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Clinical Sonography & Telecytology
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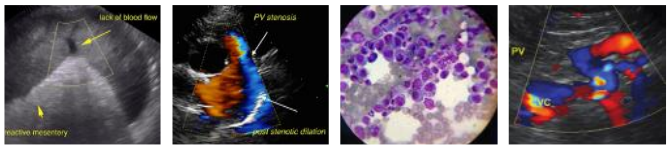

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1-800-838-4268 info@sonopath.com

PATIENT
Lily Leung

SPECIES
Canine

BREED
Maltese

SEX
FS

AGE
8yr

WEIGHT
6lb 6oz

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

IMAGING PERFORMED BY
Dr. Suciu

HOSPITAL NAME
Animal Clinic of Queens

REFERRING VET
Dr. Suciu

INVOICE
12891ag

DATE
02/05/2023

PRESENTING CLINICAL SIGNS

Presented 1/27 for bloody diarrhea, treated for presumtive hemorrhagic gastro-enteritis with fluid therapy, Cerenia, metronidazole and FortiFlora. There was some improvement after the treatment, but the soft stool perisits, and yesterday she had melena/very soft stool. Appetite is decreased, she is eating only boiled chicken.

Abnormal PE/Chem/CBC/UA Results: Blood work done 1/27/23: CBC: high hematocrit (57.3%), high hemoglobin (22.8), high RBC (8.62) – R/O dehydration CHEM: high albumin (4.1) – R/O dehydration mild stress hyperglycemia (129) low cholesterol (110) EPOC: high hematocrit (63%) – R/O dehydration PCV at the end of hospitalization was 48 %

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra 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 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 3.7 cm in length. The right kidney measured 3.4 cm in length.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.35 cm width at the caudal pole and 0.40 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 0.38 cm width at the caudal pole and 0.55 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

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 moderate dependent to non-dependent mildly striated debris. No evidence of gallbladder or peripheral gallbladder inflammation was present. The cystic and common bile ducts were normal.

Gastrointestinal

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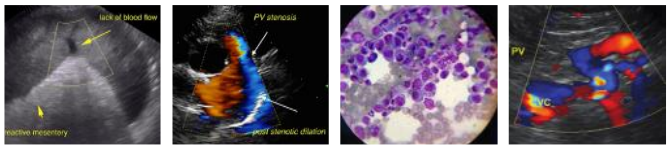

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The stomach presented mild wall thickening secondary to echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. The gastric body wall measured 0.30 cm width. Mild gastric distension with primarily anechoic fluid and ingesta was present.

The small intestine presented intact wall layering with a primarily 1:3 muscularis/mucosa ratio. Segmental subjective borderline prominent duodenojejunal mucosa and intact mildly prominent ileum wall extending to the ileocolic junction. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material. The ileum wall measured 0.31 cm in width. The duodenum wall measured 0.38 cm width. The jejunum wall measured 0.35 cm width.

The colon walls presented intact yet mildly prominent wall layering with mild thickened to echogenic submucosa. Semi formed fecal matter was present in the colon lumen with lumen dilation. The descending colon wall measured 0.20 cm in width.

Pancreas

The pancreas presented hypoechoic to heterogeneous echogenicity compared to adjacent omental fat. Mild asymmetrical capsule margination was present with mild variable parenchymal swelling and mild peripancreatic reactivity / inflammation. No overt evidence of neoplasia.

Free Abdomen

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

ULTRASONOGRAPHIC FINDINGS

- Generalized inflammatory gastroenterocolic pattern including suspect persistent ileocolitis
- Possible concurrent low-grade pancreatitis

Secondary findings

- Moderate gallbladder debris-not overtly consistent with mucocele criteria

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Sonographically the appearance of the GI tract is suggestive of possibly resolving inflammatory criteria although potential for more persistent inflammatory disease i.e., IBD or similar in conjunction with mild low-grade pancreatitis could be possible. Dietary intolerance / food hypersensitivity, occult parasitism, dysbiosis, occult Addison's disease or infiltrative gastroenterocolic neoplasia possible. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. Although considered unlikely considering normal adrenal presentation, a resting cortisol level to rule out occult Addison's disease is recommended.

Continued GI support including a limited antigen or hydrolyzed diet trial with potential long term dietary therapy, prophylactic deworming (Panacur 50 mg/kg SID x 5 consecutive days with repeat protocol in 3 weeks even if fecal testing is negative), high colony count probiotic (Proviable or Visbiome), cobalamin supplementation pending assessment of cobalamin levels as well as therapy for low-grade pancreatitis with assessment of clinical response may prove beneficial.

A recheck sonogram suggested if evidence of persistent GI signs to assess for progressive inflammatory GI changes or pancreatitis.

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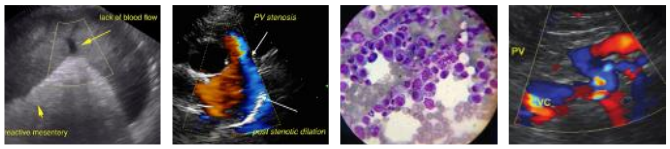

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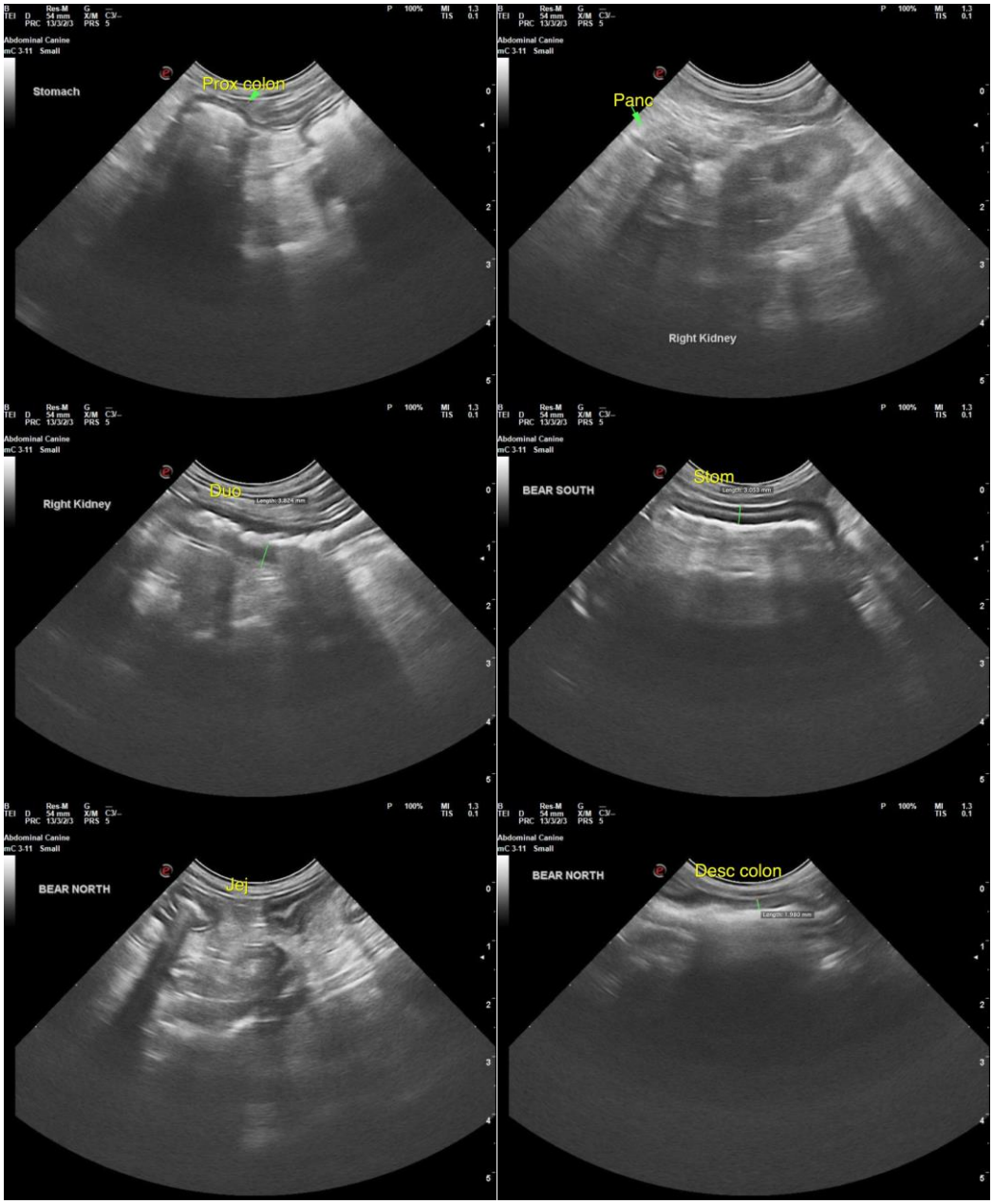

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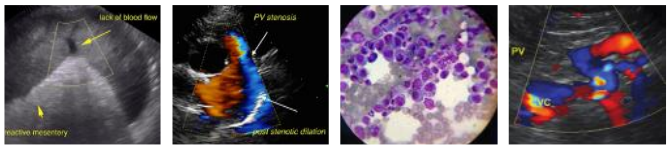

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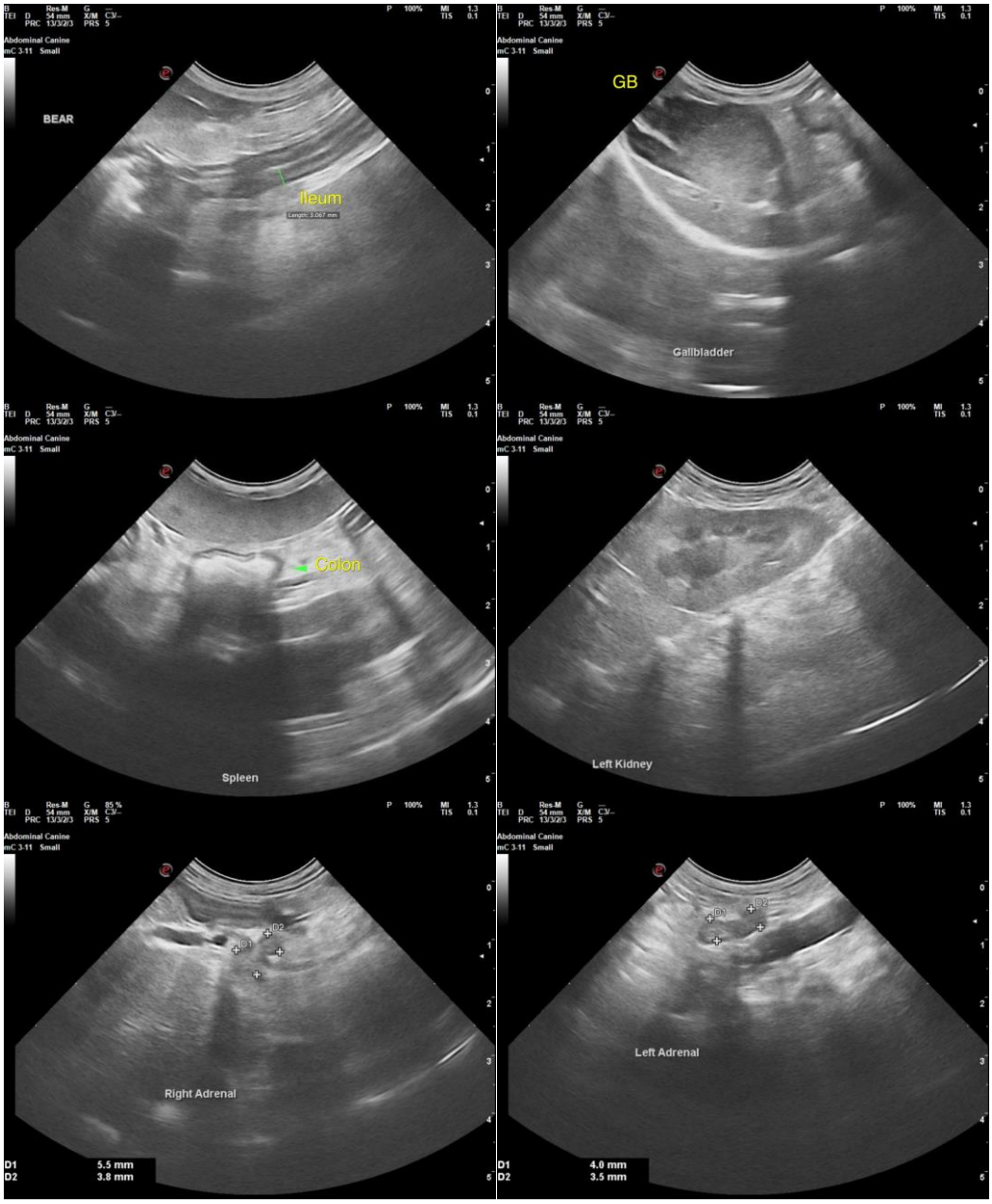

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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