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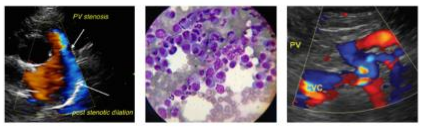


SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

PATIENT

Star Ahlers

SPECIES

Canine

BREED

Lab

SEX

Spayed Female

AGE

7 Years

WEIGHT

98 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Sarah Pender, CVT

HOSPITAL NAME

SVS Imaging QC

REFERRING VET

Dr. Elliott

INVOICE

37877

DATE

5/23/22

PRESENTING CLINICAL SIGNS

Vomiting for 3 days, not eaten anything in 4 days, vomiting within an hour of eating. Started on Friday. Drinking water ok, no diarrhea.
Abnormal PE/Chem/CBC/UA Results: Radiographs appear to have an abnormal gas pattern in the cranial abdomen. Concern of FB

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 cm exhibited normal thickness and tone. Primarily anechoic urine was present in the lumen. Minor non-dependent particulate sediment was present without evidence of calculus formation. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural 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 6.3 cm. The right kidney measured 7.1 cm.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

The adrenal glands were uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 2.7 cm length x 0.82 cm at the caudal pole. The right adrenal gland measured 3.0 cm length x 0.63 cm 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.

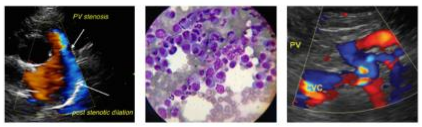
Liver

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. Mild hyperechoic luminal debris present. No evidence of gallbladder or peripheral gallbladder inflammation. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact yet subjective prominent wall layering. A mild amount of retained echogenic fluid and chyme exhibiting mild progressive distal acoustic shadowing along with likely luminal gas. Ventral gastric body wall measured 0.50 cm.

The small intestine presented intact wall layering with maintained 1:3 muscularis/mucosa ratio. Segments of small intestine exhibited mild dilation with retained non-shadowing chyme along with subjective increased segmental small intestinal gas pattern. Potential for intermittent segmental



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shadowing luminal echoes. Concurrent segments of empty small intestine without evidence of mechanical/metabolic ileus pattern or increased gas pattern also present. Small intestinal wall measured 0.38 cm.

The colon exhibited sonographically unremarkable wall layering with potential to subjective generalized mild colonic distention with nonformed to shadowing fecal matter.

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 was evident.

Free Abdomen

Intermittent enlarged mid abdominal mesenteric lymph nodes were present. Example measured 5.2 cm x 1.1 cm. These lymph nodes were homogenous, mildly hypoechoic and smoothly marginated. A normal width: length ratio was maintained (<0.5). Evidence of subtle perilymphatic inflammation was evident. No evidence of peritoneal free fluid. Overall normal omental echogenicity. No overt peritonitis.

ULTRASONOGRAPHIC FINDINGS

- Gastritis pattern with mild progressively shadowing retained fluid/chyme.
- Segmental retained small intestinal chyme with subjective increased segmental gas pattern and suspect intermittent luminal echoes.
- Concurrent empty segmental small intestine without mechanical/metabolic ileus.
- Associated mid abdominal mesenteric lymphadenopathy – subjectively benign. Lymphoid hyperplasia or mild reactive lymphadenitis secondary to inflammatory bowel episode likely. No evidence of lymphatic neoplastic criteria.

SECONDARY FINDINGS

- Mild urinary bladder sediment.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Although a definitive obstructive pattern was not present, the overall gastrointestinal presentation including suspect segmental intestinal shadowing echoes, segmental mild small intestinal ileus pattern, and presence of mildly progressive retained gastric ingesta is highly suspicious for non-obstructive to potentially partially obstructive foreign material such as fabric, stuffing, hair density or similar.

Given this presentation in combination with the patient's clinical signs, exploratory laparotomy for further assessment with intestinal biopsies strongly suggested, despite exploratoryfindings, is warranted. Hospitalization with IV fluid and gastrointestinal support with radiographic/sonographic monitoring over the next 24 hours would be a more conservative approach.

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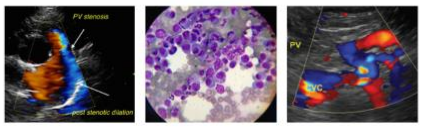

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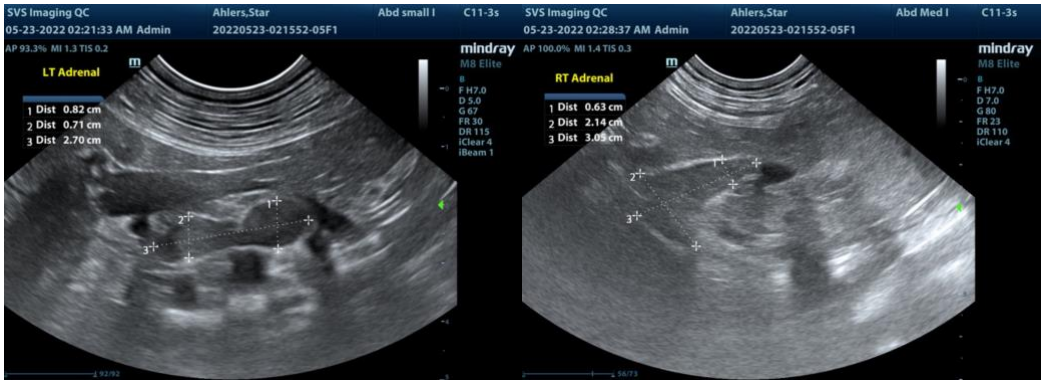

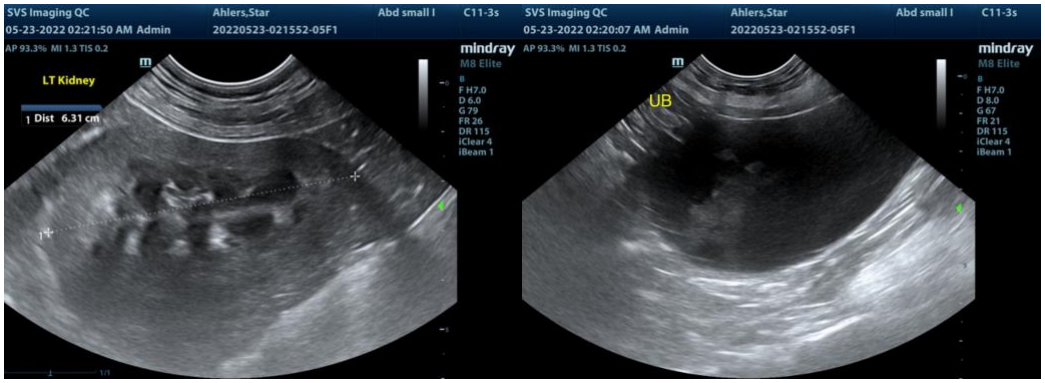

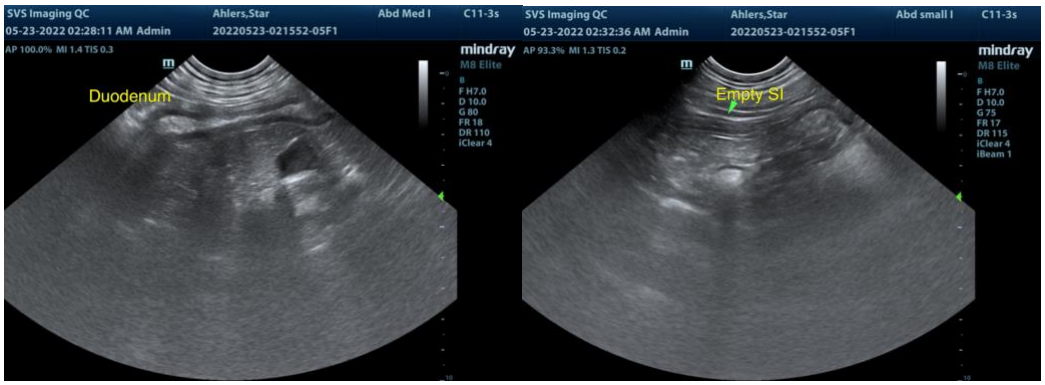

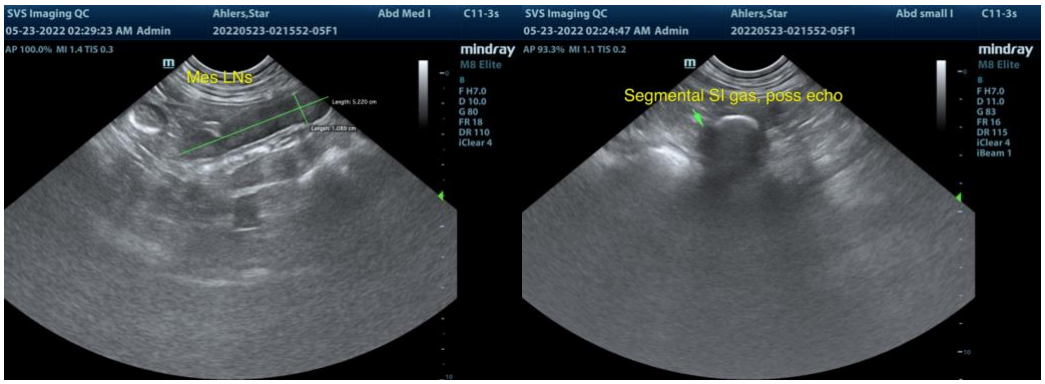

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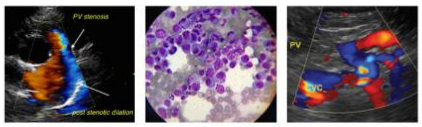

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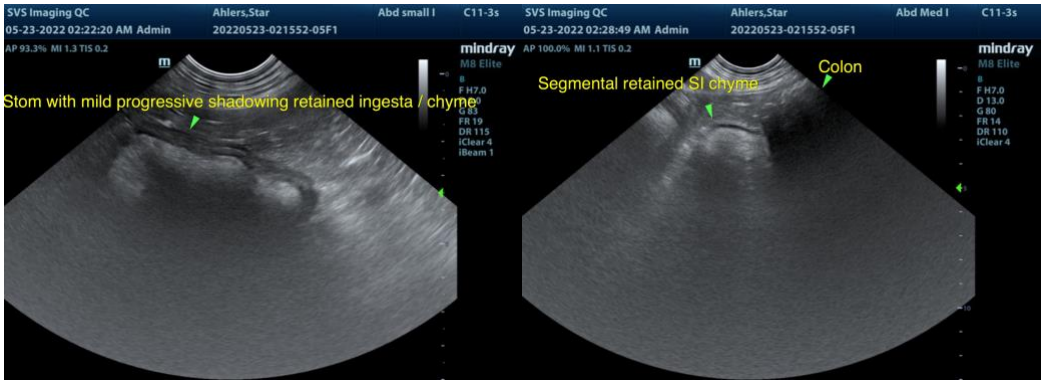

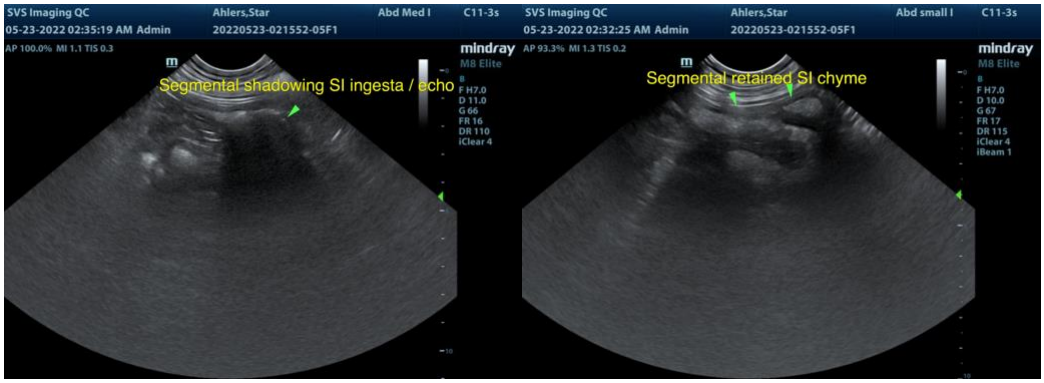

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@SonoPath.com