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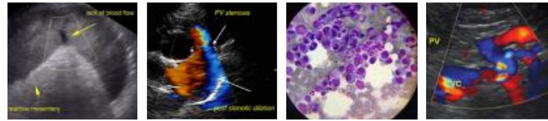


ANIMAL SOUNDS NW
MOBILE VETERINARY ULTRASOUND
IMAGING PERFORMED BY
AnimalSoundsNW.com 541-357-9423

PATIENT

Dutch Vaughn

SPECIES

Canine

BREED

Australian Shepherd

SEX

MN

AGE

8 years

WEIGHT

66.4 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Jenna Walsh, CVT

HOSPITAL NAME

Reid Veterinary Hospital

REFERRING VET

Dr. Reid

INVOICE

15055

DATE

5/5/22

PRESENTING CLINICAL SIGNS

History: - presented yesterday 5/4 on urgent care to RVH for vomiting x 5 days - several times a day, clear/yellow but keeping down food - diarrhea x 3 days - no blood per O, yellow in color - started after going hiking in the mountains - P doesn't typically eat things in the woods. no drinking odd water or salmonid exposure per o - no known dietary indiscretion but does sometimes eat paper products - no hx of illness, no coughing or sneezing - drinking more than normal and bad ammonia-like breath per o. E/D WNL - p rec'd tx at RVH, p then V 2x last night (clear fluid and then yellow with some blood) but appetite good still per o... PE: mostly unremarkable, hypersalivation, injected sclera, normal lnn., moderately tense on palpation Current Medications Cerenia inj. 11AM 5/4, Mirtaz 7.5mg PO 11AM 5/4, Propectalin tabs Radiographic Findings splenomegaly, possible mass effect on spleen. NSF of GI tract, no obstructive pattern noted Primary Question/Differential to Be Answered in This Exam DDX for V/D (even around Cerenia inj...) - primary GI (suspect FB?) or possible splenic pathology related to cx?
Abnormal PE/Chem/CBC/UA Results: NSF: mild ALP elv. 465, mildly hypokalemic 3.7 and hypochloremic 106 (cPL 178 WNL, TT4 and UA WNL)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 5.0 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 was noted.

The residual prostate was symmetrically normal in size with uniform parenchyma and slight coarse echotexture measuring 1.0 cm in diameter.

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 in length. The right kidney measured 6.8 cm in length.

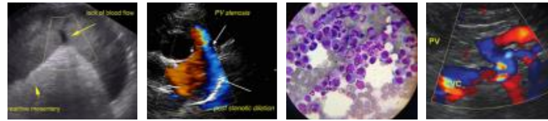
Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.80 cm width at the caudal pole and 0.57 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 0.87 cm width at the caudal pole and 0.87 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



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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 presented enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion.

The gallbladder was non distended in size with primarily anechoic content with moderate mildly congealed yet nonorganized luminal gallbladder debris. No evidence of peripheral gallbladder inflammation. The cystic duct and common bile ducts were normal without evidence of dilation.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained moderate ingesta, exhibiting mildly strong distal acoustic shadowing. No evidence of mechanical pyloric outflow obstruction. The visualized gastric walls were sonographically normal. The ventral gastric body wall measured 0.33 cm.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction, or foreign material. The duodenum wall measured 0.58 cm. The jejunum wall measured 0.38 cm.

Normal visible colon wall layers were present. The lumen was empty.

Pancreas

The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

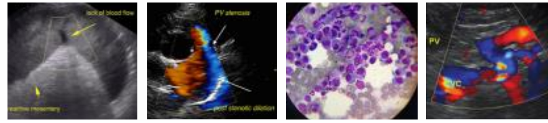
Free Abdomen

A focal, mildly prominent to enlarged mid abdominal mesenteric lymph node was present medial to the spleen. The lymph node was essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). The lymph node measured 3.2 cm x 1.1 cm.

No effusion was noted.

ULTRASONOGRAPHIC FINDINGS

- Vacuolar hepatopathy pattern
- Moderate gallbladder debris- possible very early mucocele
- Heterogeneous pancreas- nonspecific, patient variant, minor parenchymal remodeling owing to previous inflammation or low-grade to chronic inflammation possible
- Overtly normal gastrointestinal tract with moderate shadowing gastric ingesta



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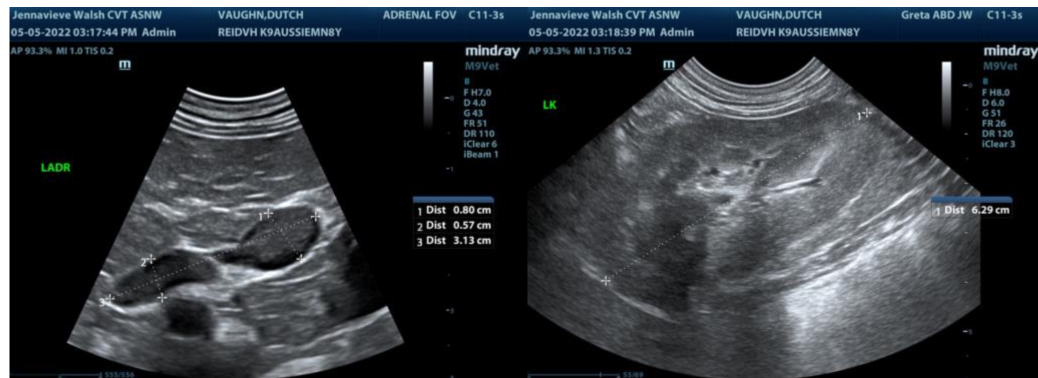
- Focal reactive/benign mesenteric lymph node- not consistent with inflammatory or neoplastic criteria

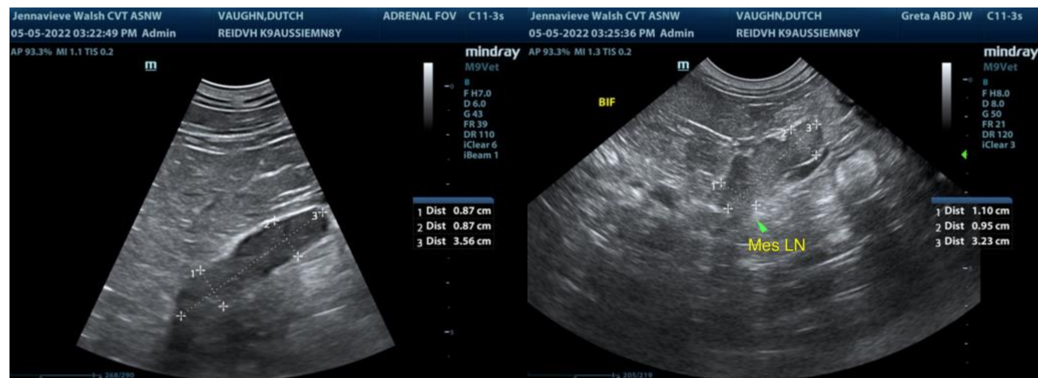
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

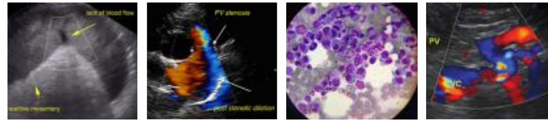
The shadowing gastric ingesta was nonspecific yet likely is consistent with recent meal ingestion. Correlation with most recent feeding suggested. If documented NPO prior to the ultrasound, some degree of metabolic delayed gastric emptying or stasis could be considered. Dietary indiscretion/food intolerance, structurally insignificant inflammatory gastroenteropathy or low-grade to chronic pancreatitis could be considered.

Monitoring for evidence of gastric emptying, if clinically indicated, is suggested. Gastric protectant protocol, as well as canned hydrolyzed diet and assessment of clinical response with potential for multiple small feedings, including at night, if presence of late evening or first AM bilious vomiting.

No evidence of splenic pathology.







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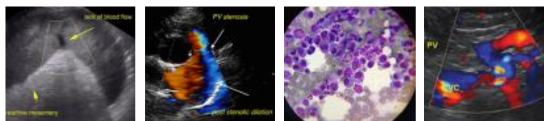

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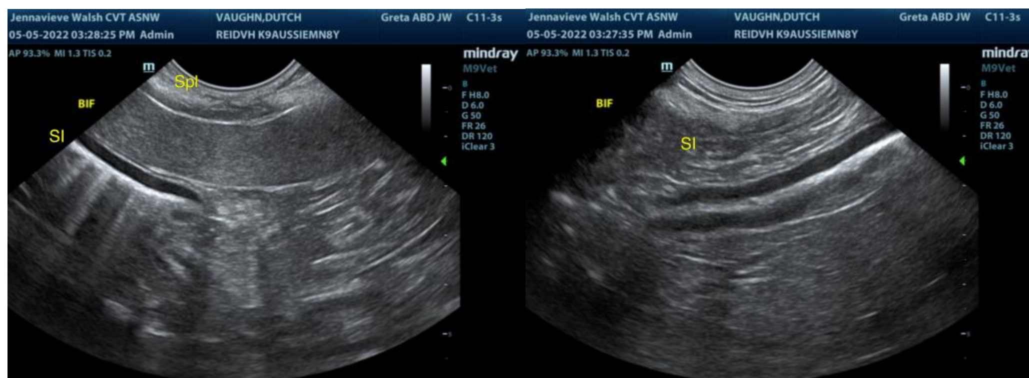

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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