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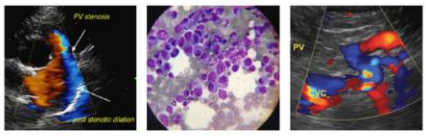

SonoPath
Clinical Sonography & Telecytology
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PATIENT
Trixie Kell

SPECIES
Canine

BREED
Coonhound Mix

SEX
FS

AGE
3.5 years

WEIGHT
45 lbs.

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

IMAGING PERFORMED BY
Amy Mayhew LVT

HOSPITAL NAME
SVS Imaging MI

REFERRING VET
Family Pet Practice

INVOICE
13919

DATE
5/20/22

PRESENTING CLINICAL SIGNS

History of anxiety. Presented May 16th for inappetence, vomiting, and diarrhea during boarding. She was unable to take meds during boarding. Treated with Pepcid and Metronidazole. Presents today for continued inappetence, vomiting foam, and diarrhea. She did eat 2 tablespoons of yogurt this morning and took pills.
Abnormal PE/Chem/CBC/UA Results: Exam May 16th: Non painful abdomen. Weight loss noted. Fecal cytology at the time showed rod overgrowth.

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 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 5.7 cm in length. The right kidney measured 6.0 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 0.50 cm width at the caudal pole and 0.46 cm width at the cranial pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.51 cm width at the caudal pole and 0.50 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 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 sonographically normal walls containing mild to moderate, nondependent yet nonorganized

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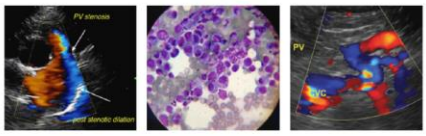

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gallbladder debris. No evidence of inflammatory gallbladder or peripheral gallbladder criteria. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact and sonographically unremarkable wall layering. The ventral gastric body wall width measured 0.33 cm. The stomach contained a mild to moderate amount of retained primarily nonshadowing ingesta / chyme, along with focal small shadowing luminal echoes. An example of a gastric shadowing echo measured 1.3 cm in diameter.

The small intestine presented intact wall layering exhibiting a maintained 1:3 muscularis/mucosa ratio. Segments of empty small intestine along with concurrent intestinal segments containing retained nonshadowing chyme and fluid were present. The small intestinal wall width measured 0.39 cm. No obvious evidence of small intestinal mechanical obstructive pattern was noted.

Normal visible colon wall layers were present with semi-formed to soft 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. No sonographic evidence of active pancreatitis was noted.

Free Abdomen

Intermittent jejunocolic lymph nodes were present. These lymph nodes were homogenous, mildly hypoechoic and smoothly marginated. A normal width: length ratio was maintained (<0.5). Evidence of perilymphatic inflammation was evident. An example of lymph node size was 4.0 cm x 1.3 cm. No free fluid was noted. The omentum exhibited uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Gastroenteritis pattern with retained focally shadowing gastric ingesta and segmental mild duodenojejunal ileus pattern exhibited by mild retained nonshadowing chyme / fluid
- Associated intermittent variably prominent jejunocolic lymphadenopathy - subjectively benign, lymphoid hyperplasia or suspected lymphadenitis owing to inflammatory bowel episode, neoplastic criteria considered unlikely

Secondary Findings

- Mild to moderate nondependent gallbladder debris (non-mucocele)

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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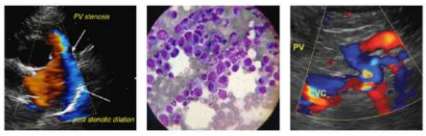

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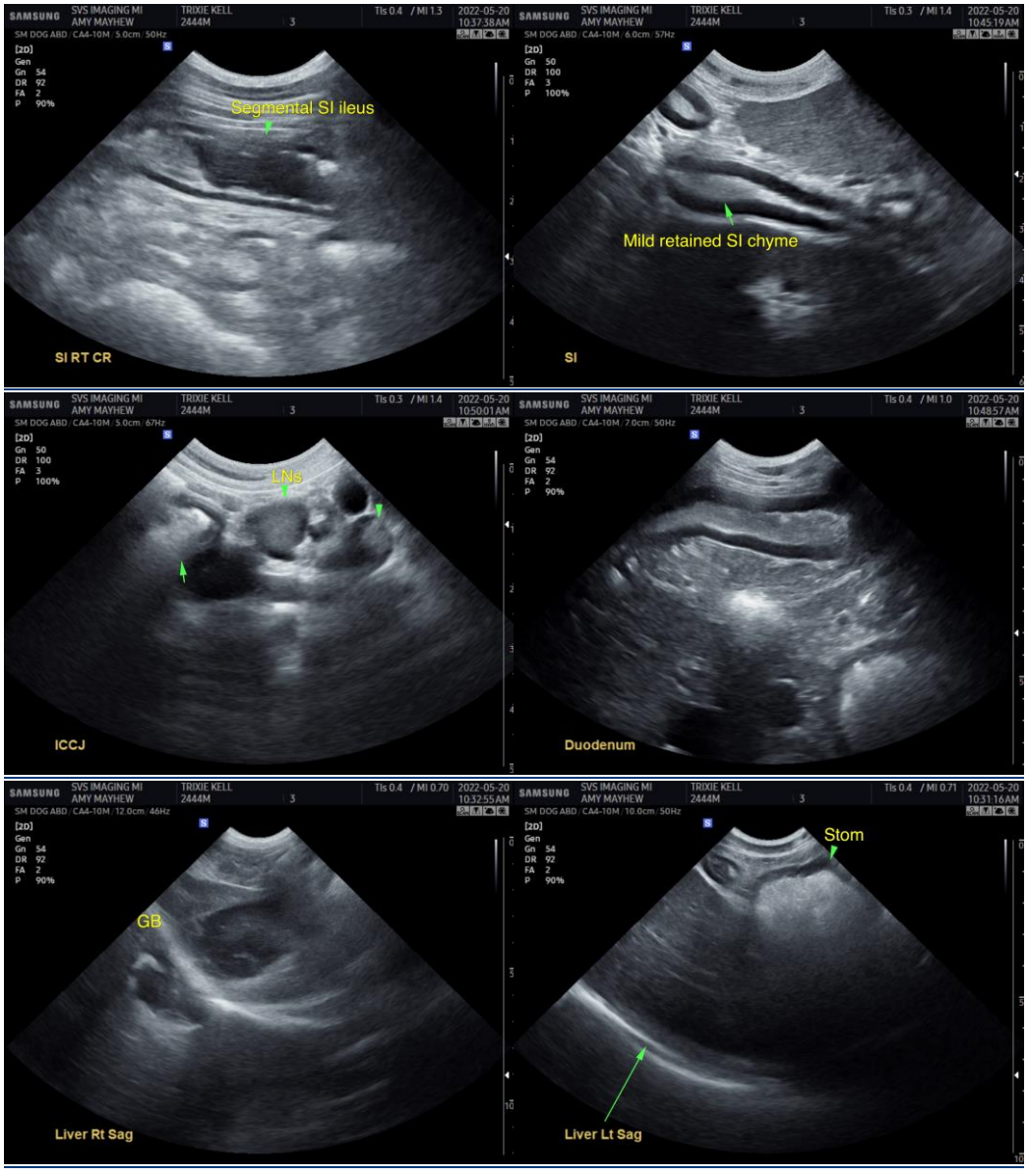
Acute gastroenteritis owing to dietary indiscretion / food intolerance, enterotoxemia, infectious gastroenteritis, or potential Inflammatory bowel disease without overt evidence of mechanical obstruction may be possible.

The shadowing gastric echoes may potentially correlate with medication given the patient's history. Technically, the possibility of small gastric and non-visualized to nonobstructive foreign material within the small bowel cannot be definitively excluded. Further assessment may Include a GI panel to include PLI/TLI/Cobalamin/Folate, as well as hospitalization with gastrointestinal supportive care, correction of any potential dehydration, and ideally sonographic monitoring of the gastrointestinal tract over the next 24-48 hours for evidence of normal gastric emptying. If persistent gastrointestinal signs and in light of the weight loss, exploratory laparotomy with gastrointestinal biopsies considered essential, should be considered if these clinical signs are noted.



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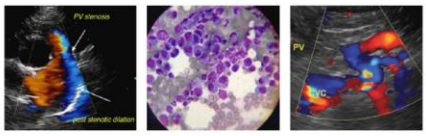

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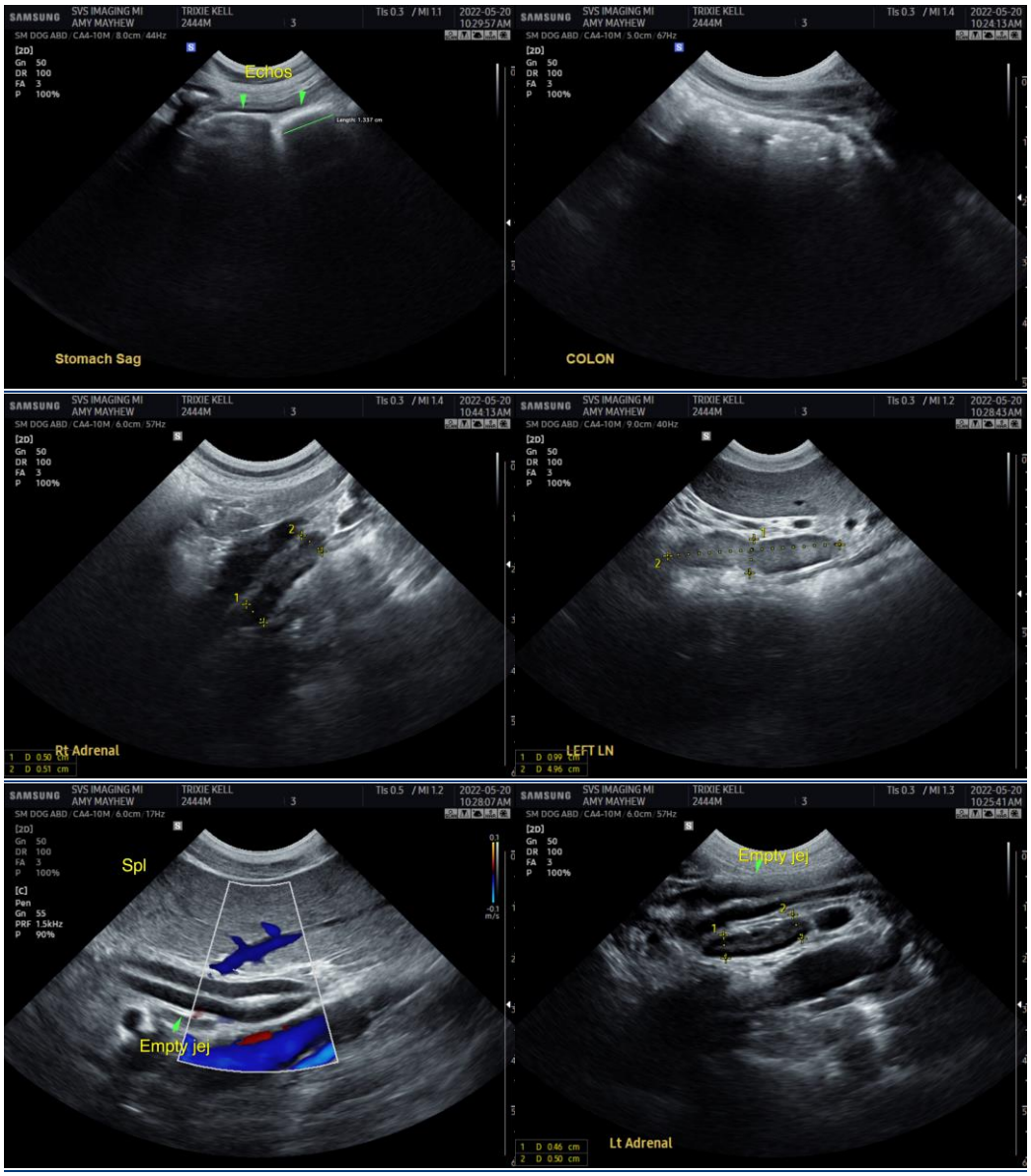

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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