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Clinical Sonography & Telecytology
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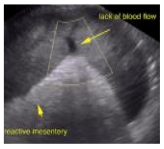

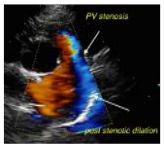

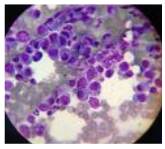
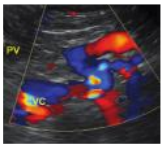

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1-800-838-4268 info@sonopath.com

PATIENT

Sadie Pakula

SPECIES

Canine

BREED

Dachshund/Mix

SEX

F/S

AGE

14

WEIGHT

15.4

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Sharkaway

HOSPITAL NAME

Kew Gardens AH

REFERRING VET

Dr. Sharkaway

INVOICE

16574

DATE

4/11/23

PRESENTING CLINICAL SIGNS

Diarrhea One-time vomiting Lethargic Slim patient

Abnormal PE/Chem/CBC/UA Results: Urine specific gravity–1.005, then improved to 1.026 Blood work–within normal limits Last fecal analysis–negative Comprehensive diarrhea panel–pending CPLI–positive

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder presented uniformly mild thickened urinary bladder wall isoechoic to the adjacent normal urinary bladder wall. The luminal margin of the thickened urinary bladder wall was mildly asymmetrical in contour. Mineralization or echogenic foci within the thickened areas of urinary bladder wall were not present. The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 cm exhibited normal tone. Anechoic urine was present in the lumen with no uroliths, sediment, or calculi. The ureteral papillae were normal. The ureters were not visible which is normal. The ventral urinary bladder wall width measured 0.48 cm. No urinary bladder tumors were 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 moderate loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation or pyelectasia was present. Suspect pinpoint areas of medullary mineral were noted. The left kidney measured 4.5 cm in length. The right kidney measured 4.2 cm in length.

Adrenal Glands

The left or right adrenal glands were not definitively visualized.

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 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 parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion. Normal hepatic vascular volume was noted. The gallbladder was non-distended in size containing primarily anechoic content with moderate, non-dependent to dependent, regionally congealed yet nonorganized, hyperechoic gallbladder debris. Potential for pinpoint mineral within the debris is possible, although not definitive. No evidence of formed cholelithsor inflammatory gallbladder criteria was noted. The cystic and common bile ducts were normal.

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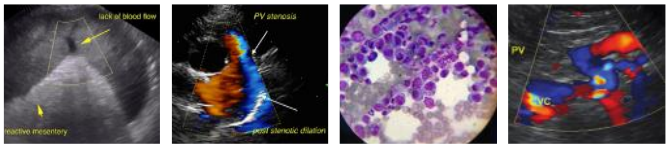

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Gastrointestinal

The stomach presented intact visualized wall layering. Within the gastric lumen, a strongly shadowing area of ingesta or possible echo was present measuring approximately 3.5 cm in diameter. No evidence of mechanical pyloric outflow obstruction or obstructive pyloric mural pathology was noted.

The small intestine presented intact wall layering and subjectively maintained 1:3 muscularis/mucosa ratio. Segmental nonspecific mildly hyperechoic duodenojejunal mucosal speckling was present with no evidence of small intestinal mechanical / metabolic ileus.

Normal visible colon wall layers were present with semi-formed fecal matter, consistent with patient history.

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 significant lymphadenopathy was present, although intermittent mild mesenteric lymphadenopathy is possible. A small pocket of scant peritoneal free fluids was noted in the ventrocaudal abdomen around the outer ventroapical urinary bladder. No visualized omental masses were present.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

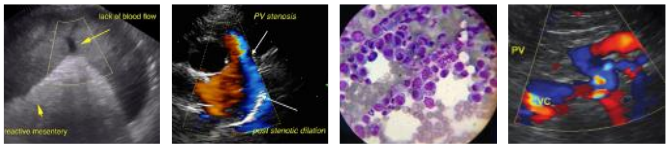
- Strongly shadowing gastric ingesta / echo
- Intact small intestinal wall layering with nonspecific duodenojejunal mucosal speckling
- Semi-formed feces in colon
- Scant pocket of ventrocaudal abdominal free fluid

Secondary Findings

- Moderate chronic renal changes
- Subjective mild cystitis
- Moderate gallbladder debris (non-mucocele)
- Minor hepatic parenchymal remodeling

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The strongly shadowing gastric ingesta / echo may indicate recent meal ingestion with dense ingesta. However, some concern for gastric foreign body is warranted, especially if documented NPO. Correlation with abdominal radiographs and/or sonographic / radiographic monitoring of the stomach



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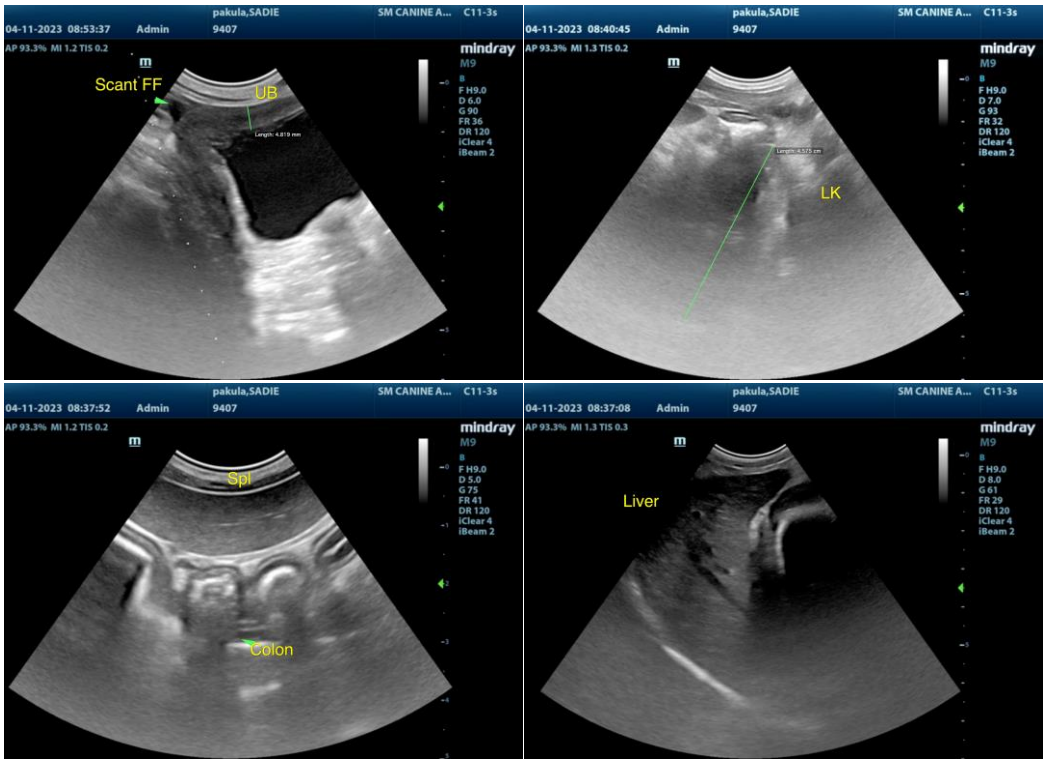
following a documented fast for evidence of gastric emptying vs. persistent gastric luminal shadowing ingesta / echo is suggested.

The small intestinal presentation was nonspecific, yet at times mucosal speckling has been associated with underlying inflammatory enteropathy, i.e., nonspecific enteritis, inflammatory bowel disease, and emerging PLE considered less likely given the normal reported albumin levels. Monitoring of albumin levels going forward is advised. Correlation with the pending diarrhea panel is suggested.

If surgery is deemed necessary in this patient, gastrointestinal biopsies would be considered essential. Likewise, if no clinical concern for gastric foreign body, a hydrolyzed diet trial with long-term dietary therapy, high colony count probiotic, empirical deworming even with negative fecal analysis, and empirical cobalamin supplementation pending assessment of cobalamin levels, +/- antibiotic trial and assessment of gastrointestinal response would be reasonable.



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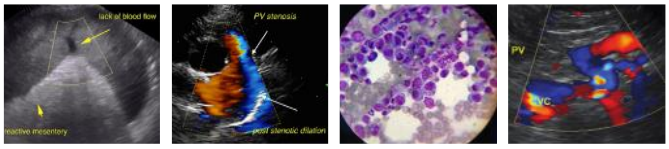

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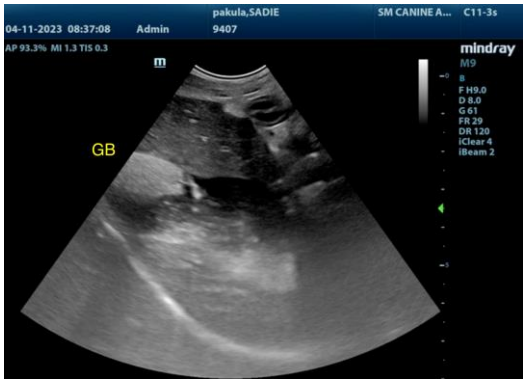

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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