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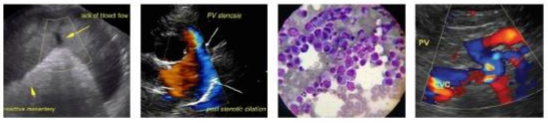

IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Mia Gehrke

SPECIES

Canine

BREED

Boston Terrier

SEX

Spayed Female

AGE

6 Years 6 Months

WEIGHT

19.6 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT LVT

HOSPITAL NAME

Sierra Oaks VC

REFERRING VET

N/A

INVOICE

21957

DATE

4/12/23

PRESENTING CLINICAL SIGNS

History: 6 month history of intermittent regurgitation, increasing in frequency over the last 2 weeks- Rads and Barium Study was done last week- AUS to further investigate GI and GDJ area fpr pyloric outflow abnormality

Abnormal PE/Chem/CBC/UA Results: LABS-WNL- Reg Rads on 3/30 report from radiologist: Conclusion Trachea malacia with mild intrathoracic luminal collapse. No indication of esophageal dysmotility. Recommend further evaluation with liquid barium and barium soaked kibble to further assess the esophagus if clinical signs persist. BARIUM series conclusion: Conclusion On the initial view of the abdomen, there is a moderate volume of barium in the caudal esophagus. If this view was performed at the time of barium administration, most likely represents normal passage of barium. If the barium was administered at the time of the earlier neck images, this could reflect either accumulation of barium within the esophagus is a result of esophageal dysmotility or mild gastric reflux. Fluoroscopic swallowing exam could be considered for further evaluation. The upper GI component of the study demonstrates no obstruction. Barium is believed to reach the colon at or before 2 hours, which is considered within normal limits. Barium does still remain in the stomach although it is largely adhered to ingesta that is present in the stomach (normal gastric emptying times are based on liquid barium only; ingesta in the stomach slows gastric emptying.

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 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 and normal corticomedullary 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 4.2 cm in length. The right kidney measured 4.3 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 0.53 cm width at the caudal pole and 0.52 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 0.62 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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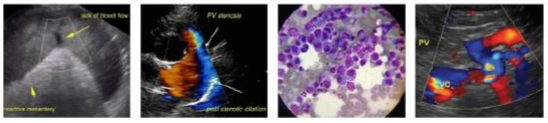

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Liver

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 and minor incidental echogenic luminal debris. 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 was empty with no signs of ileus, obstruction or foreign material.

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 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

No overt peritoneal effusion was present. Intermittent, mildly prominent to normal mesenteric nodes was present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation or neoplastic criteria and maintaining a normal width: length ratio (<0.5).

Other

No overt pathology was noted in the area of the uterine stump.

ULTRASONOGRAPHIC FINDINGS

- Sonographically unremarkable abdomen

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No sonographic evidence of visceral, specifically, gastrointestinal or pancreatic pathology as an obvious cause or contributing factor to the intermittent regurgitation. Given the previous diagnostics, empirical therapy for mild esophagitis/gastritis, which may include smaller/more frequent feedings of a canned hydrolyzed diet, with avoidance of dry foods, as needed gastroprotectants, +/- empirical therapy for helicobacter is recommended.

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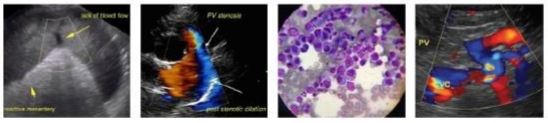

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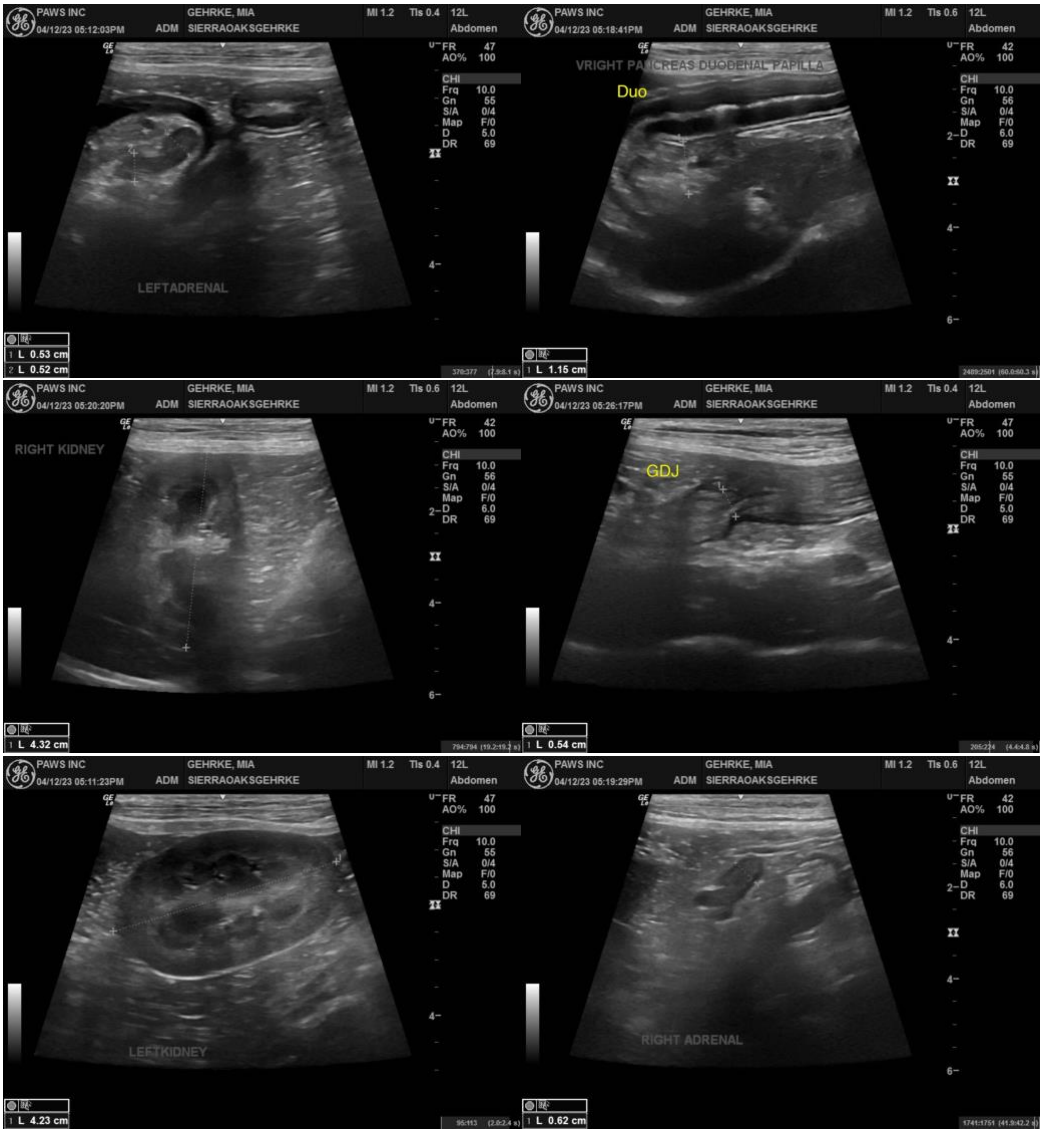

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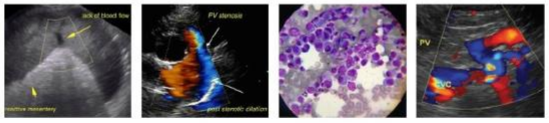

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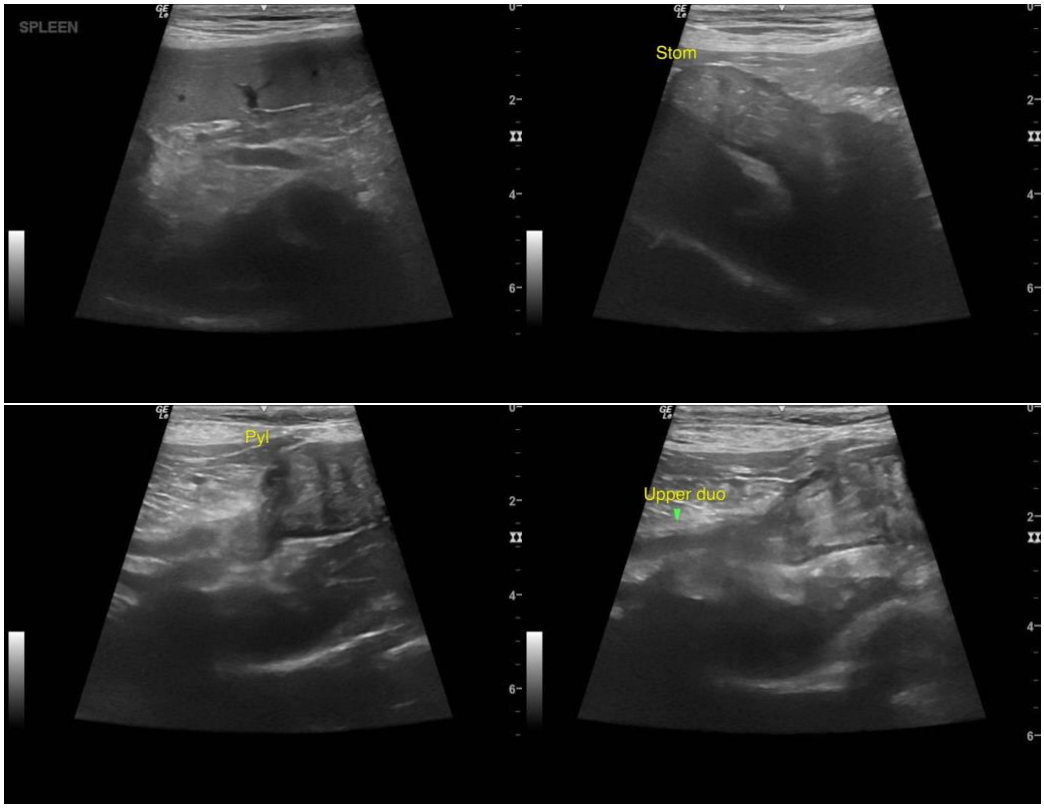

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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