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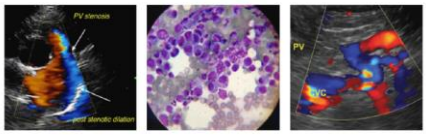
fredgromalak@gmail.com



SonoPath
Clinical Sonography & Telecytology
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PATIENT

Harper Hudy

SPECIES

Canine

BREED

PitBull

SEX

Spayed female

AGE

10 years

WEIGHT

44 pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VET

West Allis Veterinry Clinic Dr. Banceu

INVOICE

10340ag

DATE

04/11/2022

PRESENTING CLINICAL SIGNS

History: Vomiting, slightly decreased appetite & activity level, progressive weight loss

Abnormal PE/Chem/CBC/UA Results: Weight loss, mild degree of pancreatitis, hypoglycemia (spurious lab value) - checked in house - normal; insulin : glucose ratio - normal; ANTECH x-ray report - unremarkable

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3 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 were noted.

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

The area of the aortic trifurcation was free of pathology.

No evidence of pathology observed in the area of the uterine remnant.

Adrenal Glands

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

The liver presented normal in size. The hepatic parenchyma revealed diffuse reduced echogenicity compared to the spleen and renal cortical parenchyma with a mild coarse echotexture. Increased portal vein prominence was evident. The capsule of the liver was normal in margination. Distinct masses or nodules were not evident. The hepatic and portal vasculature were normal in appearance. The gallbladder was non-distended in size with primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained minor retained nonshadowing ingesta/chyme along with luminal gas. No signs of ileus, obstruction or foreign material were observed. The gastric body wall measured 0.43 cm in width.

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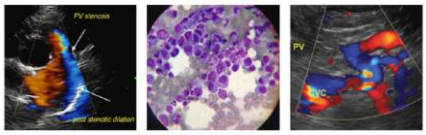

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The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material. The duodenum wall measured 0.40 cm in width. The jejunum wall measured 0.3 – 0.35 cm in width.

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 was evident.

Free Abdomen

Focally enlarged mid abdominal mesenteric lymph nodes were present. These lymph nodes were homogenous, mildly hypoechoic and smoothly marginated. A normal width: length ratio was maintained (<0.5). Evidence of perilymphatic inflammation was evident. An example of lymph node size was 2.1 cm x 0.6 cm.

Focal, mildly prominent to enlarged medial iliac lymph node was present. The lymph node was essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). The lymph node measured 2.3 cm x 0.54 cm.

No omental masses or peritoneal fluid was observed.

ULTRASONOGRAPHIC FINDINGS

- Subjective mild hypoechoic liver.
- Nonspecific mild mid abdominal mesenteric and medical iliac lymphadenopathy.
- Overtly normal GI tract and pancreas.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Overall, no sonographic evidence of significant visceral pathology as an obvious cause of the patient's GI signs and weight loss was seen. At times the presentation of the GI tract does not always correlate with the severity of GI signs or weight loss exhibited. Potential for structurally insignificant GI disease or low grade to chronic pancreatitis both of which may present sonographically normal and in light of mild mesenteric lymphadenopathy could be present. The mesenteric and medial iliac lymph nodes were not overtly suggestive of current neoplastic criteria with hyperplasia or reactive lymphadenitis potentially secondary to GI disease possible. However, sonographic monitoring of the lymph nodes for evidence of progressive changes is suggested. Further assessment to include three view chest radiographs if not done, a GI panel to include PLI/TLI/Cobalamin/Folate, thorough musculoskeletal and neurologic exam +/- resting cortisol to rule out occult disease as potential contributing factors of the patient's weight loss and clinical signs.

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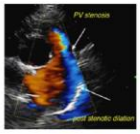
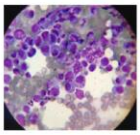
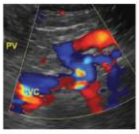

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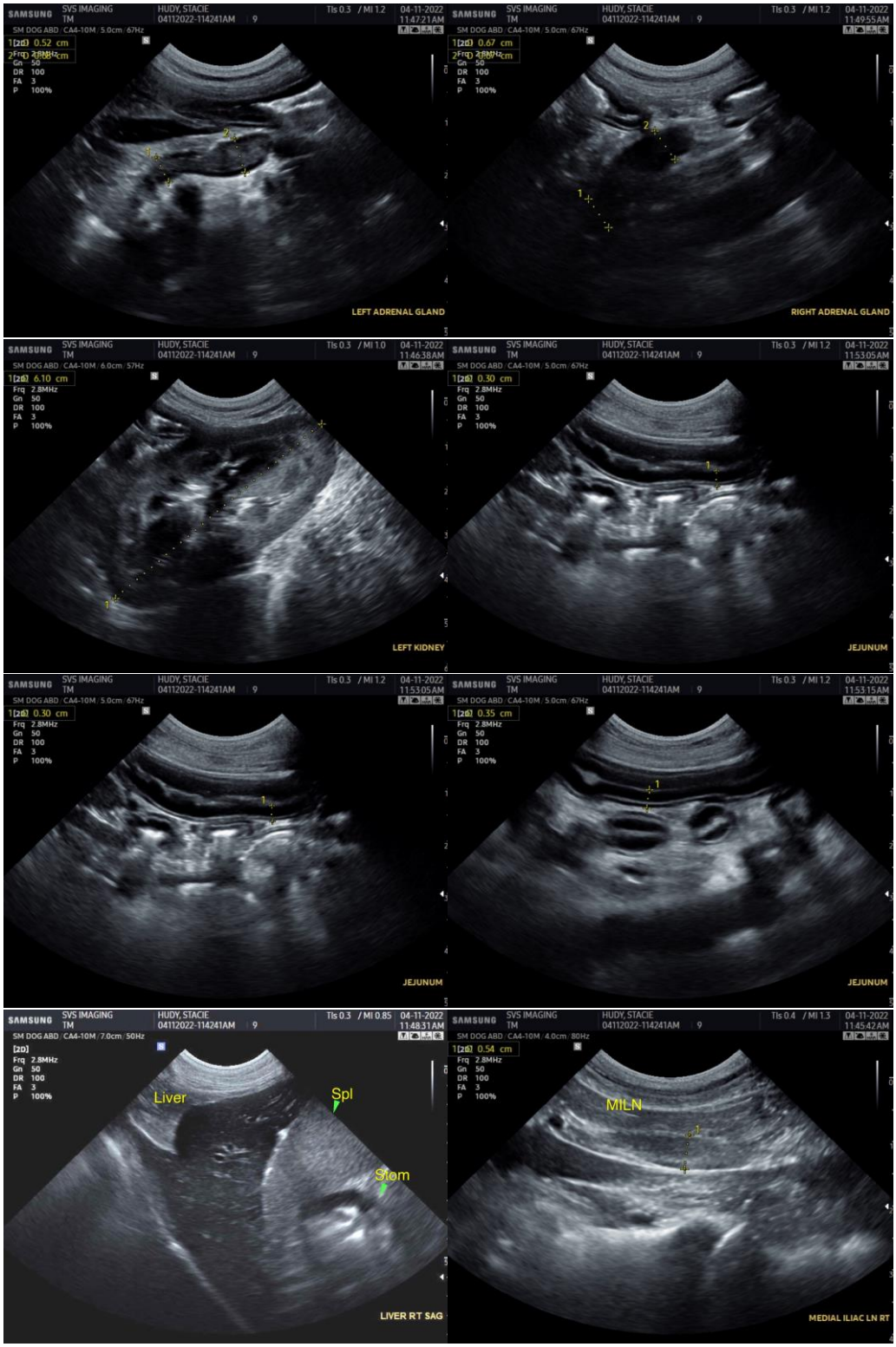

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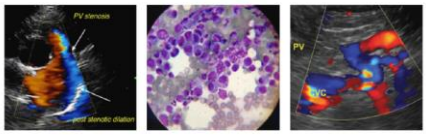

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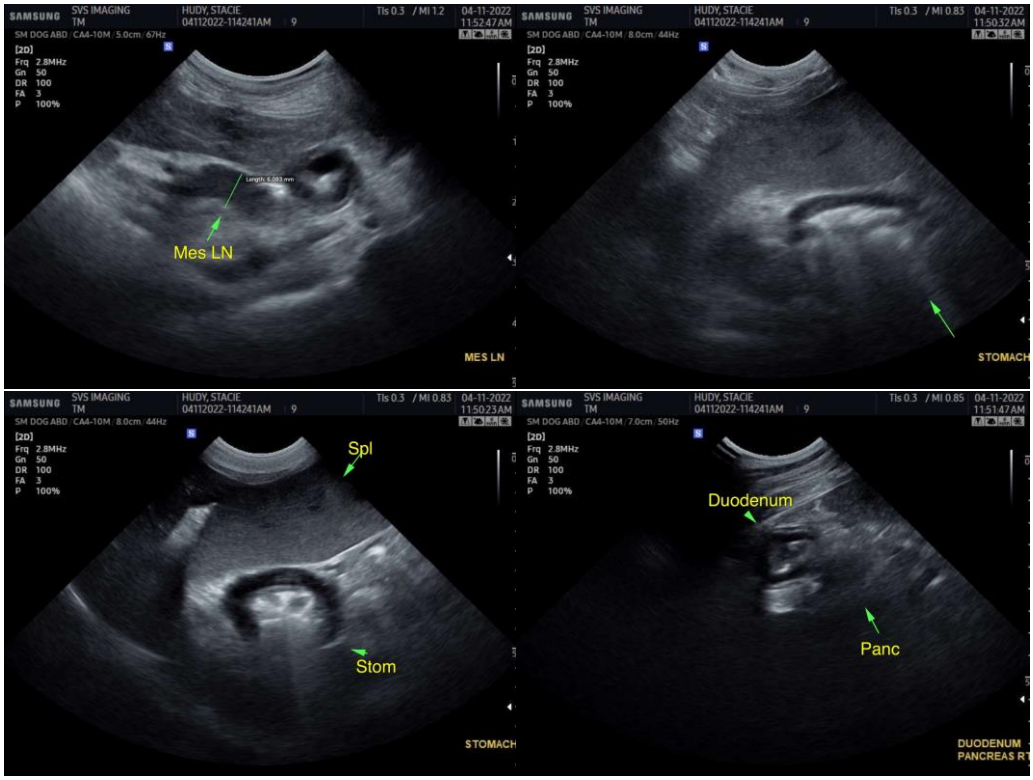

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@SonoPath.com