



PATIENT

Bam Bam Metje

SPECIES

Canine

BREED

Goldendoodle

SEX

MN

AGE

7 years

WEIGHT

83 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Kelly Vazquez

HOSPITAL NAME

Ho-Ho-Kus VH

REFERRING VET

D.r Brittany Scott

INVOICE

16382

DATE

3/15/23

PRESENTING CLINICAL SIGNS

Weight loss, exercise intolerance, murmur grade 2/6 (concern for DCM) - dog is Addisonian, not on grain free. Current meds: pred 3.8 mgs SID, Zycortal monthly, Heartgard/Nexgard.

Abnormal PE/Chem/CBC/UA Results: BUN 47, creat. 2.4, neut. 12k, neut 89k.

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 was noted.

The residual prostate was free of pathology.

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 corticomedullary definition were maintained. Minor loss of corticomedullary border demarcation was present with no evidence of pyelectasia. The left kidney measured 7.5 cm in length. The right kidney measured 6.5 cm in length.

Adrenal Glands

The left and right adrenal glands were not definitively visualized owing to hypoadrenocorticism along with concurrent corticosteroid therapy. No evidence of pathology was noted in the area of the left or right adrenal glands.

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 presented as mildly enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size containing primarily anechoic content with minor nonorganized echogenic gallbladder debris. No evidence of gallbladder or peripheral gallbladder inflammation was noted. The cystic and common bile ducts were normal.



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Gastrointestinal

The stomach presented intact wall layering. The stomach contained a mild to moderate amount of retained, variably echogenic ingesta and fluid with focal mild ingesta shadowing. 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 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 were evident.

Free Abdomen

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

ULTRASONOGRAPHIC FINDINGS

- Mild benign hepatomegaly
- Minor gallbladder debris (non-mucocele)
- Intact gastrointestinal wall layering with variably echogenic retained gastric fluid/ingesta
- Overtly normal kidneys exhibiting minor indistinct corticomedullary border

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Overall, no evidence of significant abdominal visceral pathology as an obvious cause of the patient's weight loss. Some degree of metabolic / functional gastric stasis could be possible if documented NPO.

Gastroprotectant protocol, as well as monitoring for persistent gastric stasis may be considered. A GI panel to include PLI/TLI/Cobalamin/Folate, as well as three view chest radiographs and neurological / musculoskeletal examination, are recommended to assess for or rule out occult disease which may cause weight loss.

Correlation of the azotemia with the full urinary workup to include screening C/S and baseline UPC level, if evidence of proteinuria, is suggested.

For an additional charge, internal medicine consult can be utilized through SonoPath.com. You can select the internal medicine drop down at <http://spa.sonopath.com/>.

One of the world's top internists & SonoPath associate Dr. Remo Lobetti BVSc, MMedVet, PhD, DECVIM can evaluate your case through SonoPath. <https://sonopath.com/resources/sonopath-services/internal-medicine-teleconsultation-services>



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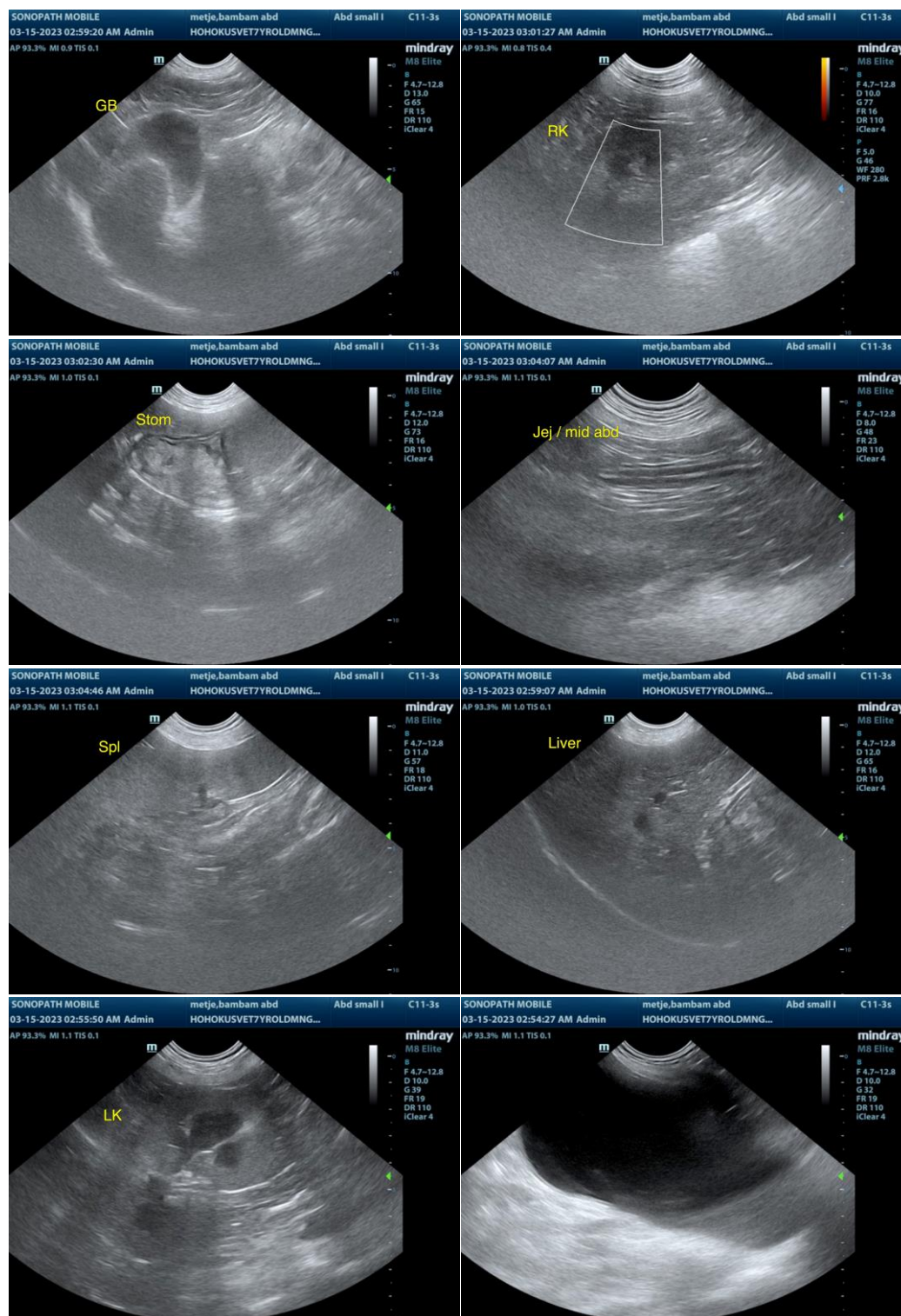
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@SonoPath.com