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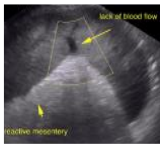
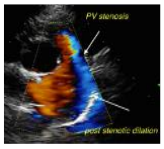
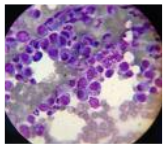
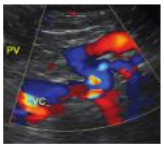

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Che Allen

SPECIES

Canine

BREED

Rottweiler

SEX

Neutered Male

AGE

6.5 Years

WEIGHT

110 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Amanda Crook- SDEP Certified Clinical Sonographer

HOSPITAL NAME

Rivers Edge PMC

REFERRING VET

Dr. Travis Gibson

INVOICE

14872

DATE

4/25/22

PRESENTING CLINICAL SIGNS

History: P has had a history of puking after eating grass. Went to Willamette Veterinary Hospital and they found a intestinal tumor that they removed. P was fine for 4 months then started vomiting again. Their veterinary cousin suggested pancreatitis and recommended a bland diet. P did well for 2 weeks then began to have decreased bowel movements with mucous and blood. Vet friend then suggested Colitis? They went to Animal Health Vet in Baja Mexico that did radiographs and blood work. They noticed a white spot in the radiographs that they thought was gas so they recommended feeding a high fiber diet. That was about 2 weeks ago. P hasn't had a bowel movement in 10 days and is dribbling blood. P hasn't had a very big appetite, eating about every other day. P has been being fed lean raw meat and raw tuna. ("Frozen so there aren't any parasites")

Abnormal PE/Chem/CBC/UA Results: See attached labwork - CBC- Monocytosis 1.40 K/uL , EOS 3.58 K/uL-- Chem- BUN 4mg/dL No Radiographs performed today

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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

No overt pathology in the area of the residual prostate.

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 6.9 cm in length. The right kidney measured 7.5 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 0.68 cm width at the caudal pole and 0.6 cm width at the cranial pole.

The right adrenal gland was not definitively visualized owing to patient size.

Spleen

The spleen was not visualized owing to previous splenectomy. No overt pathology in the area of the previous spleen.

Liver

The liver was normal in size and subjective contour. Subtle subjective reduced hepatic parenchyma echogenicity was noted, exhibiting mild to moderate coarse echotexture and minor increased prominence of portal vascular borders. No overt hepatic masses or nodules.

The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

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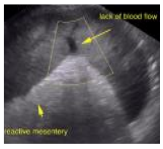
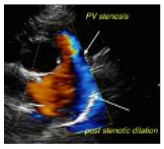
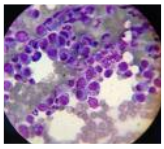
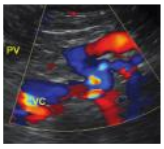

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The stomach was indistinctly visualized owing to patient size and conformation. The stomach was subjectively empty without evidence of gastric distention with retained fluid or ingesta.

The visualized segments of the small intestine exhibited intact wall layering and subjective maintained 1:3 muscularis/mucosa ratio. No overt evidence of small intestinal mechanical/metabolic ileus. An example of intestinal wall measured 0.42 cm in width.

The colon exhibited variable mural thickening with decreased mural echogenicity and loss of discernable wall layering from the approximate level of the transverse colon to proximal descending colon transition, affecting the majority of the descending colon into the colorectum. The descending colon wall measured 0.85 cm. The colorectal wall measured up to 1.3 cm in width. The visualized transverse colon contained semi-formed feces with the descending colon and colorectum primarily empty with minimal semi-formed feces and luminal gas.

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

Subtle pericolic reactive mesentery was present adjacent to the descending colon. No evidence of peritoneal effusion.

Focal to potential several, mildly prominent to hypoechoic hypogastric or possible sacral lymph nodes noted dorsal to the urinary bladder. The lymph nodes exhibited subjective maintained width to length ratio <0.5. An example of lymph node size measured 3.4 cm x 1.2 cm.

ULTRASONOGRAPHIC FINDINGS

- Variably thickened descending colon to colorectum, exhibiting decreased mural echogenicity and loss of discernable wall layering
- Overtly normal small bowel
- Mildly prominent to hypoechoic probable hypogastric versus sacral lymph nodes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Potential etiologies for the thickened descending colon and colorectum may include inflammatory (chronic colitis), infectious or infiltrative (neoplasia, fungal, other), which may present in similar sonographic manner. The concurrent probable hypogastric or sacral lymphadenopathy may indicate hyperplasia, reactive lymphadenitis with potential for early neoplastic lymphadenopathy. Given this presentation, colonic biopsies are recommended for further clarification. No other evidence of stomach or small intestinal mural changes, although the stomach was indistinctly visualized owing to patient conformation.

Empirically, continued gastrointestinal support and therapy for chronic colitis with sonographic monitoring of the colon for evidence of progressive mural changes would be reasonable.

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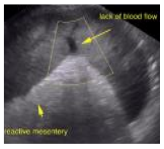
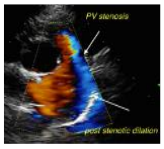
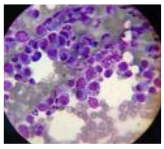
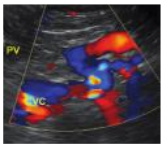

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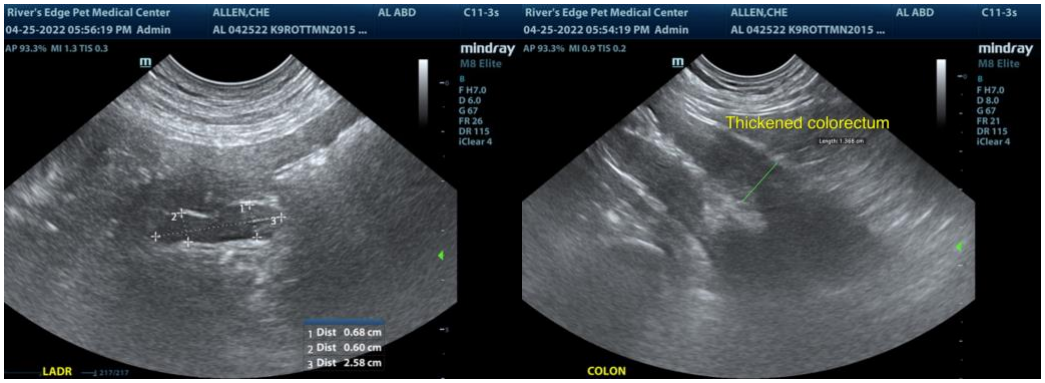

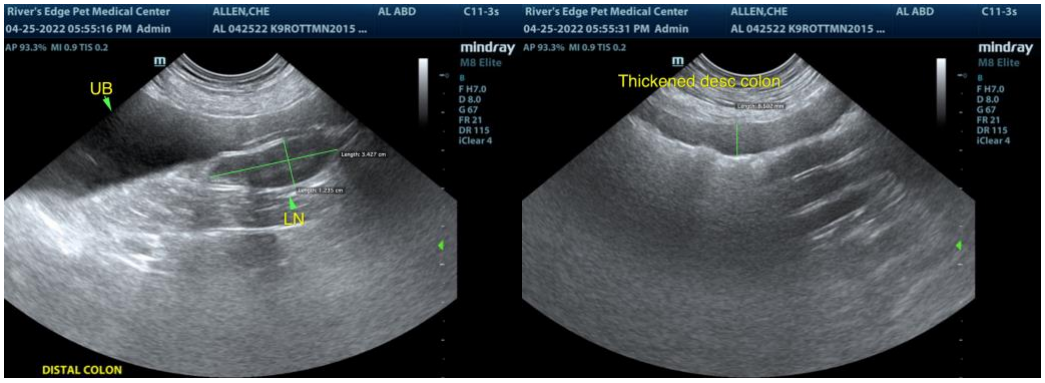

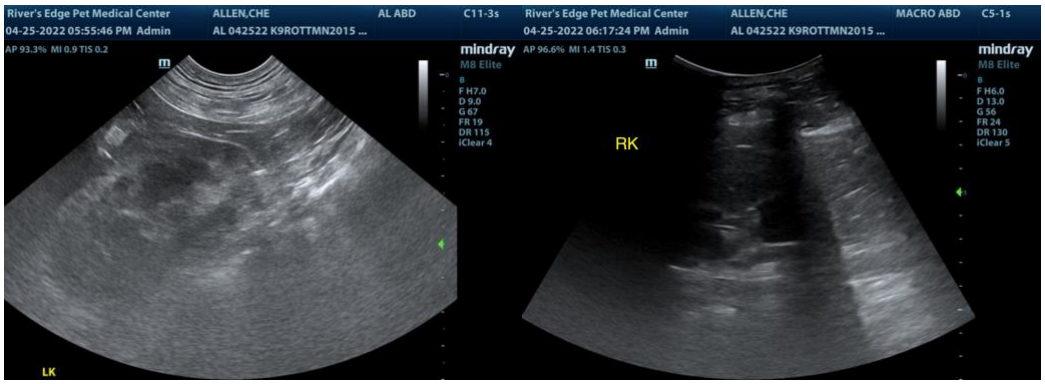

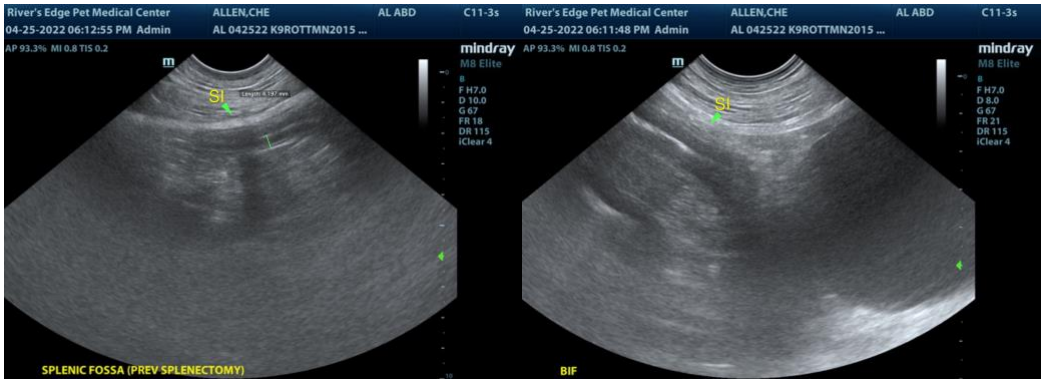

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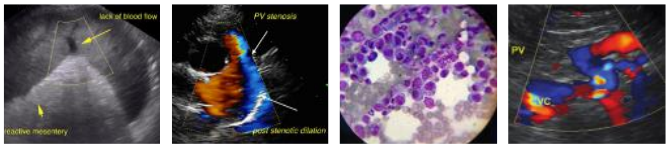

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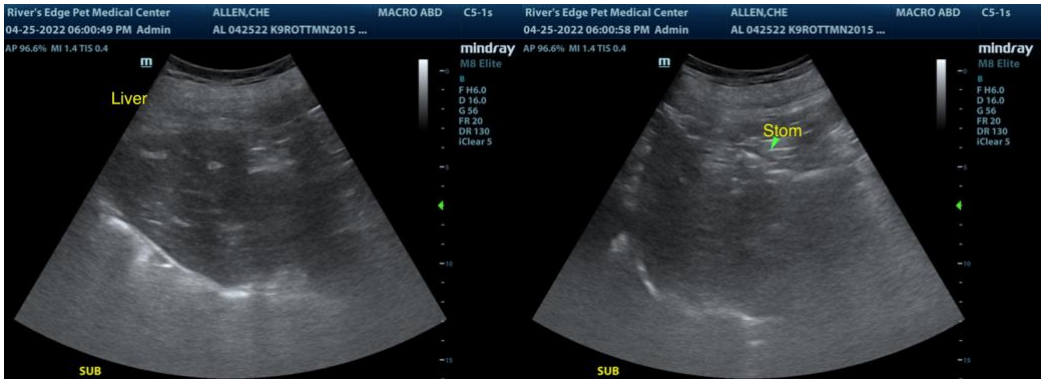

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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