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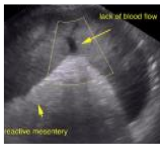
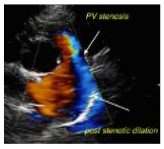
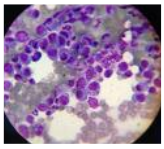
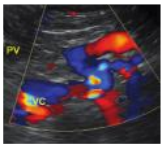

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1-800-838-4268 info@sonopath.com

PATIENT

Kai Swank

SPECIES

Canine

BREED

Rat Terrier Mix

SEX

MN

AGE

N/A

WEIGHT

26 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Brita Kiffney

HOSPITAL NAME

Northshore VH

REFERRING VET

Dr. Brita Kiffney

INVOICE

20904

DATE

2/1/23

PRESENTING CLINICAL SIGNS

Pet presented 1/18/2023 for acute vomiting/loss of appetite after spending time w/O on "job site"-no direct observation specific dietary indiscretion but presumed strong possibility. Px responded well to hospitalization, supportive care, returned next day for continued IVF/pain meds and was eating well in hospital with no further vomiting. Px returned 1/26/23 for persistent decreased appetite and was hospitalized for radiographs, repeat labs and supportive care. Follow up labs showed rising liver enzymes, normal cPli and no other abnormalities. Px responded to supportive care including appetite stimulant this time and was discharged for home care with abdominal u/s recommended and scheduled.

Abnormal PE/Chem/CBC/UA Results: 1/18/23Px labs showed stress leukogram with very subtly deranged electrolytes/dehydration, abnormal cpli, incidental UTI. 4dx: neg cortisol (resting) Pending

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 4.0 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 residual prostate appeared normal and free of pathology.

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 5.2 cm in length. The right kidney measured 4.6 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 0.46 cm width at the caudal pole and 0.5 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 0.49 cm width at the caudal pole and 0.58 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.

Liver/ Gallbladder

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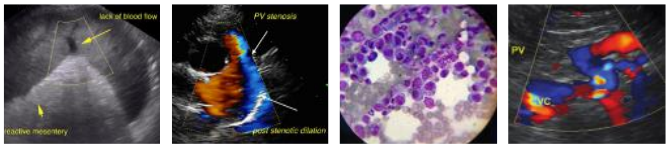

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The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion. 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 mild wall thickening secondary to echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. The pylorus wall measured 0.42 cm. A mild amount of retained anechoic fluid and luminal gas was present in the stomach. No evidence of mechanical pyloric outflow obstruction.

The small intestine presented intact subjective generalized prominent wall layering, owing to propensity for generalized prominent mucosal layer. Intermittent to minor nonspecific duodenojejunal mucosal speckling was present. A strongly shadowing echo was present in a portion of the small intestine, directly adjacent to the colon, measuring approximately 1.2 m in diameter. The echo did not appear to be obstructive given the lack of regional or generalized retained intestinal fluid or ileus pattern.

The colon walls presented intact yet mild prominent wall layering with mild thickened to echogenic submucosa. Subjective semi-formed to soft fecal matter was present in the colon lumen with lumen dilation.

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

No overt omental masses, lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Nonspecific inflammatory gastroenterocolonopathy with mild gastric stasis
- Suspicious focal subjective nonobstructive shadowing intestinal echo- strong potential for focal nonobstructive intestinal foreign body

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Sonographically, the generalized gastrointestinal tract/colon is consistent with inflammatory criteria, which may include gastroenterocolitis, inflammatory bowel disease or similar, with potential infectious or less likely alternative infiltrative etiologies possible.

The focal shadowing intestinal echo is strongly suspicious or supportive of nonobstructive focal intestinal foreign body. Potentially, this suspected to suspicious foreign body may be slowly passing yet not overtly within the colon lumen.

Some degree of low-grade pancreatitis, which may present sonographically normal, could also be possible yet no sonographic evidence of significant pancreatitis as a primary clinical factor.

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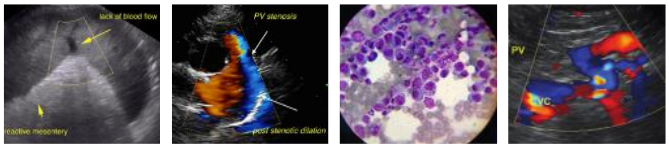

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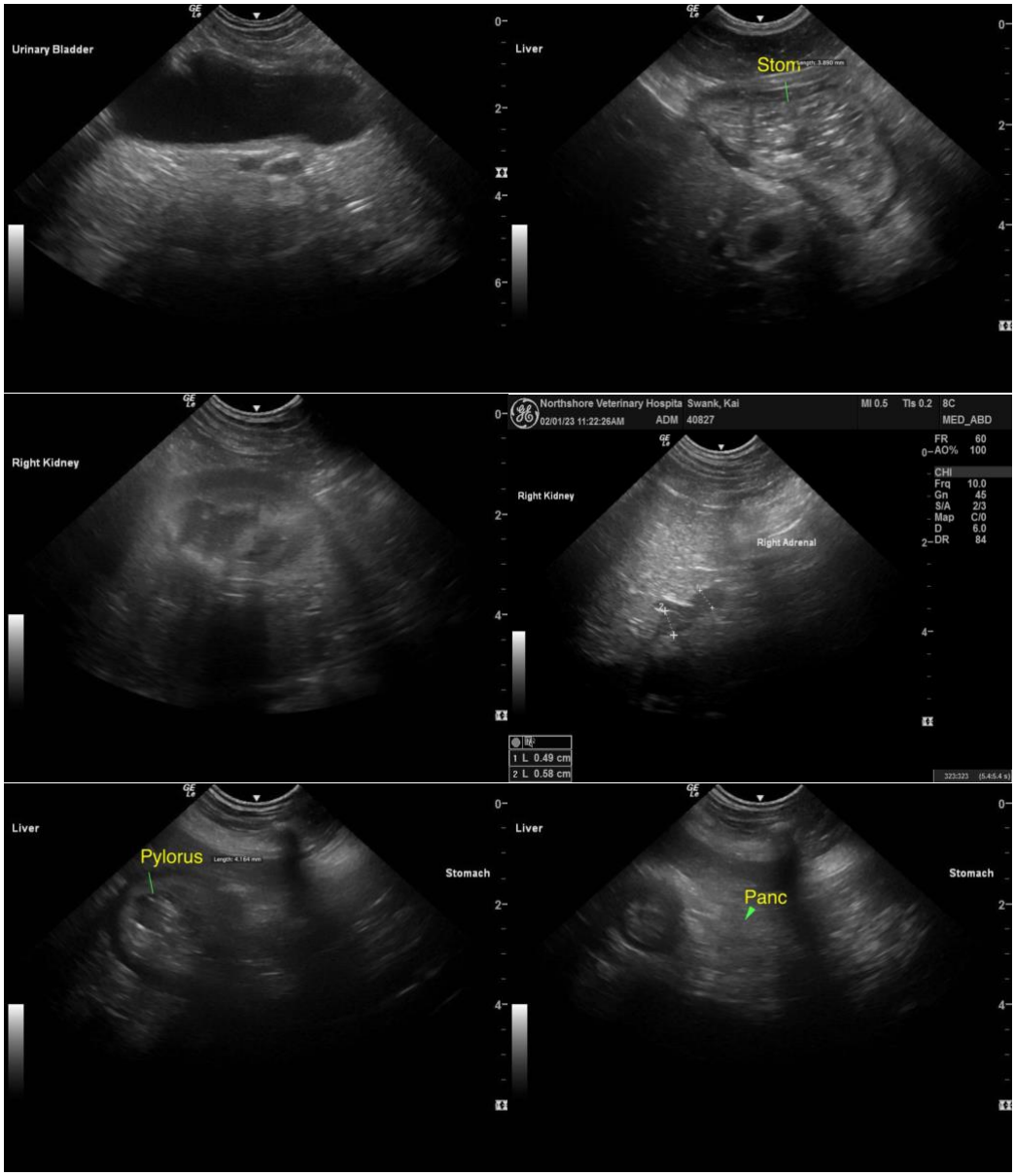
Given the recurrent gastrointestinal signs in this patient, generalized gastroenterocolic sonographic appearance, as well as highly suspicious nonobstructive intestinal foreign body, exploratory laparotomy for gross inspection of the intestinal tract, and with gastrointestinal biopsies considered essential despite exploratory findings, is warranted. Continued gastrointestinal support with sonographic reassessment of the intestinal tract in 24-hours, for resolution or persistence of suspected intestinal foreign body would be a more conservative approach. Likewise, if surgery is elected, brief sonographic reassessment to make sure that the echo has not moved prior to surgery, is recommended.



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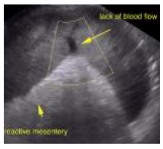
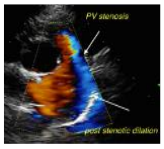
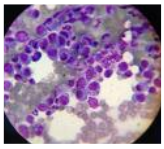
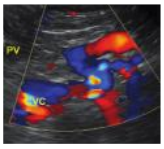

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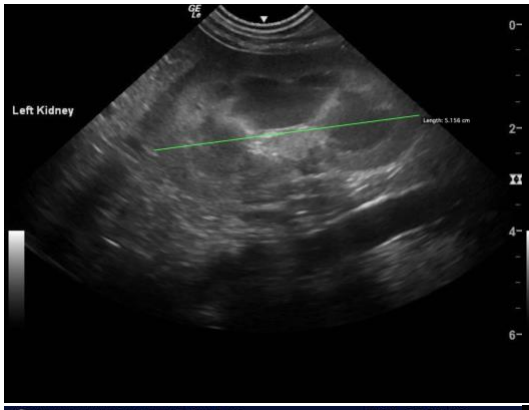

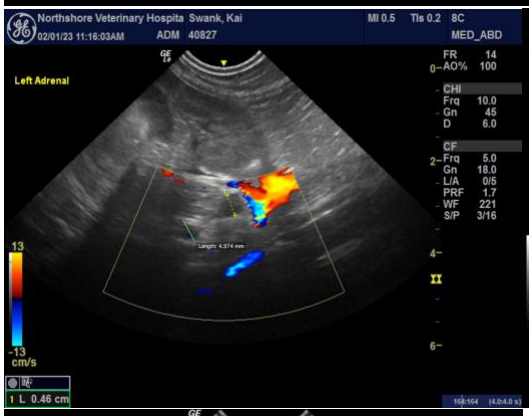

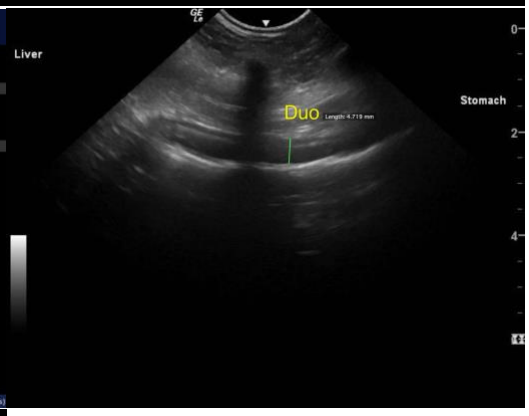

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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