



**PATIENT**

Jersey Carto

**SPECIES**

Canine

**BREED**

Aussiedoodle

**SEX**

Spayed Female

**AGE**

9 Years

**WEIGHT**

28.35 kg

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Donna Markland, DVM

**HOSPITAL NAME**

Island Mobile Paws VS

**REFERRING VET**

Mahalo VH

**INVOICE**

20270

**DATE**

12/28/22

**PRESENTING CLINICAL SIGNS**

History: Presented 12/22 for vomiting bile/mucous/and foam (red, brown, or orange) and diarrhea 1-2 times per day for past 5 days. Jersey has a long history of bilious vomit once every 6 weeks or so but has never had these persistent clinical signs. Diet is "Go!" brand Salmon and Rice. PE was normal other than yellow discharge from the anal sacs with bacilli and cocci noted on microscopic exam. Jersey has been on oral metronidazole and probiotics since December 22nd. Clinical signs have decreased but are still present. CBC, Chem, and snap cPL were done. Mildly increased ALT. Mildly increased reticulocytes with normal HCT.

Abnormal PE/Chem/CBC/UA Results: Reticulocytes=127.6 (10-110) with HCT=0.508 ALT=157 (10-125)

**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. Aortic trifurcation was normal.

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 6.4 cm in length. The right kidney measured – cm in length.

**Adrenal Glands**

Both adrenal glands exhibited normal to possible borderline subnormal size with symmetrical contour and homogenous parenchyma. The right adrenal gland measured 2.8 cm length x 0.47 cm width at the caudal pole. The left adrenal gland measured 2.4 cm length x 0.46 cm width at the caudal 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 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 exhibited variable wall thickening, exhibiting subjective decreased mural echogenicity and indistinct to loss of gastric wall layer detail. The stomach was primarily empty with mild luminal gas and without evidence of retained gastric ingesta, fluid or foreign material. No overt evidence of mechanical pyloric outflow obstruction. The gastric body wall measured potentially up to 1.5 cm wall width.



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The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was primarily empty with minor segmental gas and without evidence of mechanical/metabolic small intestinal ileus. The duodenum wall measured 0.32 cm. The jejunum wall measured 0.25 cm.

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The colon walls presented intact yet mildly prominent wall layering with mild thickened to echogenic submucosa. The colon contained generalized semi-formed to possible soft fecal matter consistent with patient history.

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***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 or peritoneal effusion was present.

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**ULTRASONOGRAPHIC FINDINGS**

**WEIGHT**

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- Variably thickened stomach, exhibiting decreased mural echogenicity and indistinct loss of gastric wall layer detail
- Sonographically unremarkable small bowel with suspect mild colitis
- Overtly normal small bowel
- Benign low grade hepatopathy
- Subjective possible borderline subnormal bilateral adrenal glands- nonspecific

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The gastric appearance may indicate inflammatory etiologies, such as chronic gastritis, although the possibility of infiltrative gastric neoplasia, which may present in similar sonographic manner, is possible. Likewise, potential for generalized inflammatory gastroenterocolonopathy, given the concurrent presence of diarrhea could be present.

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Further assessment may include a GI panel to include PLI/TLI/Cobalamin/Folate. Resting cortisol level to rule out occult Addison's disease is warranted. Endoscopy is likely ideal in this patient if available.

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Empirically, gastroprotectant protocol, i.e., Omeprazole 1 mg/kg PO SID, novel protein or hydrolyzed protein diet with initial slurry feeding progressing to canned diet BID with avoidance of dry food +/- coverage to helicobacter and gastric reassessment in 3-4 weeks or sooner, if progressive evidence of vomiting, would be reasonable.

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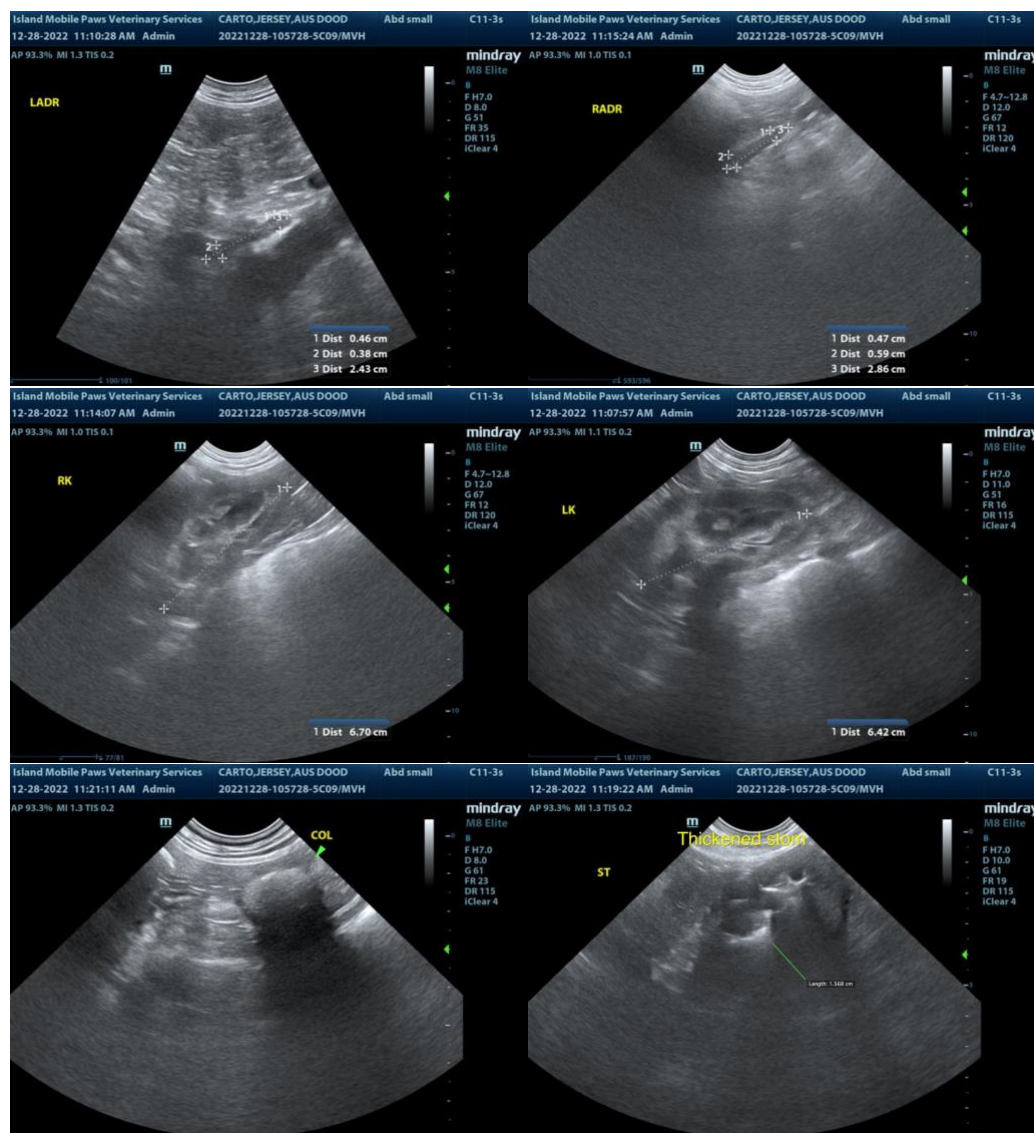
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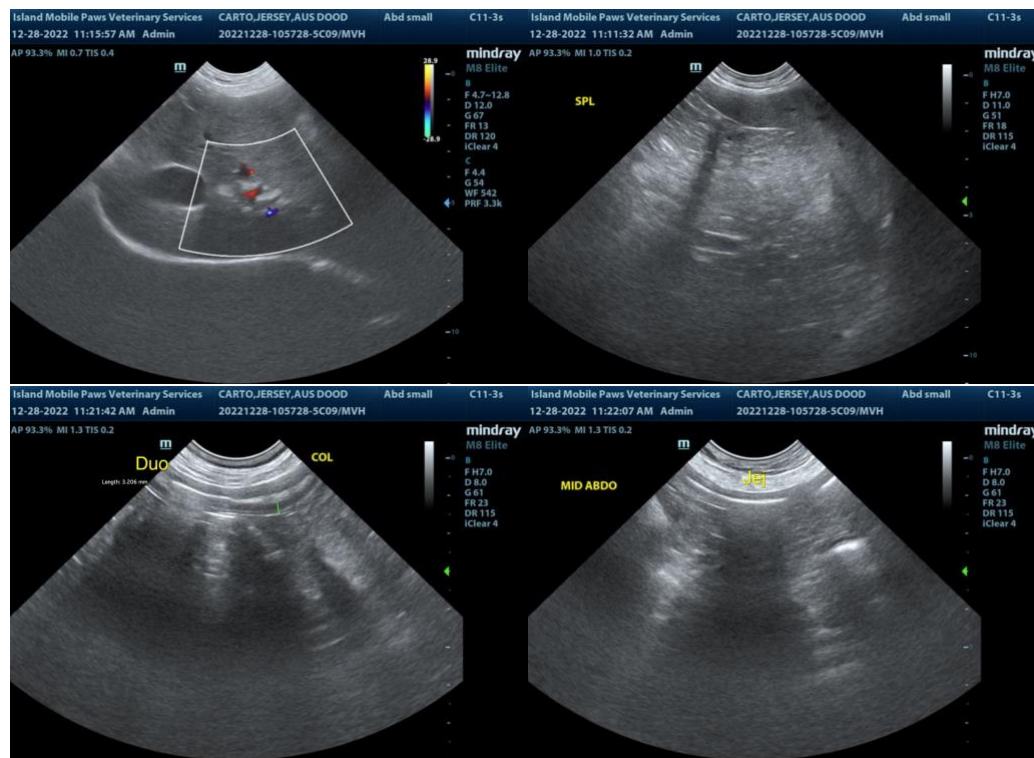
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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