History: Zookini initially presented on 12/8/22 for for episodes of excessive licking of the floor and lips. Zookini has had 3 instances of this behavior in the past years but it typically subsides within seconds. He was brought to MVS on Sunday because he had an episode several episodes of licking the floor and licking his lips which lasted several minutes. After receiving Maropitant, Zookini improved and did not have another episode until around 5pm . Zookini began laying down and licking the floor and had been more vocal and anxious then normal. The pcDVM recommended to give Pepcid 100mg PO. Zookini has had no vomiting, coughing, diarrhea, sneezing and is eating and drinking normally. Zookini is defecating and urinating normally. Zookini represented last night (12/13) for excessively licking the carpet. Since last visit, Zookini has been ok at home, and has since gone to pcDVM for a blood panel last week (Friday) and he was dewormed. It was recommended to keep doing the bland diet until the stool is normal. Owners have had him on a boiled chicken/rice bland and i/d diet still. .Tonight around 6:30pm, Zookini began licking the carpet obsessively again. Owner gave a prilosec, and brought him in. He ate like normal but started licking. Also burping/hiccups as well. Last at between 6:30-7p 12/13/22.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**Urinary System**

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 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.

The residual prostate was symmetrically normal in size with uniform parenchyma and slight coarse echotexture measuring 1.4 cm in diameter.

The area of the aortic trifurcation was free of pathology.

Normal size and margination was 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 5.2 cm in length. The right kidney measured 5.5 cm in length.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 2.0 cm in length x 0.59 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 2.0 cm in length x 0.60 cm width at the caudal pole.

Spleen

The spleen was normal in size and contour with subtle parenchyma heterogeneity. A solitary nondisruptive well demarcated hypoechoic nodule was noted in the mid spleen, measuring 0.80 cm in diameter.

Liver

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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.

Gastrointestinal

The stomach presented intact visualized wall layering. The lumen of the stomach contained a moderate amount of ingesta, exhibiting mild near field hyperechogenicity with strong distal acoustic shadowing, extending into the area of the pyloric outflow, without evidence of mechanical pyloric outflow obstruction.

The small intestine presented intact wall layering and maintained 1:3 muscularis/mucosa ratio with subjective propensity for mildly prominent to hyperechoic segmental jejunal submucosa layer. No evidence of small intestinal mechanical/metabolic ileus, loss of intestinal wall layering or intestinal foreign bodies or masses. The duodenum wall measured 0.41 cm. The jejunum wall measured 0.31 cm.

Normal visible colon wall layers were present with formed fecal matter.

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

Focal to intermittent, mildly prominent mesenteric lymph nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). An example of lymph node size measured 3.6 cm in length x 0.58 cm width. No free fluid noted.

ULTRASONOGRAPHIC FINDINGS

- Moderate strongly shadowing gastric ingesta
- Intact small bowel wall layering, exhibiting subjective propensity for mildly prominent to hyperechoic jejunal submucosa layer
- Focal to intermittent minor benign/reactive mesenteric lymphadenopathy- suspect minor hyperplasia
- Nonspecific yet subjectively benign solitary nondisruptive splenic nodule- suspect incidental focal lymphoid hyperplasia, hematopoiesis or similar

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the documented fast in this patient, the presence of strongly shadowing gastric ingesta may suggest some degree of delayed gastric emptying or metabolic stasis. The possibility of gastric foreign material or retained medication cannot be excluded. No overt evidence of mechanical obstructive gastrointestinal pattern. Given the patient history of lip and carpet licking, underlying intestinal disease,

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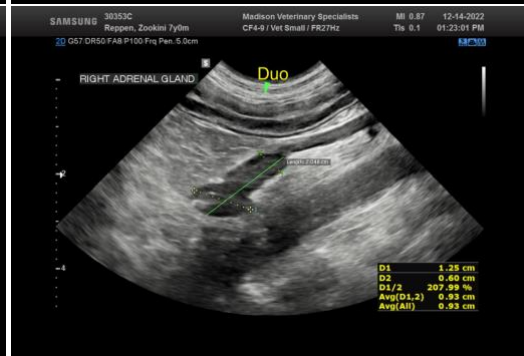
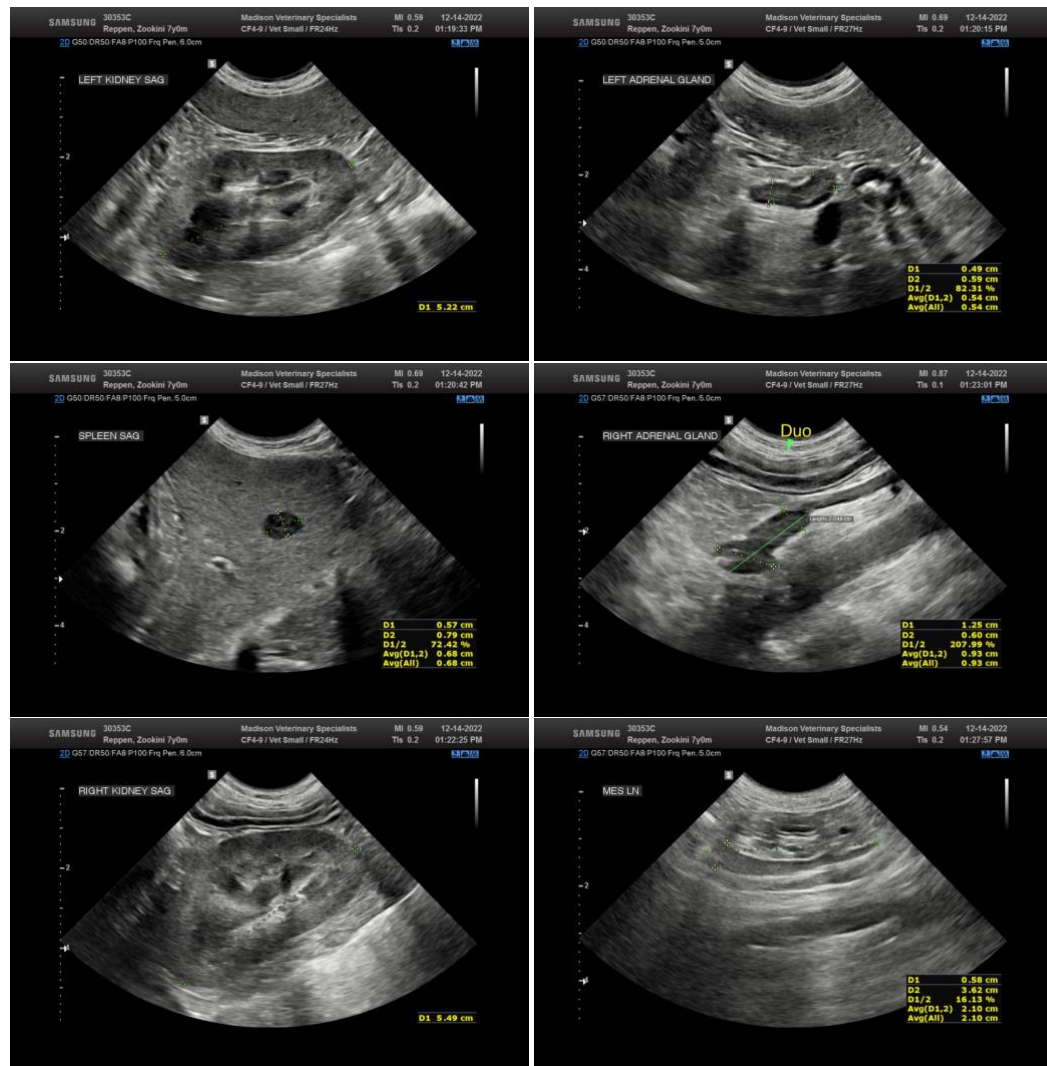
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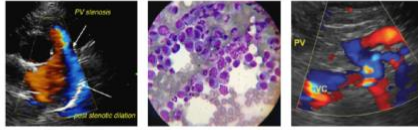
such as IBD or gastritis/esophagitis is of concern, which may present essentially sonographically normal.

A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. Ideally, hospitalization with 24-hour IV fluid and gastrointestinal support, documented 12-hour NPO and sonographic versus radiographic monitoring for gastric emptying is recommended. If persistent retained gastric ingesta, gastric emptying or endoscopy and/or exploratory laparotomy with gastrointestinal biopsies considered essential, may be indicated. Three view chest radiographs, if not done, are suggested to rule out occult thoracic or esophageal pathology as a contributing factor.



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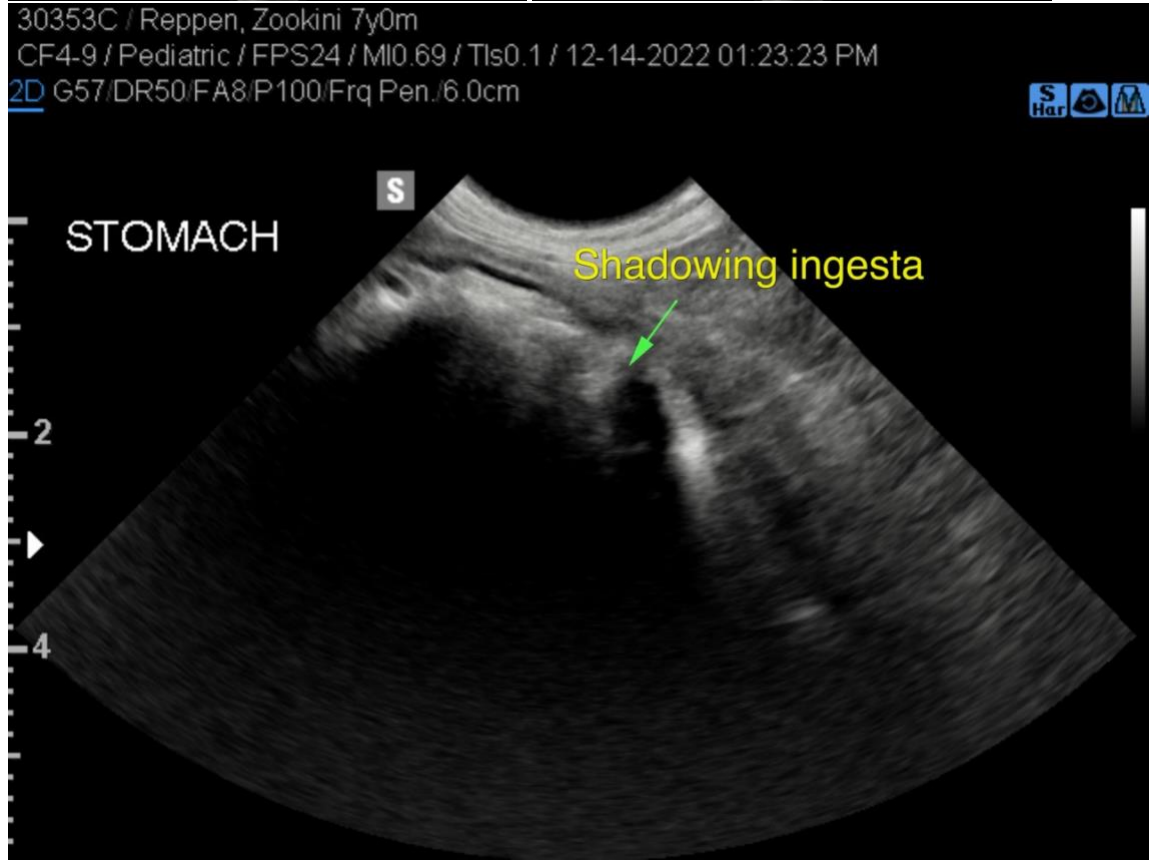
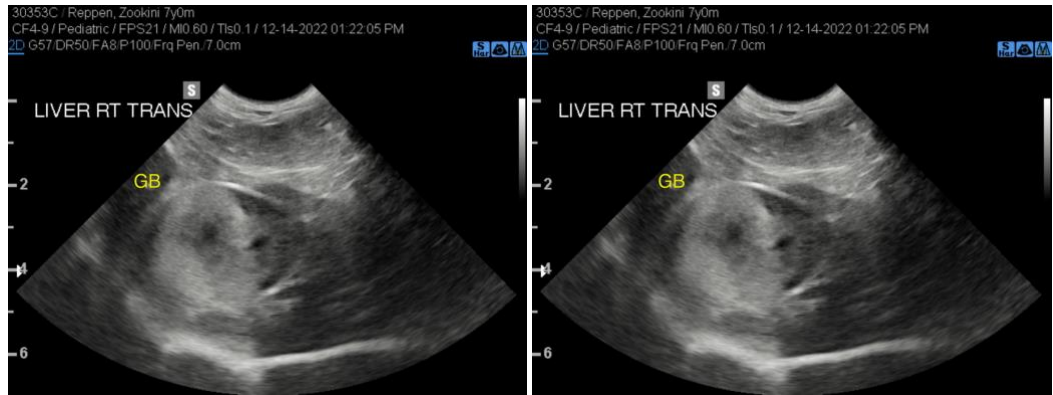
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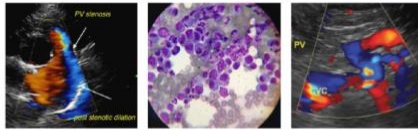
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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