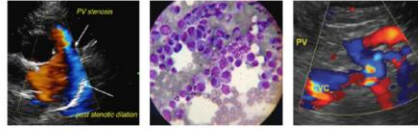


IMAGING PERFORMED BYSVS Mobile Imaging CT 262 - 366 - 5970
fredgromalak@gmail.com**PATIENT**Ella Mesheski/Garity
119775**SPECIES**

Canine

BREED

Labrador Retriever

SEX

FS

AGE

12 years

WEIGHT

28.1 kg

INTERPRETED BYR. McKenzie Daniel,
DVM, DABVP
(Canine and Feline)**IMAGING PERFORMED BY**

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VET

WVRC - Dr. Doden

INVOICE

13764

DATE

4/29/22

PRESENTING CLINICAL SIGNS

2-3 day history of vomiting and progressive diarrhea. Attempted OP care 4/28, received SQF, SQ cerenia, SQ ondansetron. Vomiting resolved but diarrhea progressed to hematochezia. Suspect HGE.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**Urinary System**

The urinary bladder, trigone, and cystourethral junction 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 minor loss of corticomedullary border demarcation expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 6.3 cm in length. The right kidney measured 6.7 cm in length.

Adrenal Glands

A small, nondisruptive, well-demarcated, uniform, hyperechoic nodule was present in the cranial left adrenal gland with mild associated symmetrical capsule expansion. The nodule did not exhibit signs of mineralization or vascular invasion. The nodule measured 0.63 cm x 0.51 cm. The overall left adrenal gland measured 0.71 cm width at the cranial pole and 0.69 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 0.71 cm width at the cranial pole and 0.55 cm width at the caudal pole.

Spleen

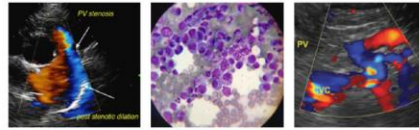
The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver/ Gallbladder

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 minor, nondependent yet nonorganized, hyperechoic gallbladder debris. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented wall thickening secondary to echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. Moderate retained anechoic to mildly echogenic fluid was present

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without evidence of gastric distention secondary to mechanical pyloric outflow obstruction. No overt evidence of gastric foreign material was noted.

The intestinal walls demonstrated intact wall layering and maintained 1:3 muscularis/ mucosa ratio. The mucosa exhibited mild decreased echogenicity with occasional mucosal speckling. A segmental to primarily diffuse small intestinal ileus to hypomotility was present with segmental subjective increased small intestinal gas pattern. Overt evidence of small Intestinal foreign material or mural pathology such as intestinal masses were not visualized.

The colon walls presented intact yet prominent wall layering with mild thickened to echogenic submucosa. Nonformed to liquid fecal matter was present in the colon lumen with lumen dilation. The colon wall width measured 0.28 cm.

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

Intermittent mesenteric lymph nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). The lymph node measured 3.1 cm x 1.2 cm. Minor peri Intestinal reactive mesentery along with focal small pocket of scant peri intestinal free fluid were present.

ULTRASONOGRAPHIC FINDINGS***Primary Findings***

- Acute gastroenterocolitis pattern with primarily diffuse gastrointestinal ileus / hypomotility
- Associated nonspecific yet subjectively benign to reactive mesenteric lymphadenopathy - lymphoid hyperplasia or minor reactive lymphadenitis secondary to inflammatory bowel episode likely
- Minor peri intestinal reactive mesentery with focal scant peri intestinal free fluid
- Nonspecific yet likely benign left adrenal nodule - suspect adenoma

Secondary Findings

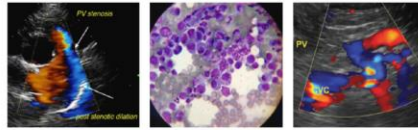
- Mild gallbladder debris - potentially owing to fasting or nonclinical cholestasis, incidental
- Mild age-related kidneys

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The overall appearance of the gastrointestinal tract is consistent with acute gastroenterocolitis without overt evidence of mechanical obstruction or visualized foreign material. Technically, the possibility of a very small passing foreign object could be present and non-visualized secondary to gas artifact, yet

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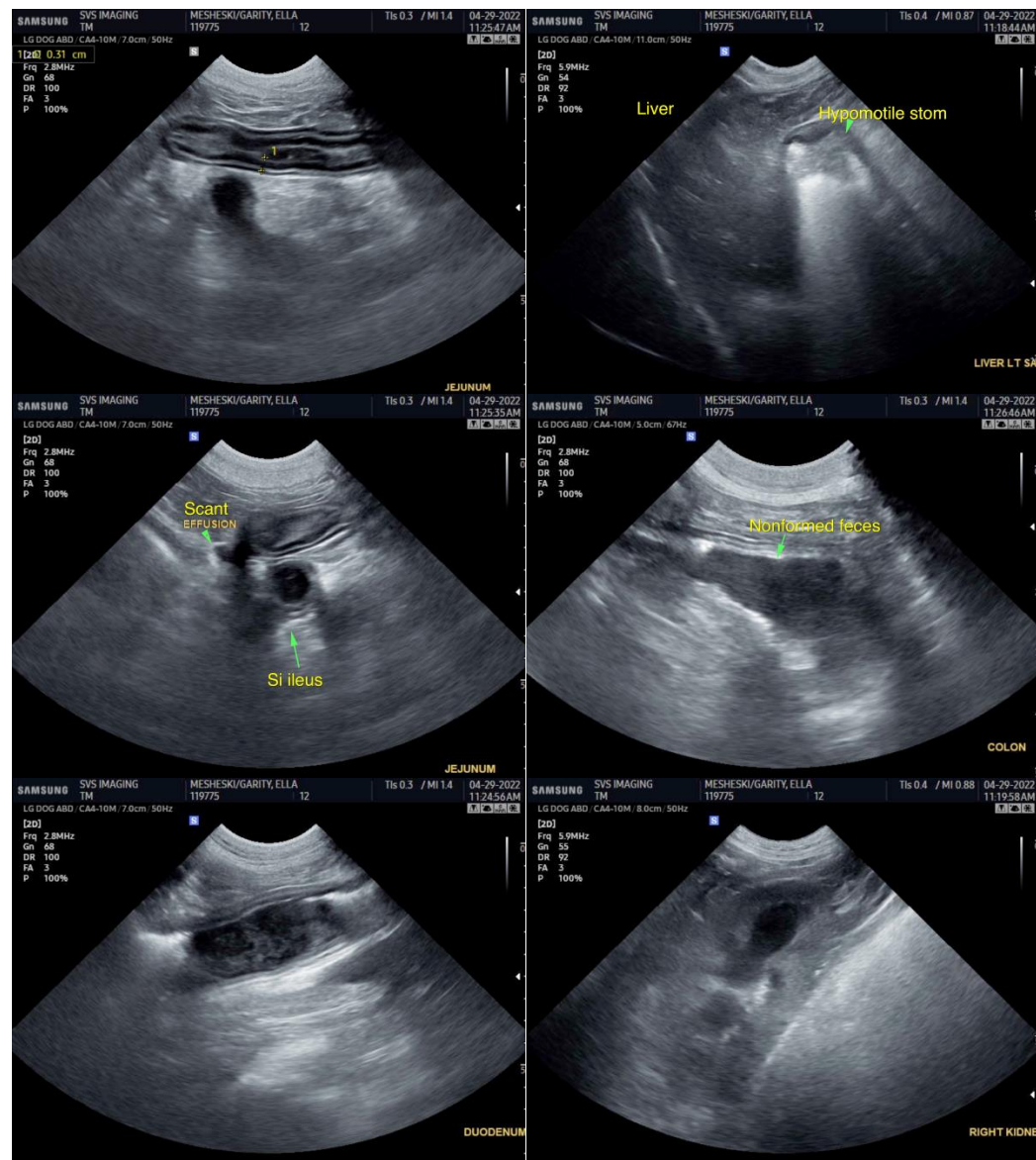
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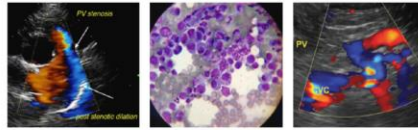
thought less likely. Dietary indiscretion, enterotoxemia, Infectious gastroenterocolitis, or less likely occult infiltrative gastrointestinal neoplasia are possible.

Aggressive medical therapy for acute gastroenterocolitis / HGE is recommended with an assessment of clinical response. Recheck sonogram could be considered to assess for progressive inflammatory gastrointestinal changes or ileus if persistent / progressive gastrointestinal signs nonresponsive to medical therapy are noted. Likewise, ideally, sonographic monitoring of the left adrenal nodule for evidence of progression is recommended.



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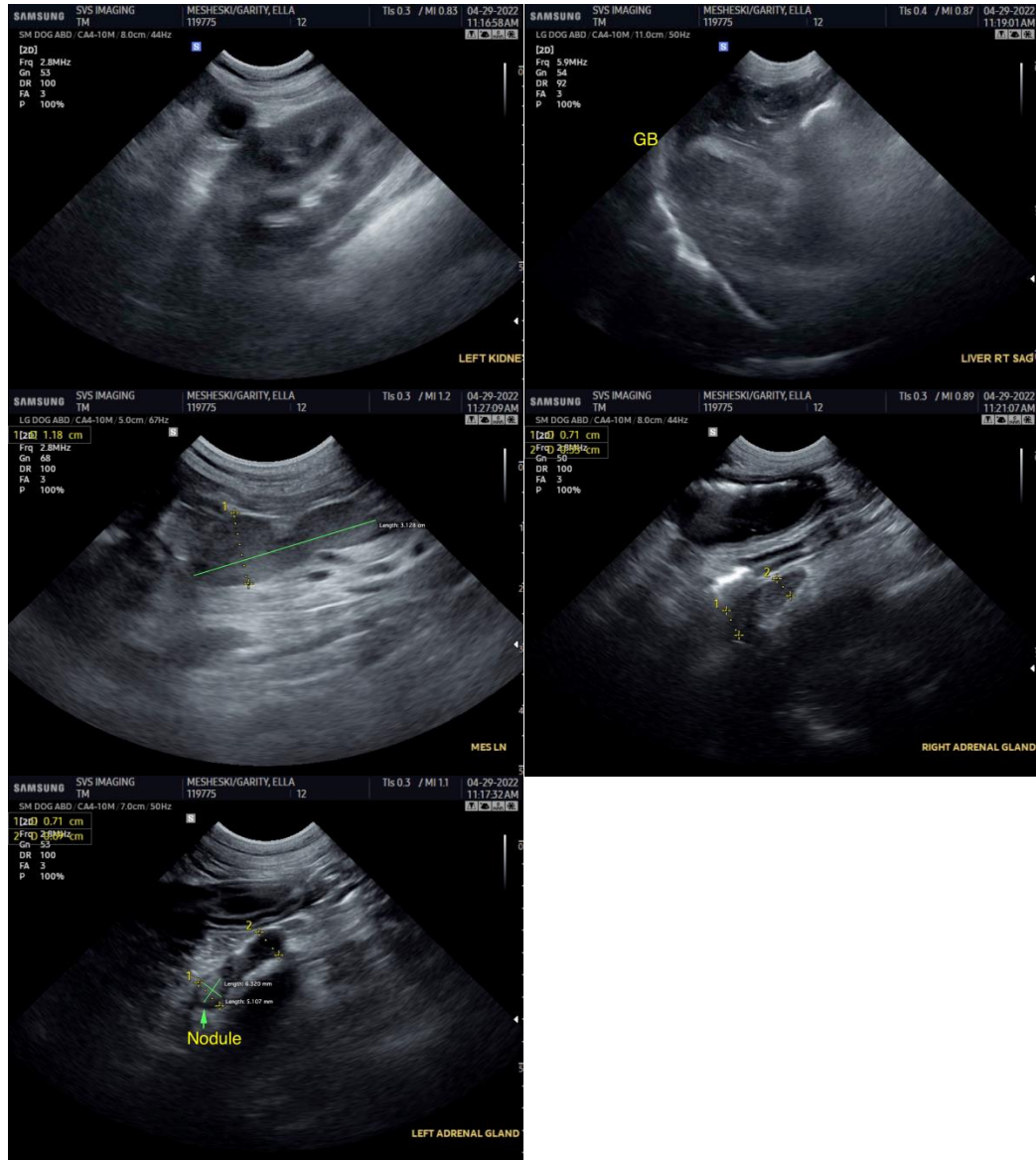
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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