



PATIENT

Lulu Hadley

SPECIES

Canine

BREED

Jack Russell X

SEX

Spayed Female

AGE

11 Years 9 months

WEIGHT

13 Pounds

INTERPRETED BY

Eric Lindquist, DMV

DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Amanda Lacey Crook
SDEP Certified Clinical
Sonographer

HOSPITAL NAME

Rivers Edge PMC

REFERRING VET

Dr. Travis Gibson

INVOICE

35496

DATE

2/8/22

PRESENTING CLINICAL SIGNS

Since Thanksgiving of 2021 P has been having Diarrhea and tested positive for Clostridium Perfringins. O thought initially it was rancid dog food from RC since they were feeding a bland diet of GI lowfat. O says that P has medication to stop the diarrhea and a probiotic to help as well. She then said that P was eating off and on and now they have been offering anything just to get P to eat. P is currently refusing to eat anything and is currently drinking less water than normal. V and D are more prominent and consistent than before. Stools are normal at this time due to current medications. P tested positive for Pancreatitis on 02/08/2022. Today P vomited very dark chocolate liquid and this is the first to notate of this type of vomit. Medications Current: Sucralfate, cerenia buprenex, omeprazole, metronidazole
Abnormal PE/Chem/CBC/UA Results: See attached cbc/chem No radiographs performed at this time

Unremarkable CBC/Chem – Alb 4.5, Glob 1.9, Sodium/Potassium ratio 32.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with very minor particulate sediment, likely indicative of minor cellular or crystalline debris with potential for mucus. 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.

The kidneys presented a normal 1:3 cortex / medulla ratio. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The right kidney was mildly subnormal in size compared to the left kidney, likely indicative of patient variant. The left kidney measured 4.1 cm. The right kidney measured 3.3 cm.

Adrenal Glands

The adrenal glands were uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 1.8 cm length x 0.46 cm at the caudal pole. The left adrenal gland measured 1.7 cm length x 0.47 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 mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to benign parenchymal remodeling. A solitary intraparenchymal cyst to cystic nodule was noted in the mid caudal liver measuring 1.0 cm in diameter. 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.



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Gastrointestinal

The stomach presented wall thickening secondary to echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. Mild to moderate retained anechoic fluid noted along with luminal gas. No overt evidence of mechanical pyloric outflow obstruction or overt ulceration. Ventral gastric body wall measured 0.39 cm.

The duodenum presented intact yet subjective mild prominent wall layering with mild generalized non-obstructive duodenal ileus. Subtle evidence of duodenal corrugation was present. Duodenum wall measured 0.34 cm. The jejunum and ileum to the level of the colon were sonographically normal. Jejunum wall measured 0.25 cm.

The colon walls presented intact yet prominent wall layering with mild thickened to echogenic submucosa. Subjective semiformal to soft feces present. Descending colon wall measured 0.23 cm.

Pancreas

The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

PRIMARY FINDINGS

- Gastroduodenitis pattern with mild gastric hypomotility
- Mild colitis
- Heterogeneous pancreas

ULTRASONOGRAPHIC FINDINGS

- Solitary hepatic intraparenchymal cyst or cystic nodule – potential for small biliary cystadenoma, subjectively benign.
- Mild chronic renal changes
- Minor urinary bladder sediment

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Urinalysis +/- urine culture and sensitivity (if evidence of inflammatory cells) may be considered. Overall, no overt evidence of significant gastroenterocolic or pancreatic pathology. In a patient exhibiting chronic gastrointestinal signs, chronic to low-grade pancreatitis, dysbiosis, dietary intolerance/food hypersensitivity, inflammatory bowel disease, or early infiltrative gastrointestinal neoplasia (unlikely in this case) all possible.

Further assessment may include fresh fecal analysis to rule out parasitic ova/giardia if not done, and GI panel to include PLI, TLI, cobalamin and folate. Empirical continued gastrointestinal support including gastroprotectants would be appropriate. 3-view chest radiographs suggested to rule out occult thoracic or esophageal pathology. Upper gastrointestinal endoscopy may be indicated if clinical signs continue, or are non-responsive to supportive care.



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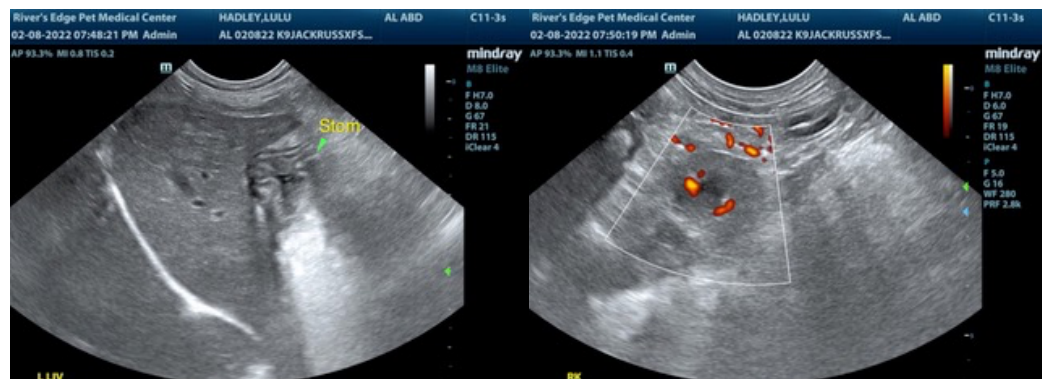
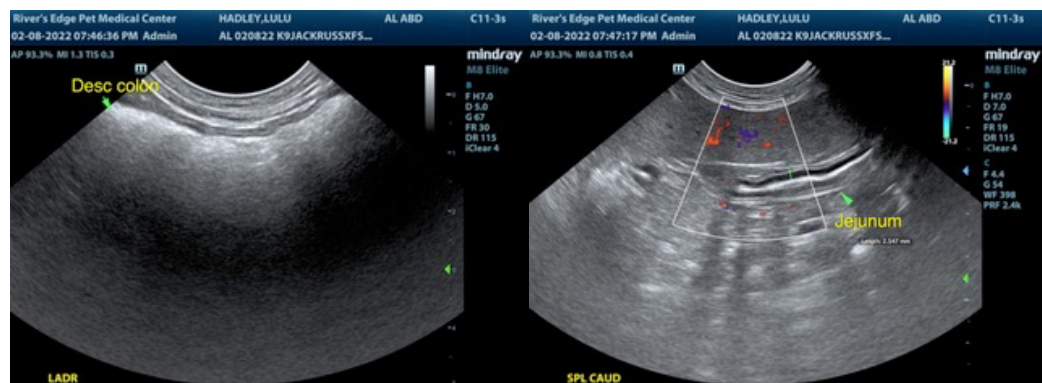
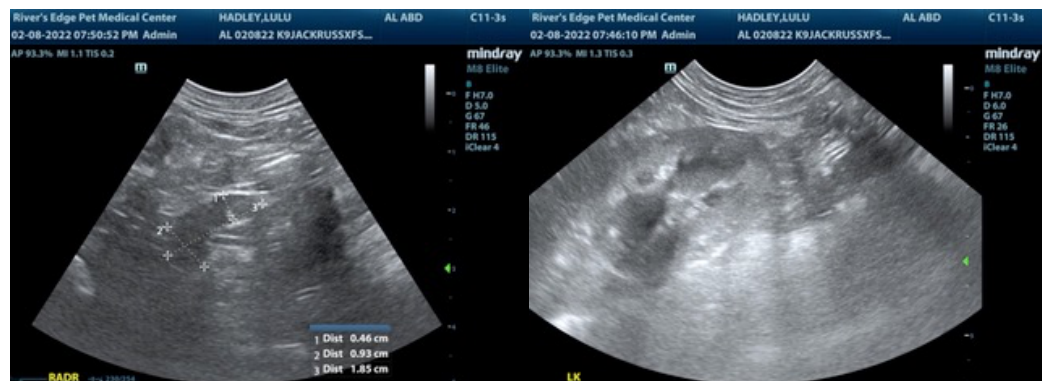
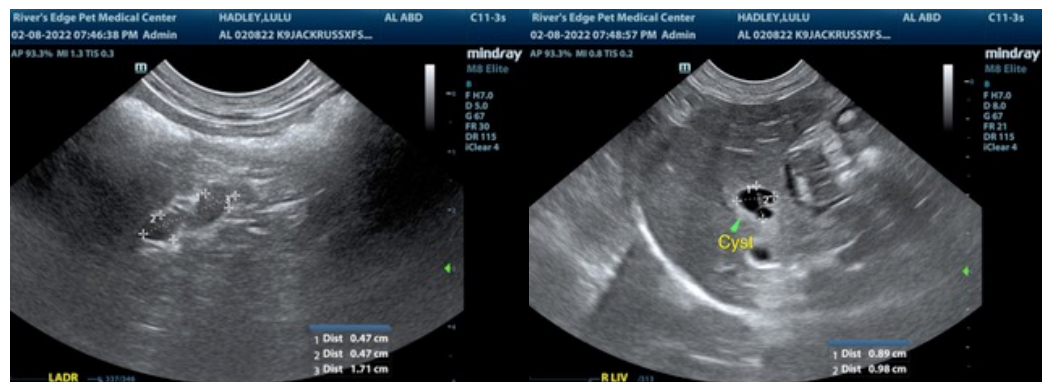
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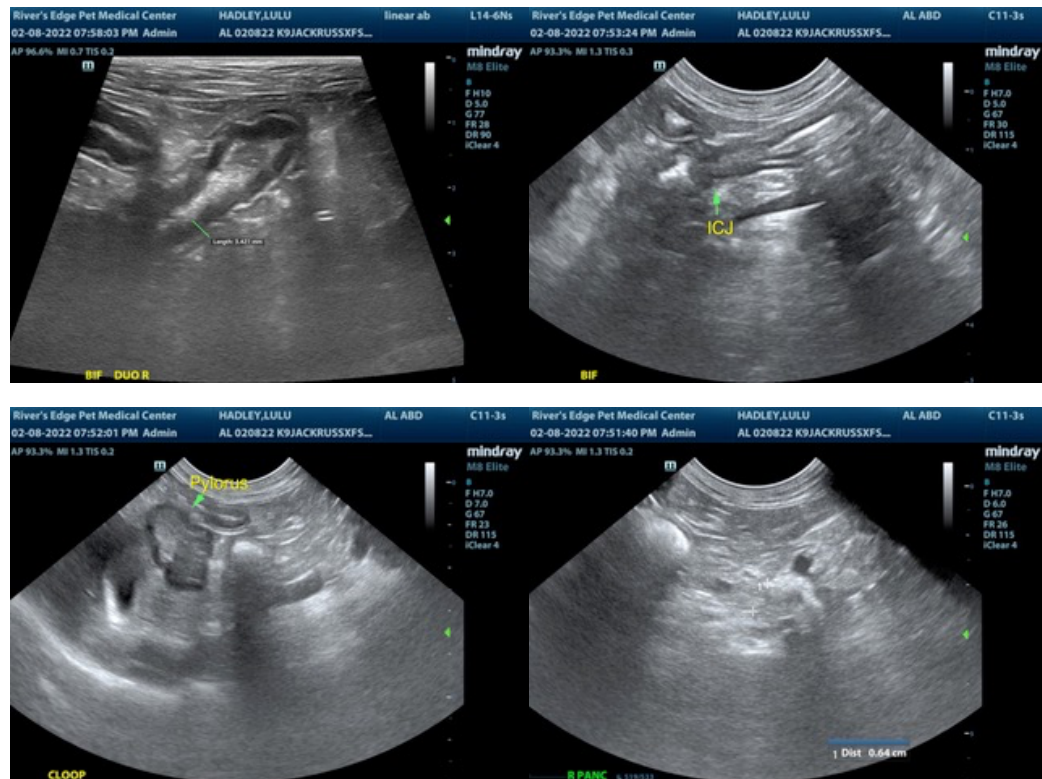
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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