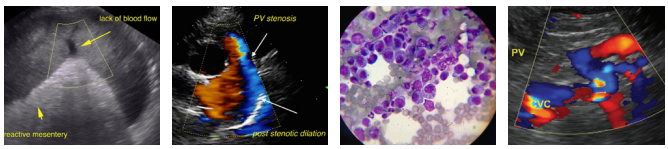
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™




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

**PATIENT**
Nillie Milstead

**SPECIES**
Canine

**BREED**
Lab X

**SEX**
Spayed Female

**AGE**
1 Year

**WEIGHT**
24.6 kg

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

**IMAGING PERFORMED BY**
Patti Mayfield, DVM

**HOSPITAL NAME**
Smiling Dog VS

**REFERRING VET**
Patti Mayfield, DVM

**INVOICE**
35931

**DATE**
2/27/22

## PRESENTING CLINICAL SIGNS

O reported that P has been very lethargic, having diarrhea, and vomiting since yesterday evening (foamy bile, no food). P has been wandering around acting uncomfortable. P's appetite has been diminishing over last couple of days, and will throw up after eating (not immediately, but shortly after). P will drink water but then vomits that up as well. P did not eat anything last night but ate a little bit this morning and did seem a little perkier. P was at doggy daycare on Wednesday, and has seemed super exhausted since then. Client states that Nillie is typically very inquisitive and will chew on many items, including plastic, toys, etc. Client is not aware of any ingested foreign material at this time. No exposure to uncooked fish. Patient vomited this morning at ~ 6:30 am, then ate 2 small bowls of food, but vomited again shortly before noon today. Her stools have been slightly more solid than cow-pie consistency at home. No hematochezia appreciated. Patient has received IVF, Cerenia, Buprenorphine and appears improved with supportive care.
Abnormal PE/Chem/CBC/UA Results: PE: Approx 7% dehydrated. Cranial abdomen is tense with mild bracing/pain. Liquid stools on rectal. Patient passed 4+ liquid, brown diarrhea following rectal exam. CBC: CHEM: WNL Albumin wnl @ 2.9 PCV/TP: 65%/4.5 g/dL cPL: Normal Fecal O&P/Giardia: Pending Abdominal Rads (lat/vd): The stomach is mostly empty, only mid amount of gas and no ingesta, obvious FB or obstruction. Gastric axis is appropriate. There is mild increased opacity and subtle loss of detail in the region of the proximal SI (duodenum) with very mild gas present, but no obvious FB or obstruction. Mild gas noted in a distal loop of SI with hypermotility appreciated. Moderate gas is appreciated in the colon.

## 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 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 6.2 cm. The right kidney measured 5.4 cm.

### *Adrenal Glands*

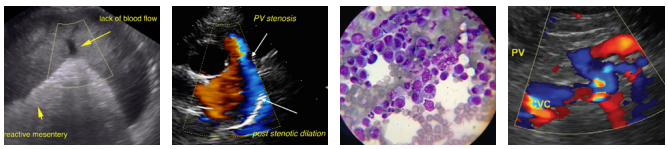
The adrenal glands were uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 2.0 cm length x 0.58 cm at the caudal pole. The left adrenal gland measured 3.1 cm length x 0.55 cm at the caudal pole.

### *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

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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 wall thickening secondary to echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. The stomach contained a mild amount of anechoic to echogenic fluid, primarily in the antrum and pylorus without evidence of distal acoustic shadowing. Ventral gastric body wall measured 0.74 cm. Pylorus wall measured 0.49 cm.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The upper to mid duodenum contained a mild amount of retained anechoic fluid without evidence of distal acoustic shadowing, consistent with mild upper to mid duodenal ileus. The jejunum and ileum to the level of the colon were empty without evidence of mechanical/metabolic ileus. Duodenum wall measured 0.52 cm. Jejunum wall measured 0.37 cm.

The colon walls presented intact yet mildly prominent wall layering. The descending colon was primarily empty, containing a mild amount of subjective semiformed feces and luminal gas. Descending colon wall measured 0.26 cm.

### *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*

Intermittent enlarged jejunal lymph nodes were present. Example measured 3.2 cm x 0.72 cm. These lymph nodes were homogenous, mildly hypoechoic and smoothly marginated. A normal width: length ratio was maintained (<0.5). Evidence of perilymphatic inflammation was evident.

Mild, primarily intestinal reactive mesentery noted along with intermittent scant pockets of peri intestinal free fluid.

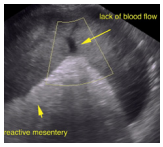
## ULTRASONOGRAPHIC FINDINGS

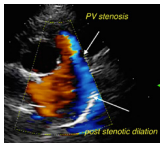
- Acute/subacute gastroenteritis pattern with mild gastric stasis
- Intermittent jejunal lymphadenopathy – suspect associated mild jejunal lymphadenitis.
- Mild, primarily peri intestinal reactive mesentery and intermittent scant pocket of peri intestinal free fluid

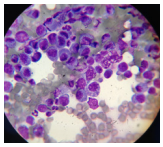
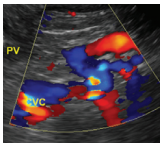
## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Overt evidence of gastrointestinal foreign material or mechanical obstruction was not evident in this study. Overall, the appearance of the gastrointestinal tract is most consistent with acute to subacute inflammatory bowel episode with concurrent, likely mild jejunal lymphadenitis. Infectious gastroenterocolitis, dietary indiscretion, gastroenterotoxic insult, or other gastroenterocolonopathy possible.

Given this presentation, no overt indication for immediate surgical intervention. Hospitalization with gastrointestinal support, IV fluids, and continued monitoring would be reasonable. The scant peri intestinal free fluid is suspected to be owing to intestinal inflammation, given albumin levels. Further assessment may include resting cortisol level to rule out occult Addison's disease and GI panel to assess PLI, TLI, cobalamin and folate. Potential for low-grade pancreatitis, yet sonographically normal. Pending clinical response to conservative therapy, recheck sonogram could be considered to assess for



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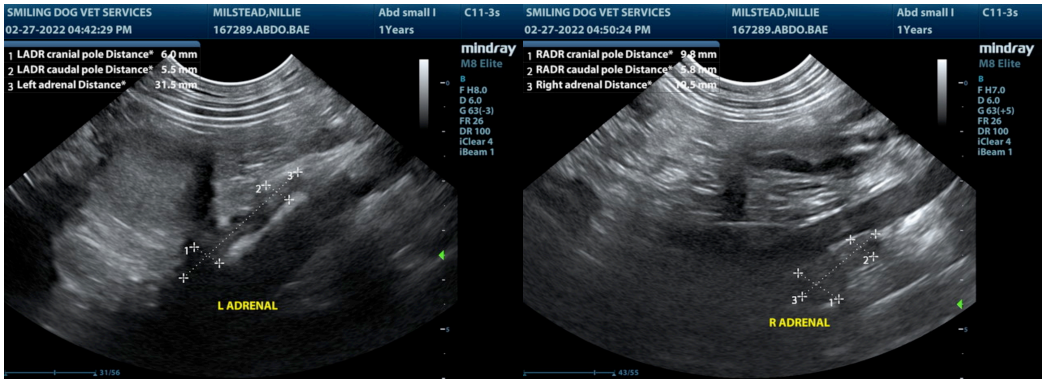
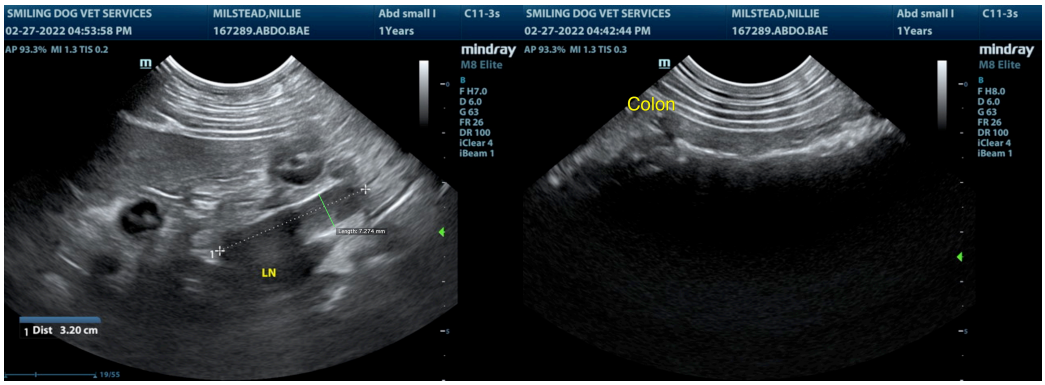
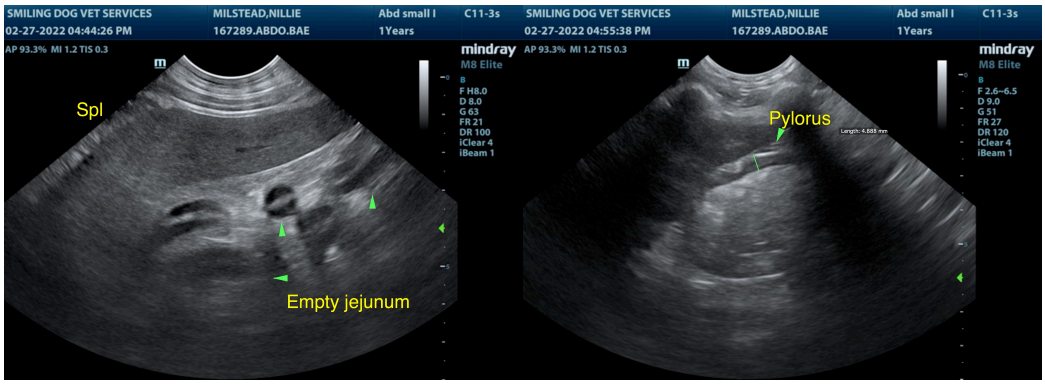
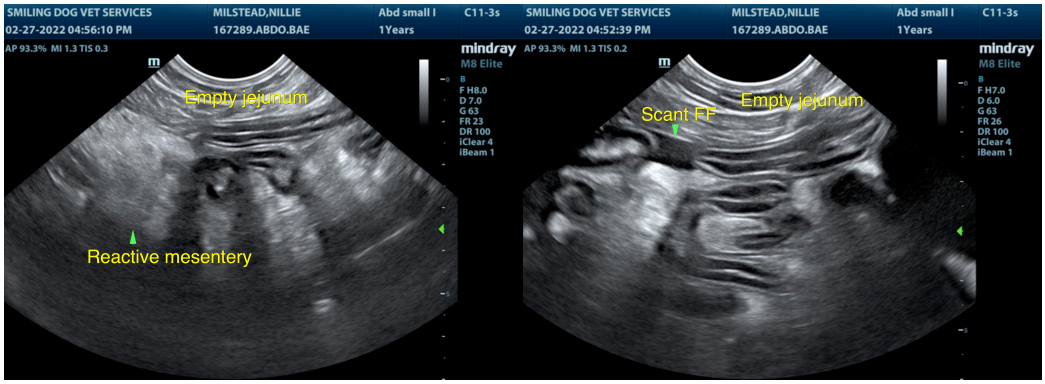
progressive inflammatory gastrointestinal or lymphatic changes if clinical signs are persistent.



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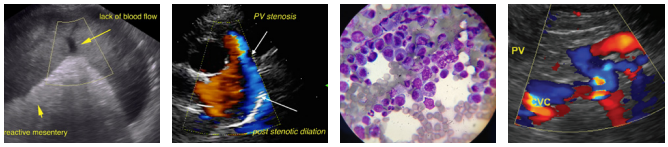


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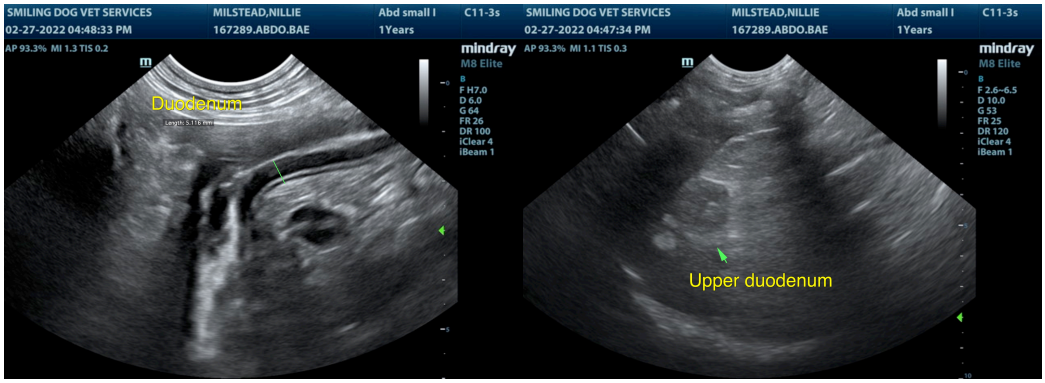


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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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