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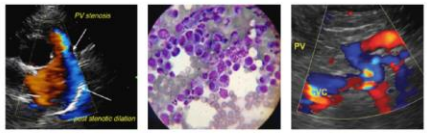
fredgromalak@gmail.com



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

PATIENT

Ever Hudson 55606A

SPECIES

Canine

BREED

Australian Cattle Dog

SEX

Female Spayed

AGE

3 years

WEIGHT

13.8 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VET

Madison Veterinary Specialists

INVOICE

15367

DATE

12/29/22

PRESENTING CLINICAL SIGNS

Ever presented to the MVS Emergency Service on Dec 28, 2022, at (4:15pm), for evaluation of vomiting through Cerenia, lethargy. Vomiting started ~5 am yesterday (12/27) - vomited yellow foamy bile ~7 times. Went to pcDVM for x-rays, SQ fluids, and Cerenia Fed bland diet of chicken and rice ~6:15 pm last night (12/27). Kept it down, so owners gave more 1 hr later. Kept that down as well. Tried more chicken and rice 2 hours later, but Ever was not interested in food at this time. Today (12/28), Ever has been very lethargic and hiding in her crate. Seems nervous/tense. She won't eat or drink today either. Nauseous today as well. Vomited more today (10-15 vomits total between today and yesterday). Consistency of vomit was still yellow but contained bits of food. Went back to pcDVM for recheck rads, bloodwork, more SQ fluids and Cerenia. Rads suggest gas, bloodwork unremarkable. Ever is still vomiting through Cerenia, owners are concerned about potential FB as she is known to eat things and she got into the trash on Thursday.

Abnormal PE/Chem/CBC/UA Results: NG tube placed overnight and patient was fasted since presentation. pDVM bloodwork on 12/28 overall unremarkable except for mild hemoconcentration (HCT 57%).

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 was noted.

The area of the aortic trifurcation was free of pathology.

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 2.9 cm in length. The right kidney measured 6.1 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 0.52 cm width at the caudal pole and 0.43 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 0.46 cm width at the caudal pole and 0.47 cm width at the cranial 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.

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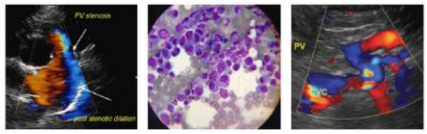

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Liver/ Gallbladder

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 and mildly prominent wall layering. The stomach contained a moderate amount of retained primarily anechoic fluid and potential minor chyme extending into the pyloric outflow. The gastric body wall width measured 0.65 cm.

Within the upper duodenum, just distal to the gastroduodenal junction, a mildly hyperechoic to shadowing echo was present potentially extending into the area of the mid-duodenum measuring approximately 4.0-5.0 cm in diameter. The echo was not strongly shadowing yet exhibited subjective mild distal acoustic shadowing. The generalized small intestine was primarily empty without evidence of additional areas of small intestinal mechanical / metabolic ileus, loss of intestinal wall layering, or other obstructive criteria. The duodenum wall measured 0.40 cm width. The jejunum wall measured 0.34 cm width.

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 were evident.

Free Abdomen

Intermittent 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 lymph node measured 3.2 cm x 0.49 cm. The lymph nodes were not consistent with neoplastic criteria.

ULTRASONOGRAPHIC FINDINGS

- Gastritis pattern with moderate retained gastric fluid - Mechanical vs metabolic gastric stasis
- Nonspecific mild shadowing duodenal echo subjective just distal to the gastroduodenal junction potentially extending into the mid-duodenum, empty small bowel otherwise
- Normal pancreas
- Intermittent mild benign / reactive mesenteric lymph nodes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Strong concern for mechanical upper intestinal obstructive pattern, given nonspecific duodenal echo in combination with moderate gastric distention with retained fluid. No other evidence of additional areas of mechanical / metabolic gastrointestinal obstruction or definitive foreign material.

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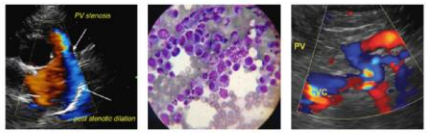

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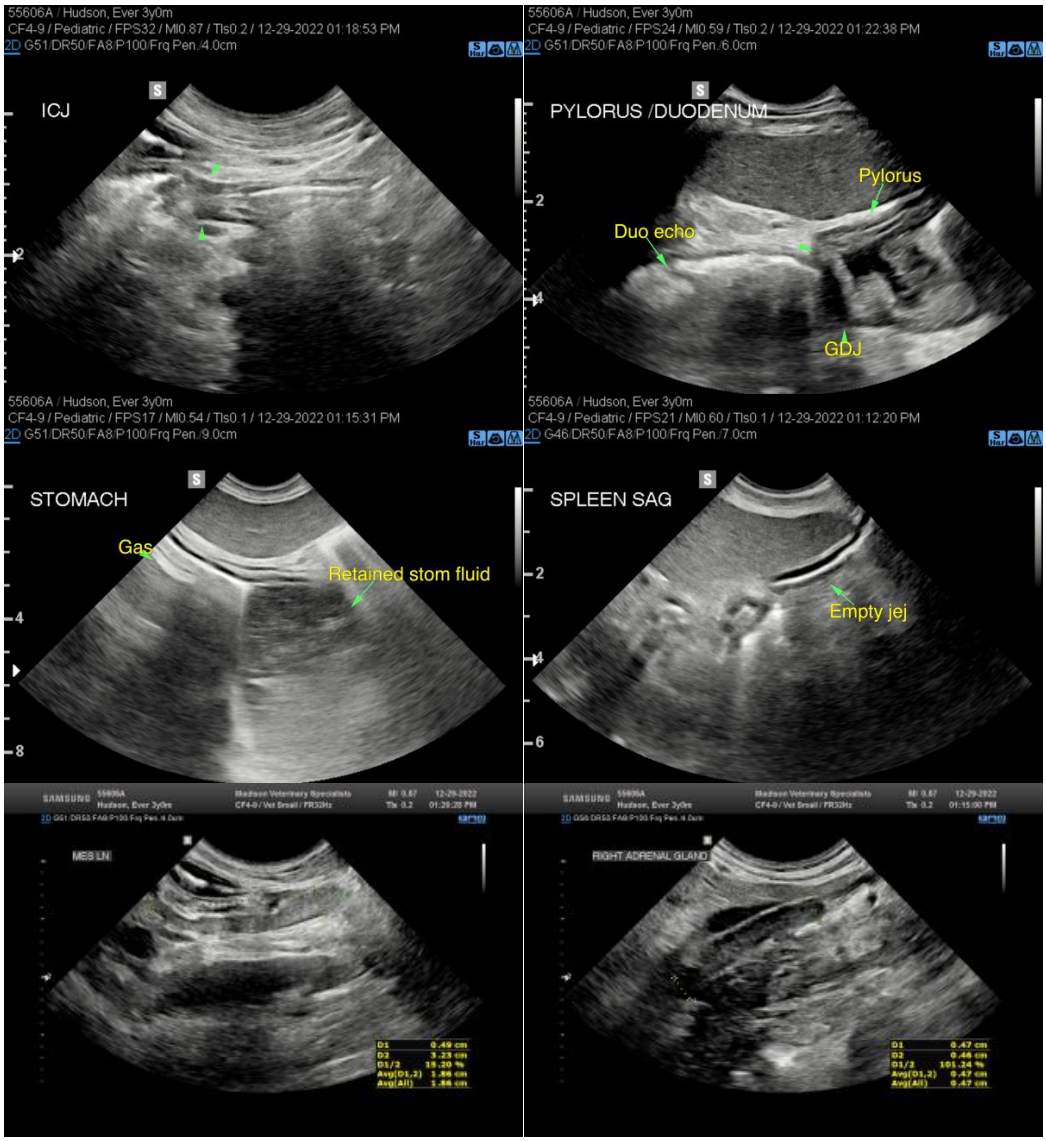
If available, endoscopy could be considered for further assessment and potential retrieval of the mechanical obstruction. However, the definitive size of the obstruction was difficult to ascertain. Otherwise, exploratory laparotomy with gross inspection of the upper gastrointestinal tract is possible. Manipulation of the obstruction into the stomach with gastrotomy and/or enterotomy is warranted. Intestinal biopsies may be considered pending gross inspection of the intestinal tract despite exploratory findings.



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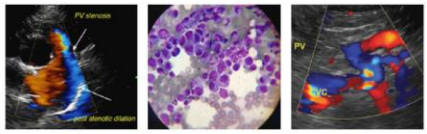

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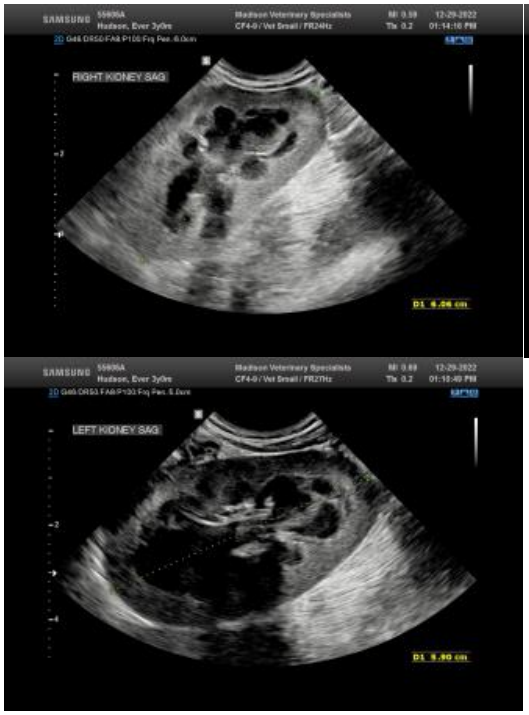

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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