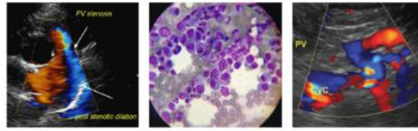


PATIENT

Trooper Quattromani

SPECIES

Canine

BREED

Labrador Retriever

SEX

Neutered Male

AGE

7 Years 6 Months

WEIGHT

33 kg

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

IMAGING PERFORMED BY

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VET

Dr. Maller

INVOICE

20951

DATE

PRESENTING CLINICAL SIGNS

History: Trooper presented to the MVS Emergency Service on Feb 03, 2023, at 4:45am, for evaluation of vomiting and inappetence. Trooper has been vomiting with associated coughing for three days (since Tuesday 1/31) and has been unable to keep food down for 2 days (since Wednesday 2/1). He had a normal bowel movement on Wednesday evening and was possibly gassy on Sunday evening. There is no obvious evidence that Trooper got into non-food items. In November 2022, Trooper was diagnosed with hookworms, treated with oral medications, and tested negative in January/December.

Abnormal PE/Chem/CBC/UA Results: Thorax: No murmur or arrhythmia; harsh BV sounds bilaterally and tachypneic, few episodes of retching in treatment area Abdomen: Tense in cranial abdomen, active retching when palpated Rectal: Soft, mucoid diarrhea Signs of hypovolemic shock Thoracic radiographs: Alveolar pattern in the cranial and caudal lobe of the left cranial lung lobe on VD and middle ventral lung fields on both laterals- suspect aspiration pneumonia Moderate gas dilation of esophagus Nasogastric tube placement with aspirations: 9am 2090mLs air, 10mLs fluid 10am 125mLs air, 0mLs fluid 12pm 318mLs air, 0mLs fluid Bloodwork: ADMA 15 Crea 2.0 BUN 48 TP 9 Glob 5.4 ALP 249 Chol 335 Na 161

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 were noted.

The residual prostate was symmetrically normal in size with uniform parenchyma and slight coarse echotexture measuring 1.3 cm in width.

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 7.2 cm in length. The right kidney measured 6.9 cm in length.

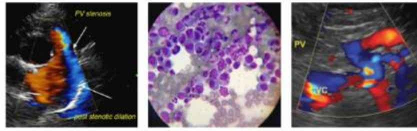
Adrenal Glands

The adrenal glands were borderline prominent in size based on caudal pole measurement in light of body weight yet without evidence of significant adrenomegaly. No adrenal tumors were present. This is likely a normal patient adrenal variant. The left adrenal gland measured 0.85 cm width at the cranial pole and 0.82 cm width at the caudal pole. The right adrenal gland measured 0.84 cm width at the caudal pole and 0.67 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



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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 content and minor echogenic luminal debris, likely secondary to fasting. No evidence of mucocele criteria. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach exhibited subjective moderate gas distention. The visualized gastric and pyloric walls were sonographically normal without evidence of mechanical pyloric outflow obstruction or overt obstructive pyloric mural pathology. The ventral pylorus wall measured 0.62 cm wall width. The ventral gastric body wall measured 0.35 cm.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of mechanical/metabolic ileus, obstruction or foreign material.

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 was evident.

Free Abdomen

Intermittent, mildly prominent to enlarged mesenteric and focal medial iliac 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). The medial iliac lymph node measured 2.8 cm x 0.56 cm. An example of mesenteric lymph node measured 3.0 cm x 0.53 cm. No omental masses or peritoneal effusion.

ULTRASONOGRAPHIC FINDINGS

- Gas distended stomach, exhibiting sonographically unremarkable gastric wall layering
- Normal small bowel- no evidence of mechanical/metabolic ileus
- Intermittent minor benign/reactive mesenteric and medial iliac lymphadenopathy

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Overall, no sonographic evidence of significant visceral, specifically gastrointestinal pathology as an obvious or definitive cause of the patients gastrointestinal signs. Mild gastritis/esophagitis, metabolic gastric hypomotility, mild inflammatory gastroenteropathy, low grade to chronic pancreatitis, which may present sonographically normal, are all potentials. No evidence of intraabdominal neoplastic criteria. Spec cPL could be considered to assess for evidence of low grade or chronic pancreatitis as a contributing factor. Although considered unlikely, resting cortisol level to rule out occult Addisons disease may be considered. Upper gastrointestinal endoscopy (if available or possible) is likely ideal.

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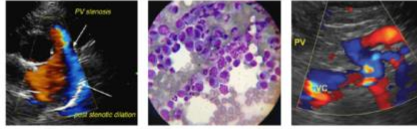

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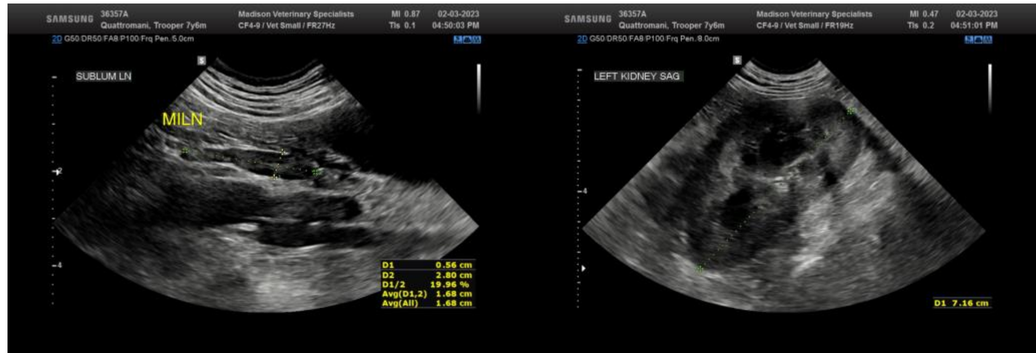

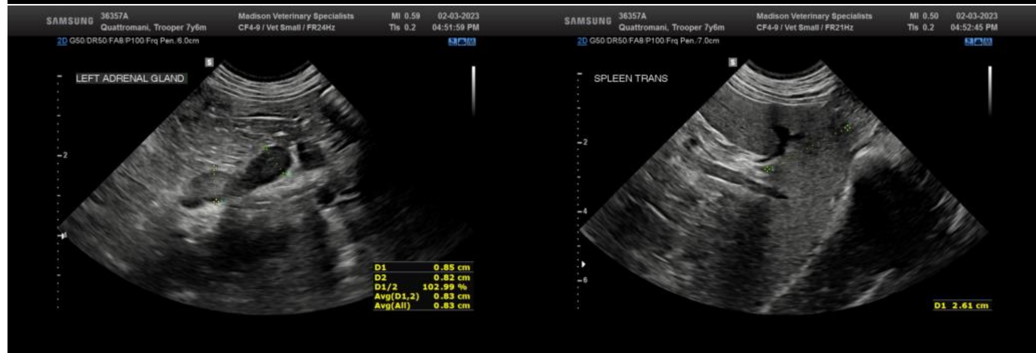

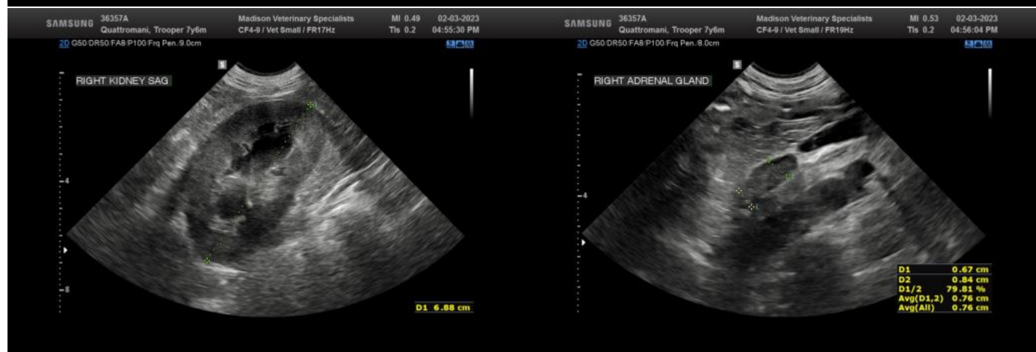

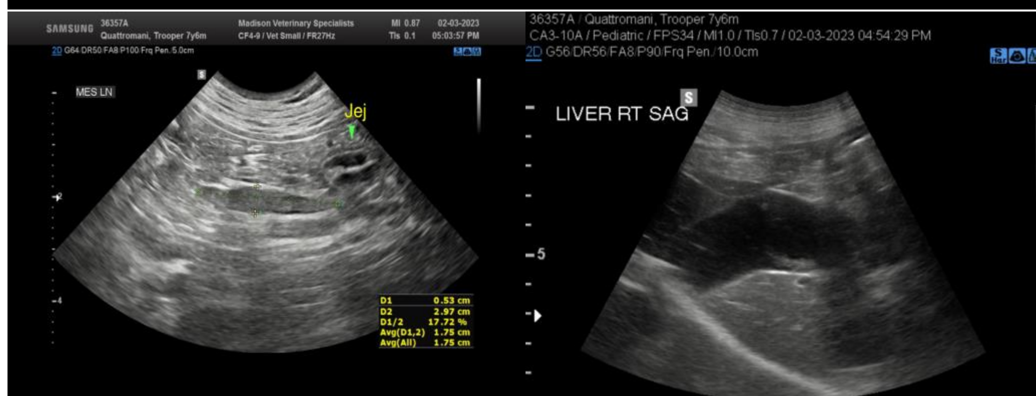

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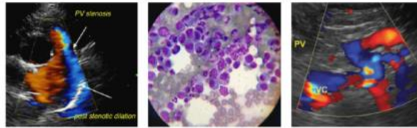

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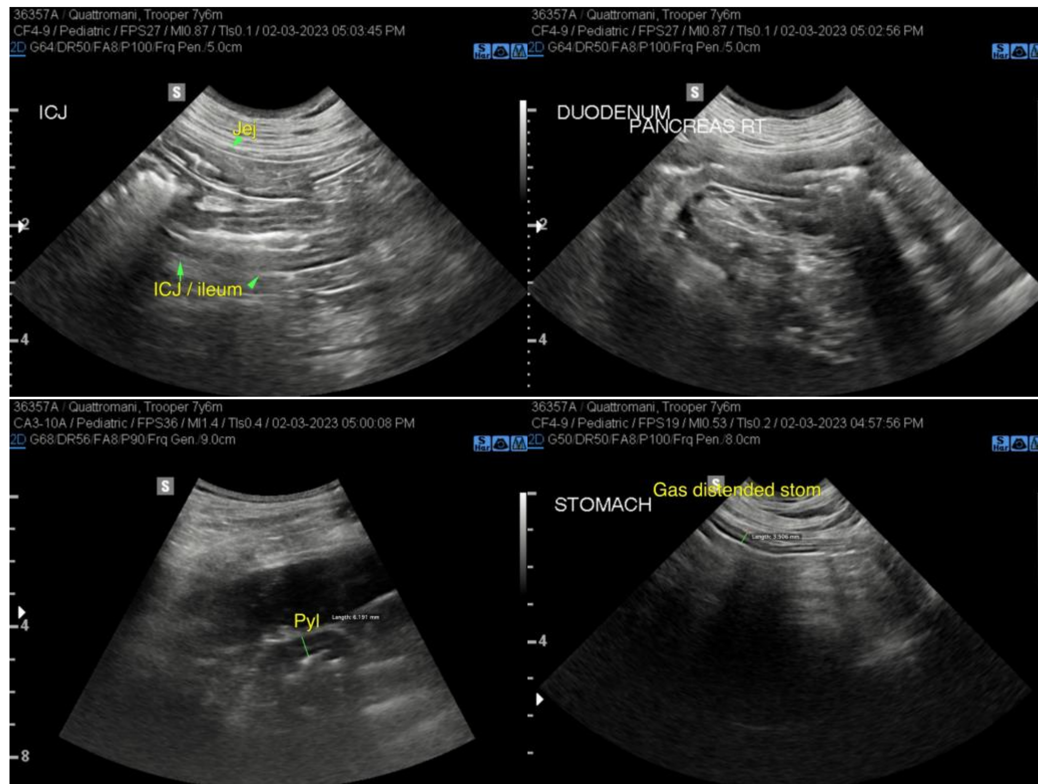

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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