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Clinical Sonography & Telecytology
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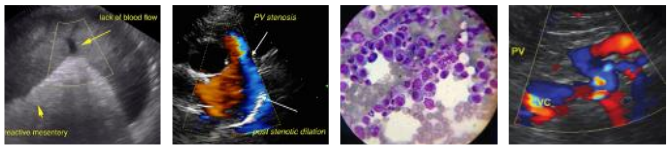

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Cooper Friske

SPECIES

Canine

BREED

Labrador Retriever

SEX

MN

AGE

6yr

WEIGHT

86lb

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Jessie Evoniuk

HOSPITAL NAME

State Avenue Vet Clinic

REFERRING VET

Dr. Jessie Evoniuk

INVOICE

13689ag

DATE

05/02/2023

PRESENTING CLINICAL SIGNS

Thursday- every time P ate he vomited rancid odor, mostly food, same signs on Friday Change in breath feeding Blue Buffalo, milk bone treats Sunday P vomited again Monday P didn't want to eat at all Is drinking and keeping water down as far as O knows Tuesday- did eat this morning, P was outside so unsure if P vomited or not, slower to eat Still BAR No change in food/treats Diarrhea started a few weeks ago and has been off and on Now diarrhea is pretty consistent Nothing P got into that O knows of Used to eat random objects but hasn't in a long time No meds Fargo this weekend and got slightly better. Sunday night vomited and wouldn't eat yesterday.

Abnormal PE/Chem/CBC/UA Results: PE: more lethargic than normal sl low ALP sl elevated GLU, EOS, RBC, HCT

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 were noted.

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 6.7 cm in length. The right kidney measured 6.9 cm in length.

The area of the aortic trifurcation was free of pathology.

The area of the residual prostate appeared normal and free of pathology.

Adrenal Glands

The bilateral adrenal glands were indistinctly visualized with no overt pathology. The left adrenal gland measured 0.55 cm width at the caudal pole. The right adrenal gland measured 0.70 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 thin walls and primarily anechoic luminal content with mild congealed echogenic debris. No evidence of gallbladder or peripheral gallbladder inflammation was present. The cystic and common bile ducts were normal.

Gastrointestinal

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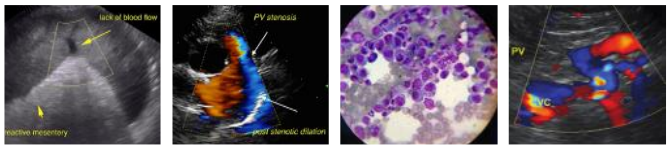

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The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained moderate variably echogenic ingesta exhibiting mild progressive distal acoustic shadowing. The area of the pyloric outflow was indistinctly visualized with no overt evidence of ileus, obstruction or foreign material.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. Segmental non-specific mildly prominent to hyperechoic intestinal submucosa layer. The lumen of the small intestine contained mild segmental non-shadowing ingesta/chyme and segmental gas patten with no signs of ileus, obstruction or foreign material.

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

Pancreas

The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. Suspect thinly walled right limb pancreatic cyst measuring 2.2 cm in diameter. No signs of active inflammation or neoplasia.

Free Abdomen

No omental masses or peritoneal effusion was present.

Intermittent mildly prominent to enlarged 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). This finding is considered incidental and is not consistent with inflammatory or neoplastic criteria.

ULTRASONOGRAPHIC FINDINGS

- Structurally unremarkable GI tract with moderate gastric and mild segmental intestinal ingesta.
- Suspect benign right pancreatic limb cyst.
- Gallbladder debris (non-mucocele).
- Mild benign/reactive mesenteric lymphadenopathy.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Overall, there is no overt evidence of significant abdominal visceral, specifically GI mural pathology as a definitive cause of the patient's clinical signs. No GI obstructive pattern.

The presence of gastric ingesta is nonspecific and likely indicates post-prandial presentation. Correlation with most recent meal ingestion is recommended. If documented NPO prior to the ultrasound, the presence of gastric ingesta may indicate some degree of gastric hypomotility or delayed peristalsis. The sonographic presentation of the ingesta was most consistent with food, without overt evidence of foreign material.

Dietary indiscretion / food hypersensitivity, dysbiosis, structurally insignificant inflammatory gastroenteropathy or low grade to chronic pancreatitis both of which may appear sonographically normal, or occult Addison's disease are all potentials. Infiltrative neoplasia is considered less likely.

Ideally sonographically reassessment of the empty GI tract is recommended. Monitoring for GI emptying following documented 12-18 hour NPO is suggested if clinically indicated.

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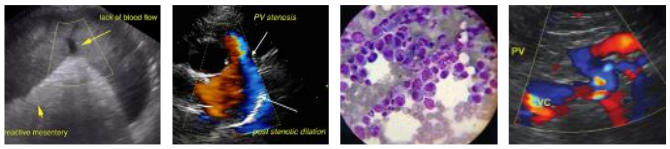

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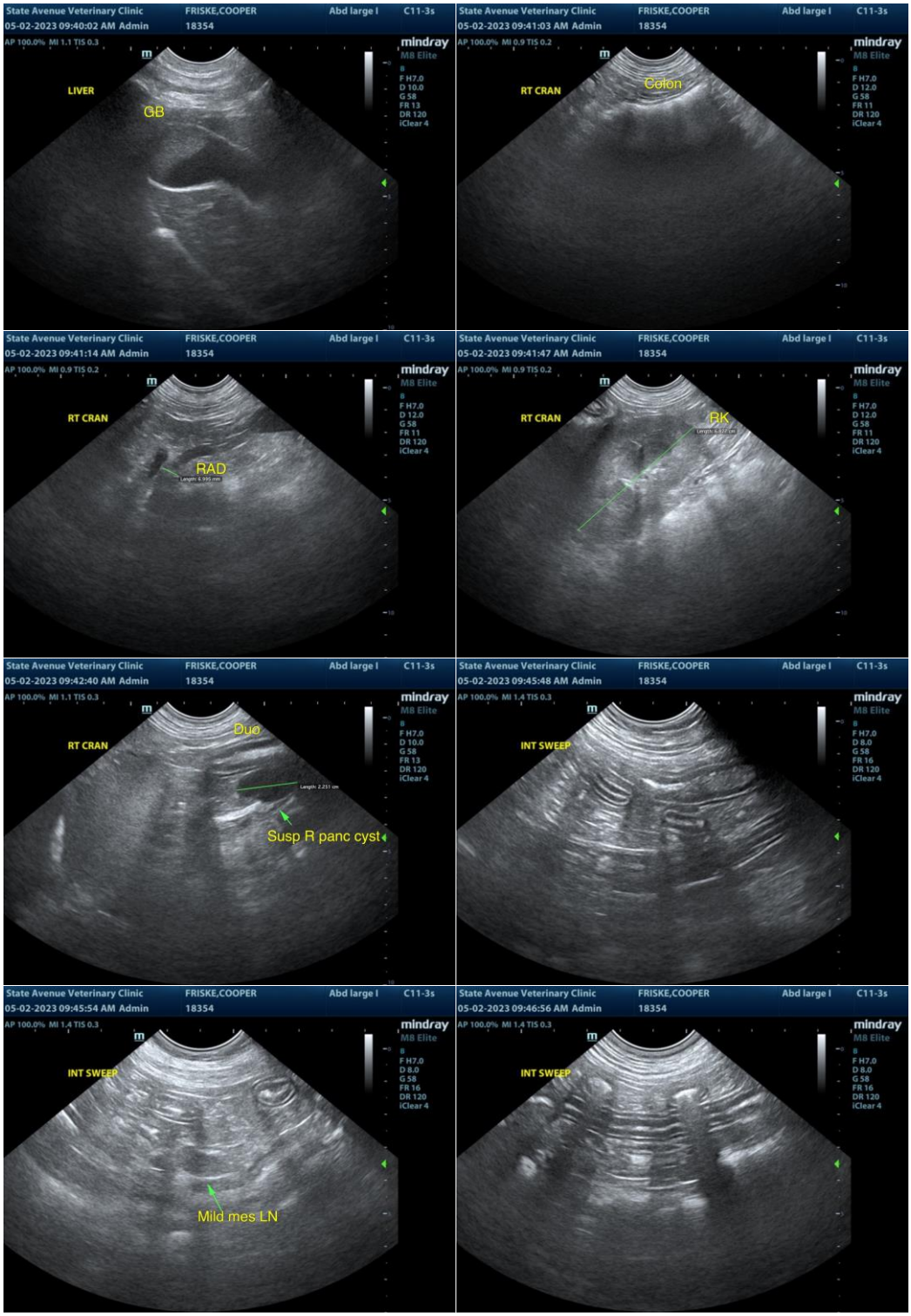

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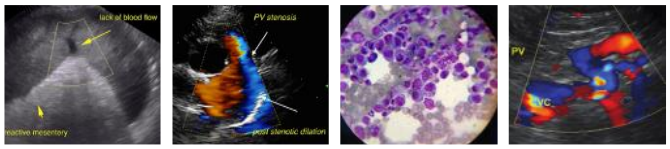

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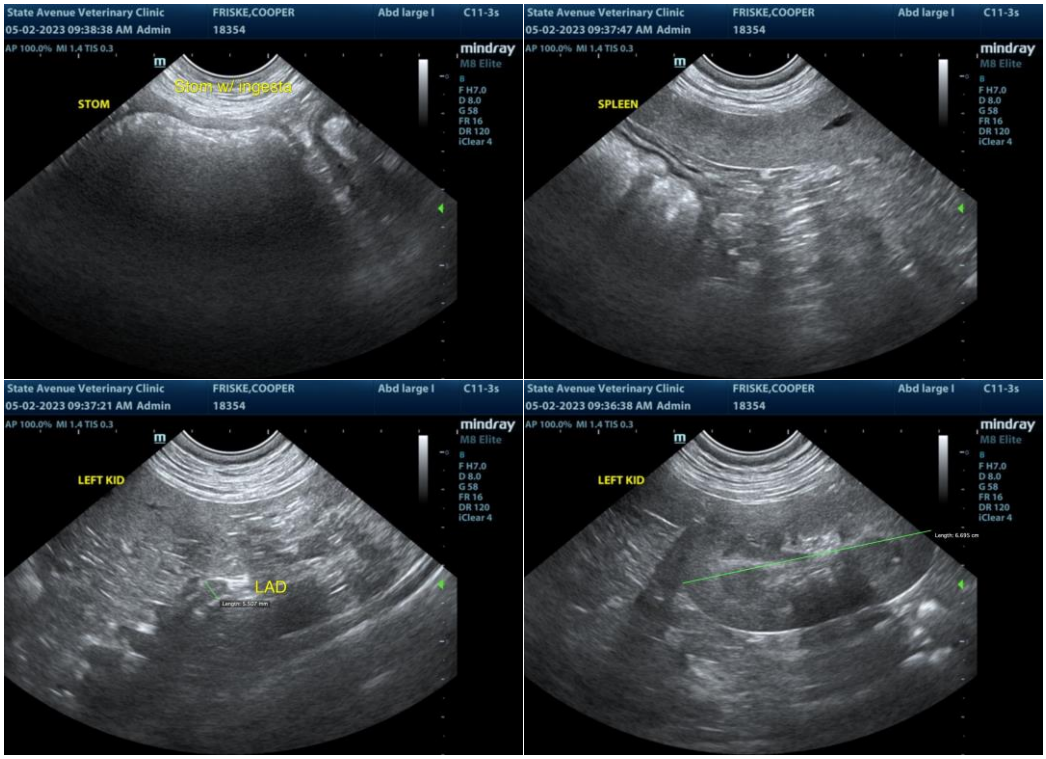

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
mac.daniel@sonopath.com