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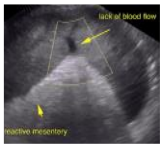

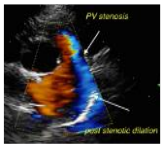

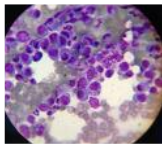
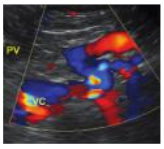

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Roscoe Dietrich

SPECIES

Canine

BREED

Vizsla

SEX

MN

AGE

2

WEIGHT

47

INTERPRETED BY

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

IMAGING PERFORMED BY

Tasha

HOSPITAL NAME

Dillsburg VC

REFERRING VET

Dr. Jacobs

INVOICE

13709

DATE

4/22/22

PRESENTING CLINICAL SIGNS

Vomiting since sunday, inappetence, weight loss, diarrhea. O unsure if p is defecating. O has hickory tree in yard, discussed toxicity (juglone) vs foreign body. O said p also drinks from puddles in yard, discussed possibly infectious cause (lepto, giardia). Started Doxycycline, metronidazole, carprofen, cerenia, SQF. Has only eaten ice cubes since Sunday, no water consumption.
Abnormal PE/Chem/CBC/UA Results: See attached BW; O declines all further diagnostics (x-rays, hospitalization and fluids)

Chemistry Panel- ALP 344, AST 72, TBili 0.8, CBC- WBC 5.6 with lymphopenia

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder was indistinctly visualized secondary to overlaying intestinal gas. No overt pathology associated with the urinary bladder was noted.

The residual prostate and proximal urethra were not visualized.

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 6.4 cm in length. The right kidney measured 6.4 cm in length.

Adrenal Glands

The left adrenal gland was indistinctly visualized yet without overt pathology subjectively measuring 0.56 cm width at the caudal pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.52 cm width at the caudal pole and 0.56 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/ Gallbladder

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.

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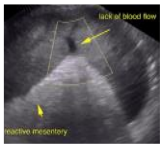

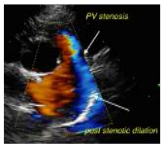

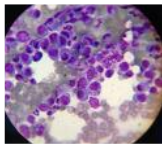
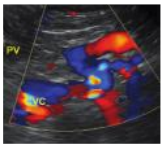

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Gastrointestinal

The stomach presented mild wall thickening secondary to mild echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. Minor retained nonshadowing echogenic fluid and chyme were present. No overt evidence of gastric distention or mechanical pyloric obstruction was noted. The ventral gastric body wall width measured 0.40 cm.

The small intestine presented intact wall layering and primarily maintained a 1:3 muscularis/mucosa ratio with subjective propensity for segmentally prominent mucosa. A segment of mid-abdominal small intestine exhibited mild to moderate mural hypertrophy, decreased mural echogenicity, and intact to indistinct wall layering with minor associated intestinal corrugation. This segment of abnormal intestine measured potentially 5.0-6.0 cm in length with wall width measuring up to 0.5 cm. No overt evidence of mechanical obstruction pattern or overt foreign material. Mild increased luminal gas artifact was noted within the midabdominal segmentally abnormal small intestine.

The colon walls presented intact yet mild to moderate prominent wall layering with mildly thickened to echogenic submucosa. The colon was primarily empty with mild nonformed feces, consistent with diarrhea.

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

Multiple, variably sized, midabdominal mesenteric lymph nodes were present. These lymph nodes were swollen, primarily hypoechoic, exhibiting mild mixed echogenicity and smoothly marginated. A borderline abnormal width: length ratio was maintained (approximately 0.5). Evidence of perilymphatic inflammation was evident. An example of lymph node size was 3.0 cm x 1.5 cm. Associated peri intestinal to perilymphatic reactive mesentery was present. No overt free fluid was noted.

ULTRASONOGRAPHIC FINDINGS

- Acute gastroenterocolitis pattern with segmental midabdominal thickened to corrugated small intestine exhibiting decreased mural echogenicity and intact to indistinct wall layering - acute inflammatory bowel episode, infectious enteritis, enterotoxemia, IBD, segmental infiltrative enteropathy (neoplasia, fungal, etc.,) or other
- Enlarged variably echogenic mesenteric lymph nodes - hyperplasia, lymphadenitis, early neoplastic lymphadenopathy
- Associated primarily regional peri intestinal to perilymphatic reactive mesentery
- Acute hepatopathy - reactive hepatopathy, acute hepatitis (viral, bacterial, Leptospirosis, toxin), mild hepatic congestion, occult hepatic neoplasia, possible

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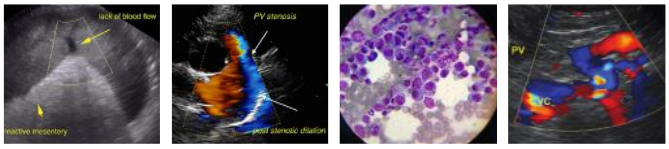

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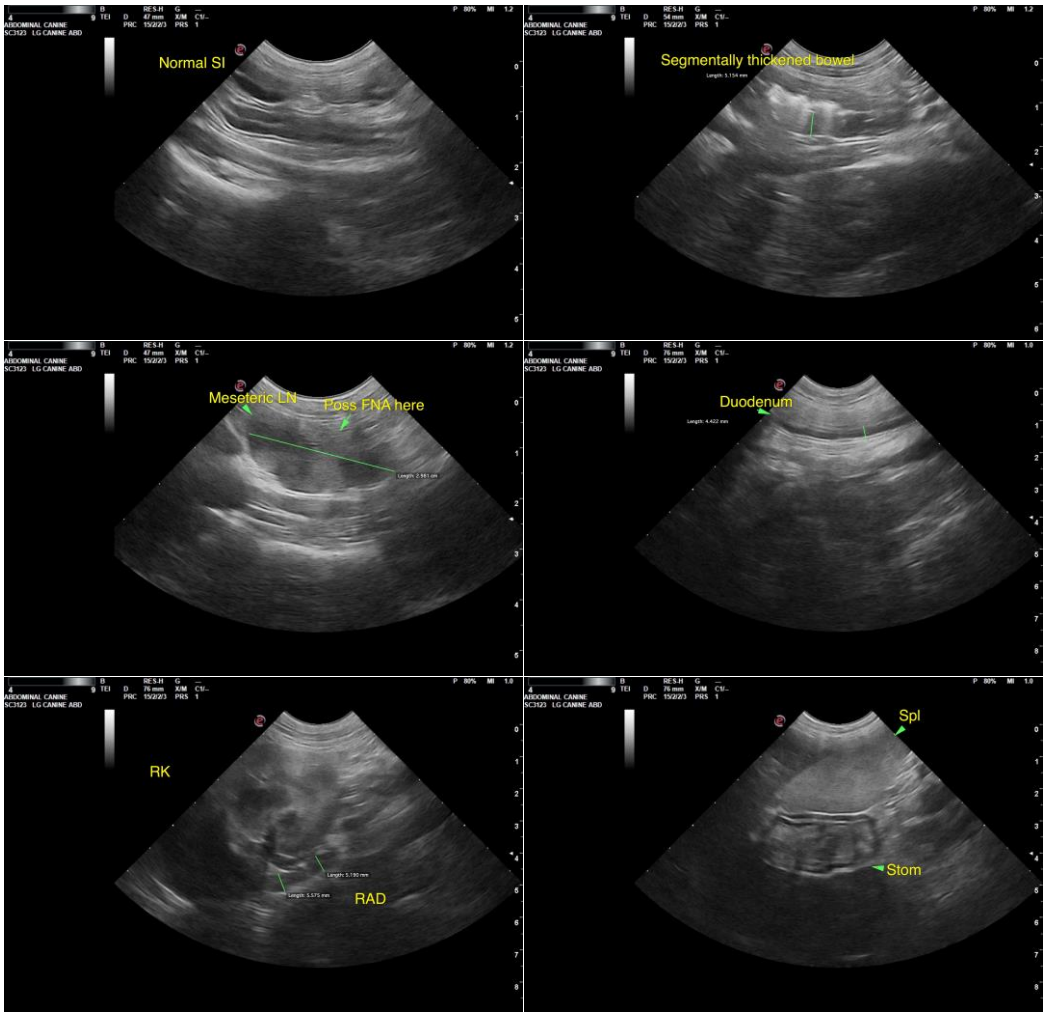
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Assuming normal clotting status and using a 25-gauge needle, hepato-lymphatic FNA is warranted for screening cytology. A GI panel to include PLI/TLI/Cobalamin/Folate and fresh fecal analysis to assess for parasitic ova / Giardia are warranted.

Aggressive medical therapy for acute gastroenterocolitis would be reasonable pending additional diagnostics. Pending clinical response to therapy and additional diagnostics, exploratory laparotomy with gross inspection of the intestinal tract and mesenteric lymphadenopathy with intestinal and lymphatic biopsies considered essential may be considered for a definitive diagnosis. No overt evidence of an obvious gastrointestinal foreign body or mechanical obstructive pattern was noted. However, a potentially passed or passing nonobstructive foreign body with secondary segmental intestinal trauma cannot be excluded.



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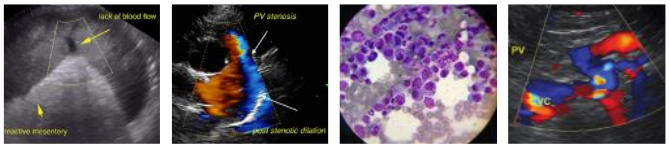

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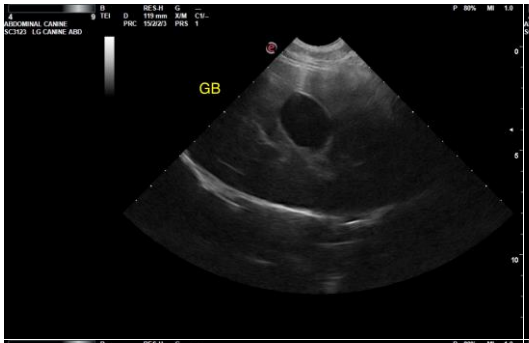

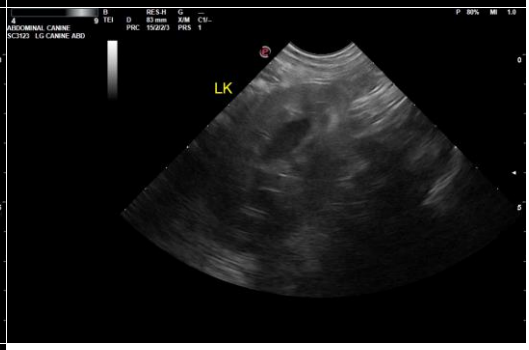

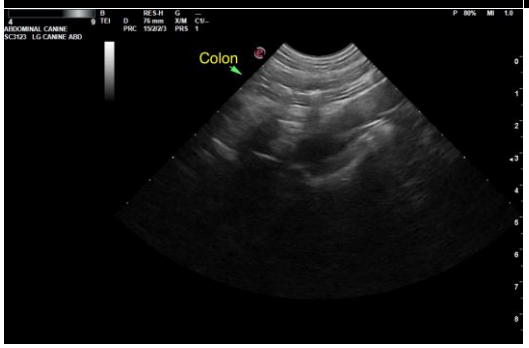

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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