

**PATIENT**

Niko Bardon

SPECIES

Canine

BREED

Pomeranian

SEX

FS

AGE

9 years

WEIGHT

11.4 lbs.

INTERPRETED BYR. McKenzie Daniel,
DVM, DABVP (Canine
and Feline)**IMAGING
PERFORMED BY**

Amy Mayhew LVT

HOSPITAL NAME

SVS Imaging MI

REFERRING VET

Dr. Gentile

INVOICE

16111

DATE

2/9/23

PRESENTING CLINICAL SIGNS

Current Medications: Atropine 1% ophthalmic solution - Apply one drop in the left eye every 24 hours for 3 days, then every 48 hours for 4 days. Wait 5 minutes between eye drops. Flurbiprofen 0.03% ophthalmic solution - Apply one drop in the left eye every 6 hours. Wait 5 minutes between eye drops. NeoPolyDex ophthalmic solution - Apply one drop in the left eye every 6 hours. Wait 5 minutes between eye drops. Deracoxib 12 mg 1/2 tablet by mouth every 24 hours for 14 days Doxycycline 50 mg/ml 0.5 ml by mouth every 12 hours for 14 days Patient History: Acute onset of photosensitivity, blepharospasm and epiphora.

Abnormal PE/Chem/CBC/UA Results: OS) Mild blepharospasm. Epiphora. Marked scleritis. Anterior chamber has increased opacity and a reddish hue. Difficult to visualize posterior chamber. Moderate diffuse calculus. Moderate gingivitis. No pain on opening mouth. Schirmer Tear Test - OS) 23 // OD) 20 Intraocular Pressure - OS) 8 // OD) 14 Fluorescein Stain - OU) Negative Thoracic Radiographs - Increased irregular soft tissue opacity extending from the thoracic inlet to the base of the heart. Otherwise normal cardiac silhouette. Lungs have small mineral opacities and mild bronchial pattern - suspect age-related. CBC - NEU 3.43 (3.62-12.3), MONO 0.07 (0.14-1.97) Chem - BUN 29.6 (9.0-29) Lytes - WNL T4 - 1.9 (1.2-4.3) 4Dx - Negative UA (cysto) - SpG 1.034, pH 8, Protein trace, RBC occasional

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN AND HEART**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 was noted.

No evidence of medial Iliac or sublumbar lymphadenopathy.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomodullary 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 3.4 cm in length. The right kidney measured 3.4 cm in length.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.41 cm width at the caudal pole and 0.29 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 0.52 cm width at the caudal pole and 0.45 cm width at the cranial pole.

Spleen

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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 normal gallbladder walls without evidence of inflammation criteria. The gallbladder contained primarily anechoic content with a suspect small amount of congealed nonobstructive sludge and mucus in the area of the gallbladder neck. Potential for nonobstructive polyp is possible measuring 0.7 cm in diameter. No evidence of peripheral gallbladder inflammation was noted. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The stomach was mildly gas distended with mild nonshadowing ingesta / chyme primarily in the antrum and pylorus. No evidence of mechanical pyloric outflow obstruction was noted.

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 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 were evident.

Free Abdomen

No evidence of omental masses, lymphadenopathy, or peritoneal effusion.

Heart

Brief sonographic assessment of the heart revealed overtly normal structure and function with normal left and right heart chamber enlargement and subjective adequate left ventricle function. No evidence of pericardial effusion or obvious tumors.

Concurrent brief sonographic assessment of the cranial thorax and mediastinum revealed aerated lung exhibiting normal linear pulmonary interface. No overt or visualized evidence of displacing cranial mediastinal mass was noted. Aerated lung was visible in the cranial thorax.

ULTRASONOGRAPHIC FINDINGS



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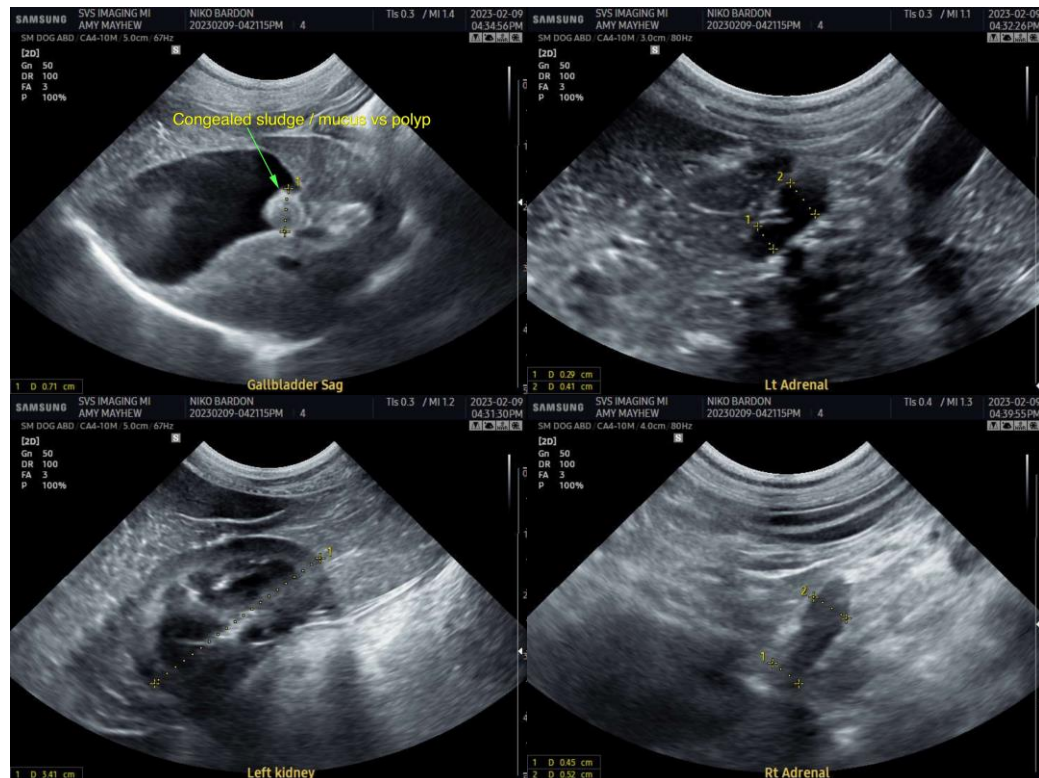
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- Suspect focal nonobstructive congealed gallbladder neck sludge / mucus, potential for nonobstructive gallbladder polyp
- Overtly normal cardiac structure and function - no evidence of pericardial effusion or cardiac tumors
- Normal appearing aerated lung cranial thorax / area of mediastinum

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Sonographically, no evidence of overt abdominal visceral, cardiac, or cranial thoracic / mediastinal pathology. The possibility of a non-visualized lesion within the cranial mediastinum surrounded by aerated lung, which at times could be possible, cannot be definitively excluded. No evidence of intraabdominal or cardiac neoplastic criteria as a potential cause of cranial thoracic or mediastinal metastasis. If strong clinical concern for thoracic inlet or cranial thoracic lesion, thoracic CT if available may be considered.





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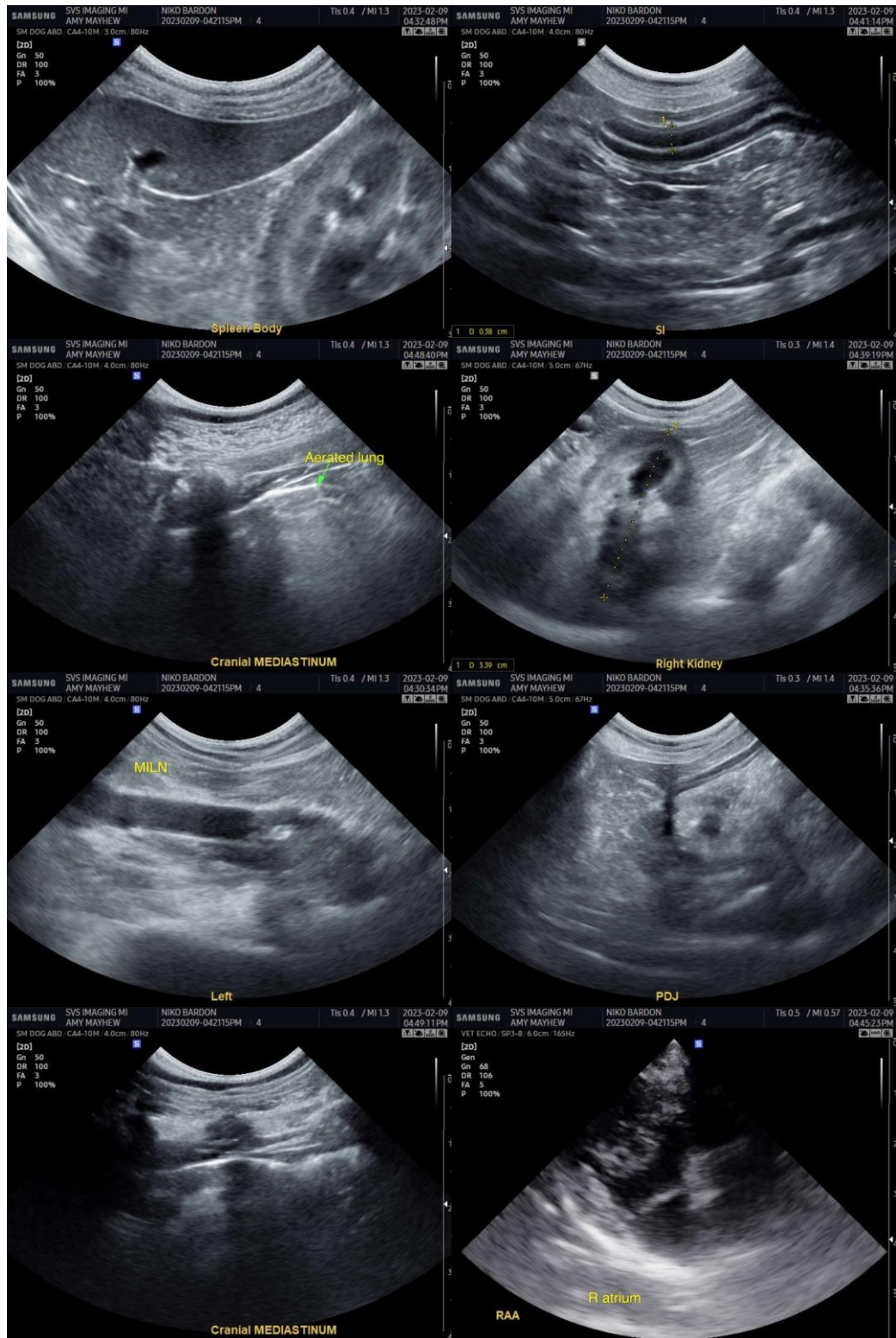
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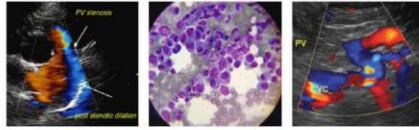
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1-800-838-4268 info@sonopath.com SonoPath.com

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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.

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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.

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