



PATIENT

Peppermint Patty
Thomas Blais

SPECIES

Canine

BREED

Labrador Retriever

SEX

FS

AGE

10 years

WEIGHT

74 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Karen Ebersole, DVM,
DABVP (Canine/Feline
Practice)

HOSPITAL NAME

Scanvet

REFERRING VET

Dr. Lane

INVOICE

16616

DATE

4/14/23

PRESENTING CLINICAL SIGNS

Intermittent bouts of vomiting (bile) and diarrhea. No change with GI diet. Has been treated with Cerenia, Omeprazole, Metronidazole and Gabapentin to use prn when stressed.

Abnormal PE/Chem/CBC/UA Results: PE: suspect laryngeal paralysis, respiratory stridor, normal exam otherwise. Dental w/2 extractions done in February. Fecal AG: Neg. HW4Dx: Neg. CBC/Chem WNL. RADS: WNL

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra 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 5.9 cm in length. The right kidney measured 6.6 cm in length.

Adrenal Glands

A discrete, nondisruptive left adrenal nodule without evidence of capsular distortion was present measuring 1.0 cm x 0.82 cm. The nodule did not exhibit signs of mineralization or vascular invasion. The overall left adrenal gland measured 1.1 cm width at the caudal pole and 0.88 cm width at the cranial pole.

The right adrenal gland was normal in size. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The right adrenal gland measured 2.7 cm length x 0.62 cm width in the cranial pole.

Spleen

The spleen exhibited primarily finely textured parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Mild generalized parenchyma heterogeneity was present without evidence of nodular changes. 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. The parenchymal heterogeneity is likely consistent with benign changes such as extramedullary hematopoiesis or age-related remodeling with minor potential for inflammatory or neoplastic disease.

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



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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.

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Gastrointestinal

The stomach presented sonographically unremarkable gastric wall layering. The lumen of the stomach was empty with mild luminal gas and no signs of ileus, obstruction, or foreign material. No evidence of retained ingesta or fluid was noted. The gastric body wall width measured 0.40 cm.

The small intestine presented intact wall layering and maintained a 1:3 muscularis/mucosa ratio with minor areas of nonobstructive duodenojejunal ileus. Subjective mild prominent yet intact ileum walls were noted extending into the ileocolic junction. The ileum wall width measured 0.33 cm. The duodenum wall measured 0.42 cm width. The jejunum wall measured 0.35 cm width.

Normal visible colon wall layers were present with apparent formed fecal matter in lumen.

Pancreas

Mildly prominent to isoechoic to mildly heterogeneous right pancreatic limb was present exhibiting minor capsule asymmetry. No evidence of peripheral inflammation was noted.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

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ULTRASONOGRAPHIC FINDINGS

- Sonographically unremarkable empty stomach
- Intact small intestinal wall layering with mild nonobstructive duodenojejunal ileus
- Suspect possible ileitis
- Mildly prominent to heterogeneous right pancreas
- Formed stool in colon
- Subtle nondisruptive caudal left adrenal nodule - suspect adenoma

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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No sonographic evidence of significant gastroenterocolic mural pathology. At times, the gastroenterocolic presentation may not correlate with history of intermittent to chronic gastrointestinal signs. Considerations may include dietary intolerance / food hypersensitivity even with previous gastrointestinal diet, dysbiosis, inflammatory bowel disease, or low-grade to chronic pancreatitis, which may present as essentially sonographically normal, occult parasitism, occult Addison's Disease, and infiltrative neoplasia (less likely). A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. A resting cortisol level to rule out occult Addison's Disease is warranted.

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Diet rotation to a hydrolyzed diet with likely long-term dietary therapy, prophylactic deworming, i.e., Panacur 50 mg/kg PO SID for at least 5 consecutive days with possible repeat protocol in 3 weeks, high colony count probiotics such as Provable, cobalamin supplementation pending assessment of



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cobalamin levels, and as-needed gastrointestinal support with continued monitoring may prove beneficial.

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Sonographic monitoring of the subtle left adrenal nodule for evidence of progression with initial recheck in 2-3 months is recommended.

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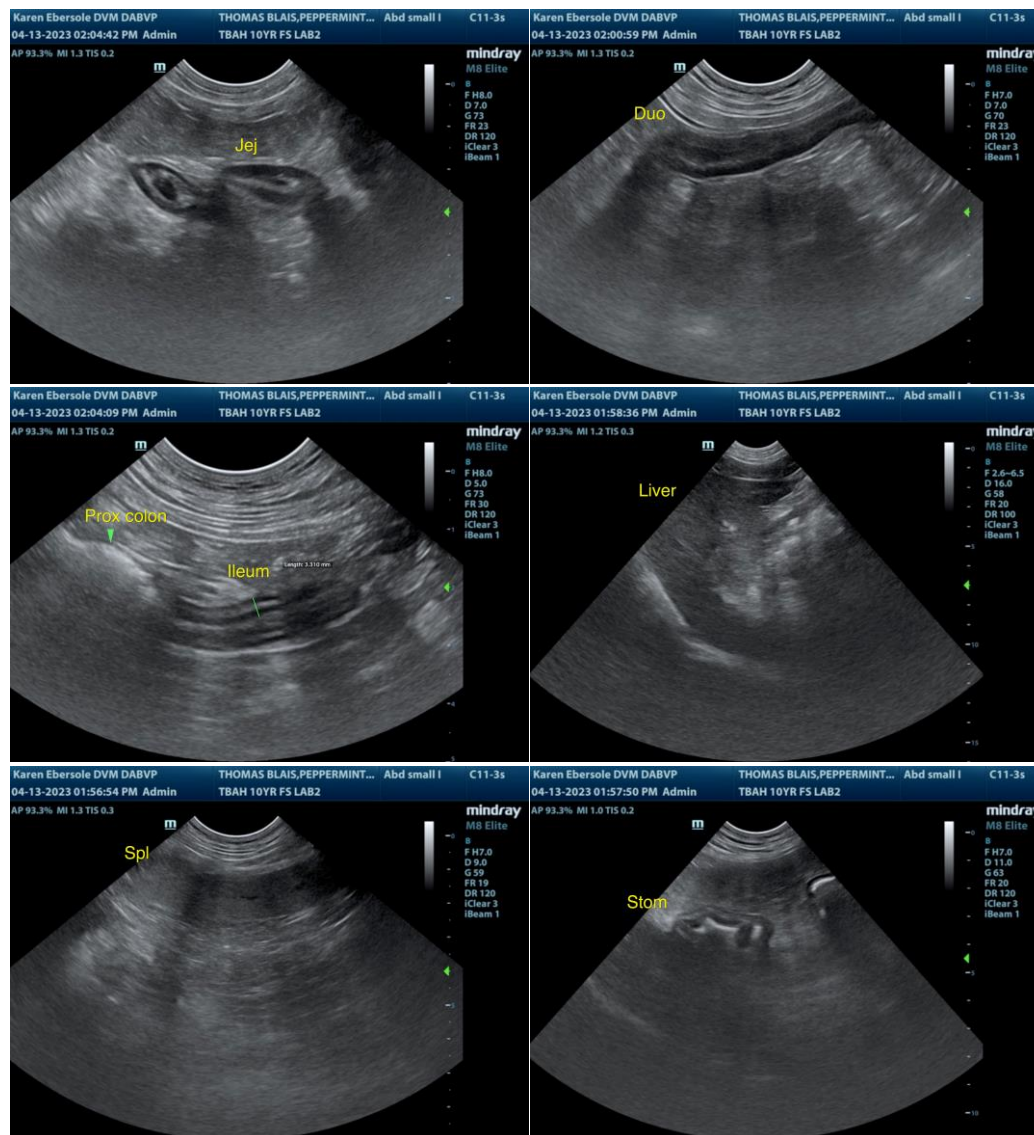
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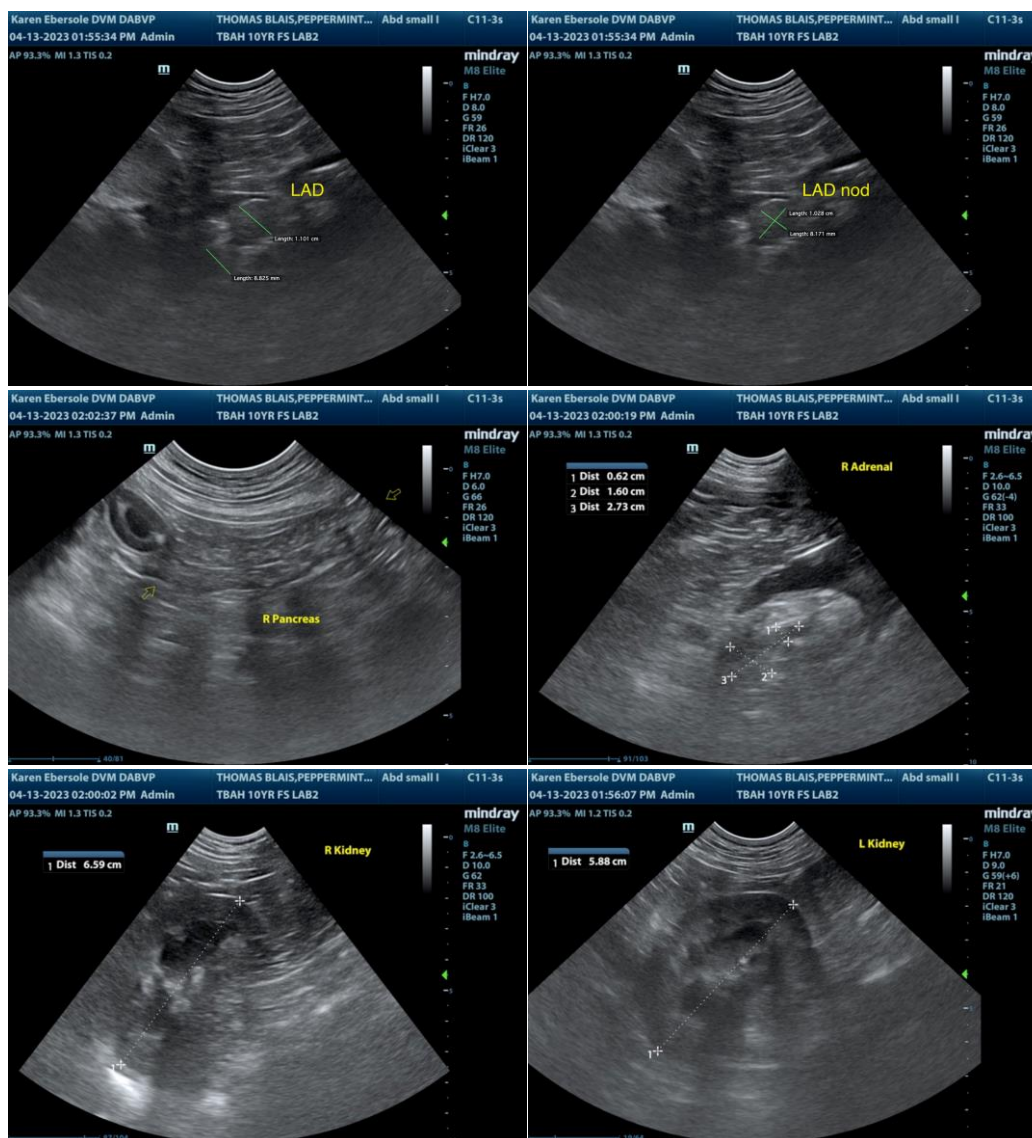
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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