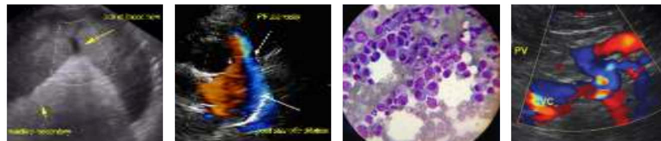

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Bobbie Brown

SPECIES

Canine

BREED

Boxer

SEX

FS

AGE

10 years

WEIGHT

28 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Patti Mayfield DVM

HOSPITAL NAME

Riverside AC

REFERRING VET

Deb Putnam DVM

INVOICE

13449

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3/8/22

PRESENTING CLINICAL SIGNS

Bobbie presented for AUS to evaluate the pancreas. She is currently clinically normal, but is coming off an "episode" of presumptive pancreatitis last week. Bobbie has been experiencing intermittent episodes of pancreatitis (q 2-3 weeks) for the last 6 months. Blood work and cPL to IDEXX have confirmed the pancreatitis, without any other significant abnormalities noted. Survey radiographs have historically been unremarkable. Bobbie has been responding well to use of Cerenia, Omeprazole and a probiotic. She eats only GI low fat, as well as some other home prepared bland diets from BalanceIt.com. There may be a stress response, but client is not confident. Clinical signs include loss of appetite, signs of abdominal pain, vomiting and loose stools with occasional hematochezia. Bobbie tends to respond well to medical management, within 1-2 days feels better. Patient also receives Soloxine, 0.6 mg PO BID
Abnormal PE/Chem/CBC/UA Results: PE: Lenticular sclerosis OU and moderate dental disease. Otherwise unremarkable exam; abdomen is soft and comfortable. 2/19/2022: CBC: WNL CHEM: ALP: 327 U/L (5-160) All else WNL UA: yellow, clear, USG: 1.019, pH: 7 Inactive sediment T4: WNL

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 was noted.

The area of the aortic trifurcation was free of pathology.

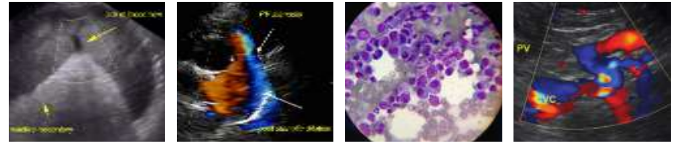
Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 7.6 cm in length. The right kidney measured 8.3 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 0.78 cm width at the caudal pole and 0.81 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 0.74 cm width 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.



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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. The cystic and common bile ducts were normal.

Gastrointestinal

The visualized gastric walls were sonographically normal. The lumen of the stomach contained mild nonshadowing ingesta / chyme most consistent with post prandial presentation without signs of ileus, obstruction or foreign material.

The small intestine presented intact wall layering with segmental propensity for mildly prominent mucosa and potentially mildly prominent to echogenic submucosa layer. No evidence of loss of intestinal wall layering or other structural pathologies such as masses were noted. The duodenum wall width measured 0.42 cm The jejunum wall width measured up to 0.54 cm.

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 overt lymphadenopathy or peritoneal effusion was present.

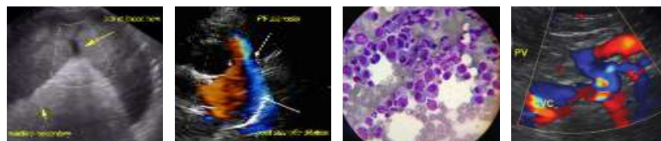
ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Intact yet mild segmental prominent small intestinal walls - potential segmental inflammatory bowel
- Overtly normal colon
- Mild gastric ingesta / chyme - likely indicative of recent meal ingestion
- Sonographically unremarkable pancreas
- Low-grade hepatopathy - suspect mild vacuolar hepatopathy

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Overall, no overt evidence of significant abdominal visceral specifically gastroenterocolic or pancreatic pathology was noted. At times, the gastroenterocolic or pancreatic presentation does not always correlate with history of recurrent to chronic gastrointestinal signs. In patients with chronic to recurrent gastrointestinal signs, mild to low-grade pancreatitis, dysbiosis, dietary intolerance / food hypersensitivity, structurally insignificant inflammatory bowel, or less likely in this case, intestinal neoplasia could be possible.



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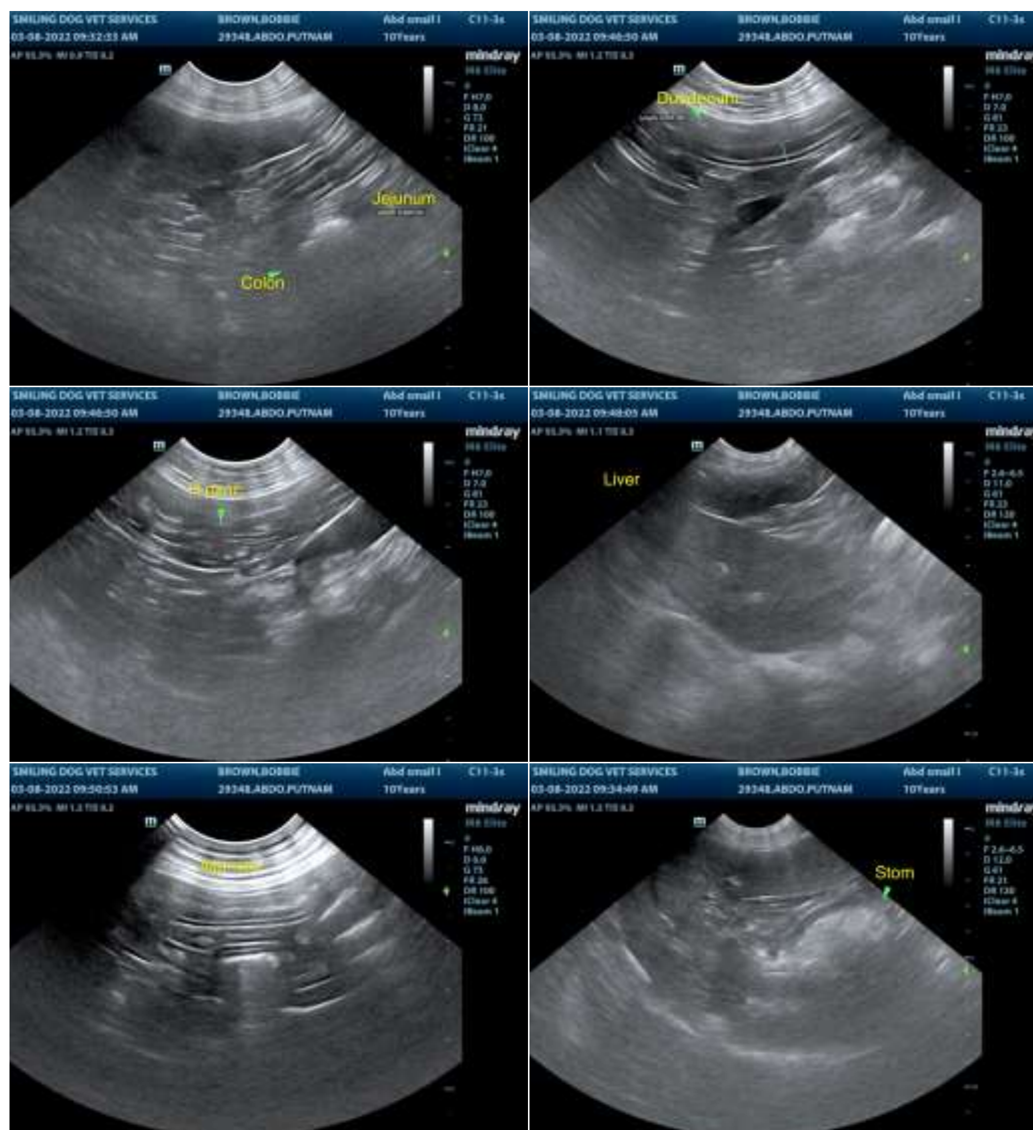
Further assessment may include a GI panel to include PLI/TLI/Cobalamin/Folate, ideally during a gastrointestinal episode. Likely concurrent intermittent bouts of colitis, given the reported occasional hematochezia.

Empirically, 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), antibiotic trial and as needed gastrointestinal support with an assessment of clinical response may prove beneficial. Cobalamin supplementation may be Indicated pending assessment of serum cobalamin levels. Intestinal biopsies may be indicated if GI signs continue despite empirical therapy.



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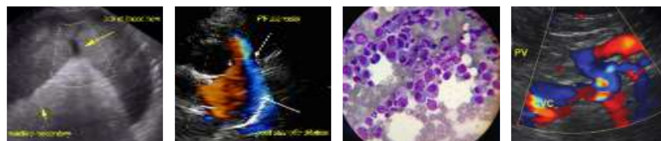

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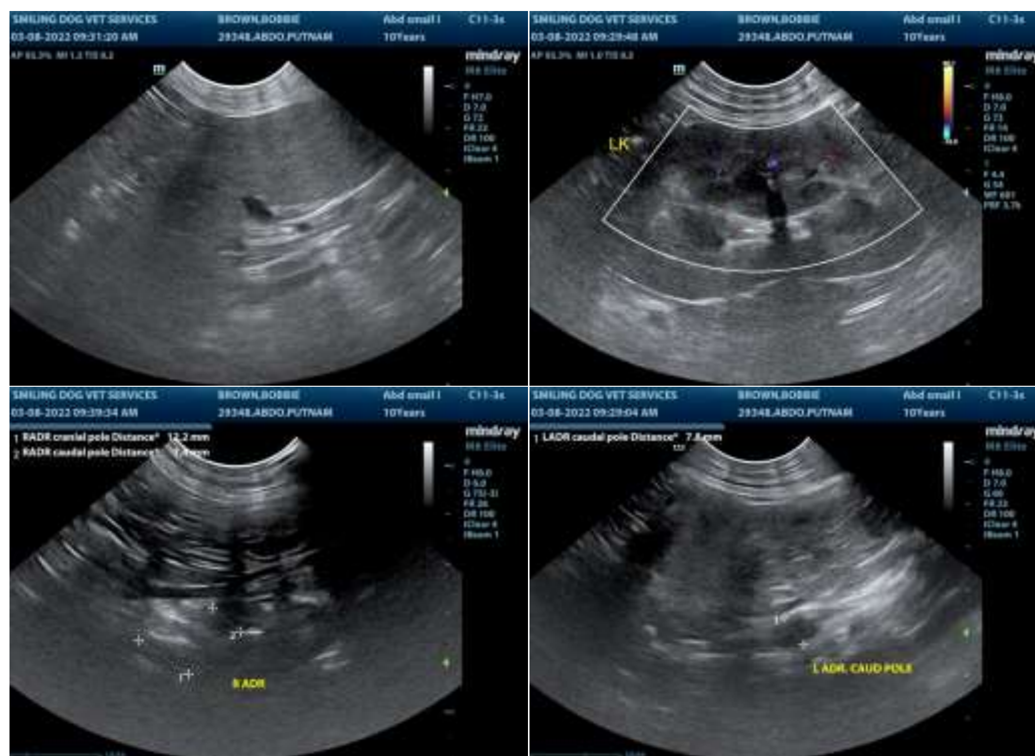

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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