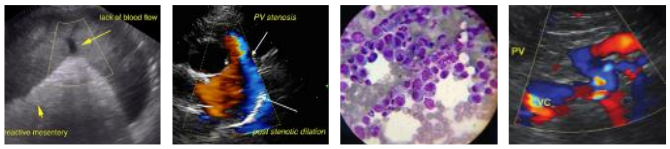
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Angelina Scott

SPECIES

Canine

BREED

Standard Poodle

SEX

FS

AGE

10yr

WEIGHT

20.1kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Donna Markland DVM

HOSPITAL NAME

Island Mobile Paws

REFERRING VET

Island Animal Hospital

INVOICE

12947ag

DATE

02/14/2023

PRESENTING CLINICAL SIGNS

Angelina initially presented to her regular veterinary hospital on January 23rd for intermittent vomiting. PE was unremarkable. CBC/Chem/SDMA was normal other than a slightly low magnesium. An ultrasound was booked but then cancelled as Angelina improved. Last week, she started vomiting again. An ultrasound was booked for later this week, but then on February 11th, Angelina was taken to the emergency hospital for continued vomiting. A cortisol level was run and was normal. Angelina is on a commercial grain free diet (Acana). She has no reported history of foreign body ingestion. Her energy level remains normal.

Abnormal PE/Chem/CBC/UA Results: 1/24/23: Mg=0.6 (0.7-1.3)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 4 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 left kidney. 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 6.3 cm in length. The right kidney was not definitively visualized.

The area of the aortic trifurcation was free of pathology.

The area of the iliac trifurcation was free of pathology including no evidence of overt or significant medial, iliac or sublumbar lymphadenopathy/masses.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.65 cm width at the caudal pole. The right adrenal gland was not definitively visualized.

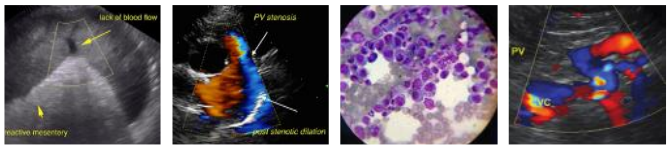
Spleen

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

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 with minor non-organized echogenic debris. No evidence of gallbladder or peripheral gallbladder inflammation was present. The cystic and common bile ducts were normal.

Gastrointestinal



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The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained mild luminal gas with no obvious signs of ileus, obstruction or foreign material. The presence of luminal gas prohibited full evaluation of the gastric lumen. The ventral gastric body wall measured 0.38 cm in width.

The small intestine presented generalized intact wall layering with 1:3 muscularis/mucosa ratio. A focal area of thickened dorsal duodenum wall potentially in the area of the duodenal papilla was present measuring ~ 2.2 cm in length x 0.71 cm in width. By comparison, normal appearing duodenum wall measured 0.41 cm in width. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material.

Normal visible descending colon wall layers were present with apparent semi formed to soft feces in lumen.

Pancreas

The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum, likely consistent with age related changes and considered incidental. No signs of active inflammation or neoplasia.

Free Abdomen

Regional non-uniform to nodular mixed echogenic omentum was present in the cranial abdomen and around the area of the stomach/pancreas appearing to extend caudally along the ventrum to the level of the left kidney and into the area of the spleen. No overt evidence of splenorenal or hepatic involvement. Suspect likely mildly prominent to hypoechoic associated regional mesenteric lymphadenopathy. Potential for intermittent very scant cranial abdominal peritoneal free fluid although not definitive.

ULTRASONOGRAPHIC FINDINGS

- Unspecified non-uniform nodular omentum cranial abdomen, primarily perigastric/peripancreatic extending caudally along the ventrum-non-specific peritonitis, ill-defined omental mass vs carcinomatosis/lymphomatosis or similar, ill-defined pancreatic/upper GI pathology all potentials
- Intact non-distended stomach with mild luminal gas
- Focally thickened duodenum possibly in the area of the duodenal papilla
- Non-distended gallbladder with mild luminal debris-no evidence of post hepatic obstructive criteria
- Heterogenous pancreas base/right limb
- Mild age related left kidney
- Sonographically normal liver/spleen

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Assuming normal clotting status, an abnormal nodular omentum FNA for screening cytology is warranted for further assessment. A spec cPL recommended to assess for evidence of concurrent pancreatic inflammatory criteria. Three view chest radiographs are recommended if not done to assess for occult thoracic pathology.

Pending cytology if elected, hospitalization with empirical therapy for pancreatitis with as needed GI support and sonographic monitoring of the abnormal omentum for evidence of progression vs resolution could be considered. If persistent/progressive vomiting, laparotomy with gross inspection of the abdominal cavity and potential for biopsies may be indicated.

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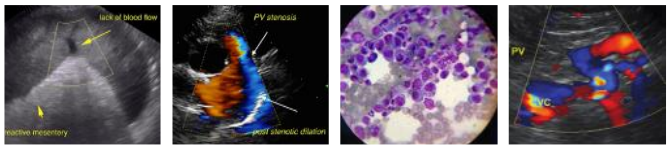

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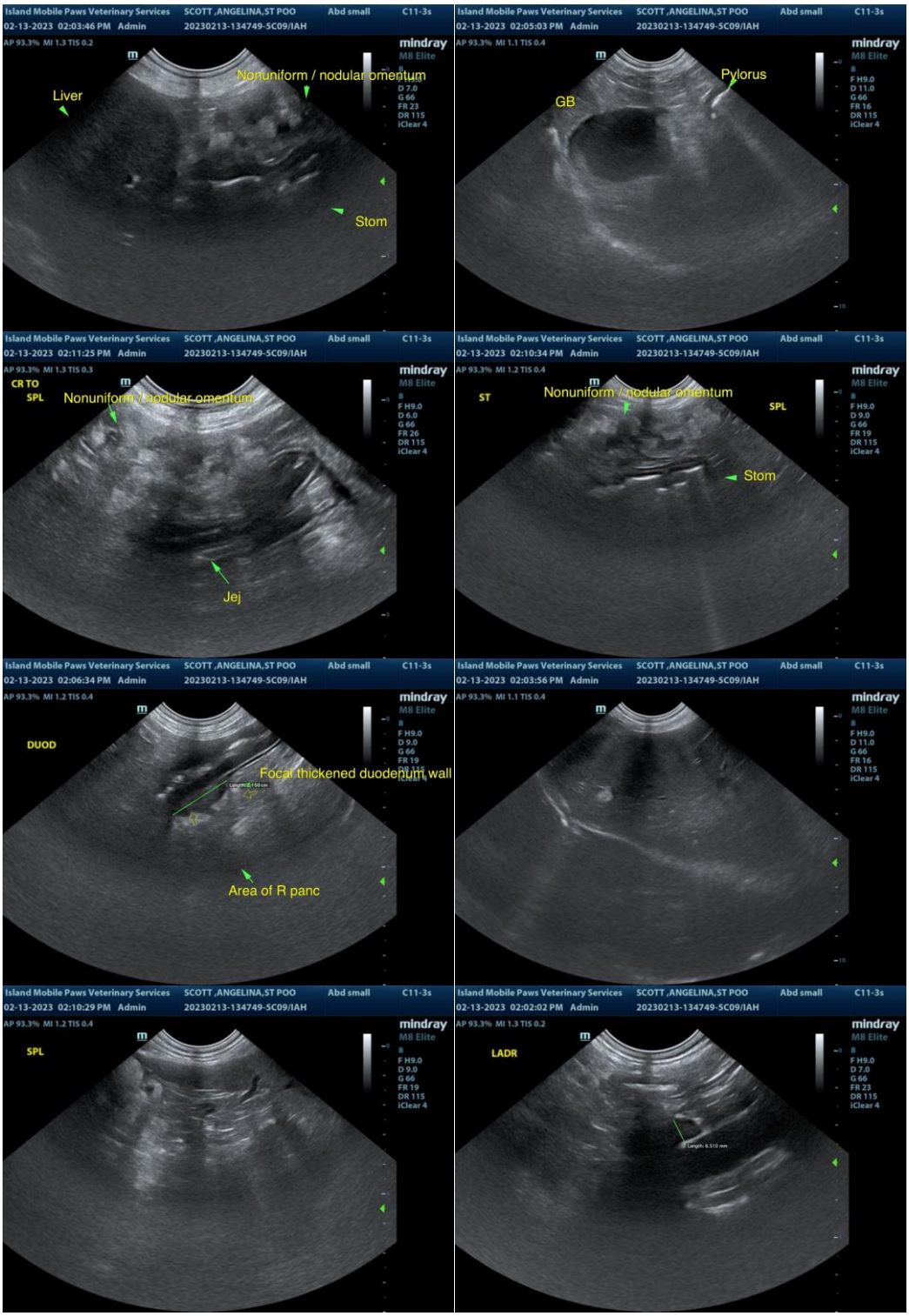

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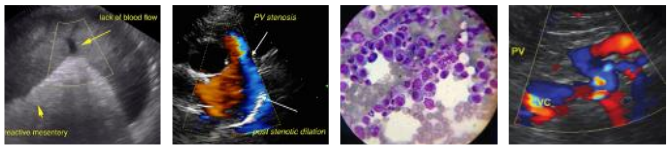

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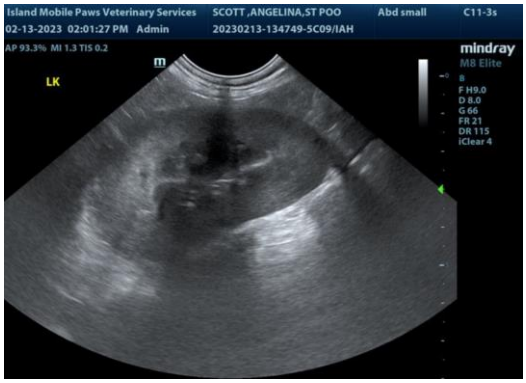

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
mac.daniel@sonopath.com