



PATIENT PRESENTING CLINICAL SIGNS

Luna Wyatt

SPECIES

Canine

BREED

Cockapoo

SEX

Spayed Female

AGE

10 Years

WEIGHT

17.6 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Sara Hansen

HOSPITAL NAME

Banfield South Eugene

REFERRING VET

Dr. Wright

INVOICE

16189

DATE

6/20/22

History: P presented for fasted AUS to investigate possible cause of recurrent gastrointestinal issues (history of blood stool, diarrhea, vomiting, nausea) and pancreatitis. P is currently doing okay - no vomiting since 6/4/22, no diarrhea, but O reports bloody stool. Pet was recently treated with metronidazole and probiotic. Pet has been on royal canin GI food only for the past few months. Pet is eating per O. WT: 17.60 lbs / 8.15 kgs BCS: 5/9 BAR, TPR- wnl; CRT < 2 sec/pink, moist MM. euhydrated COAT/INTEG: no lesions nor ectoparasites appreciated. EYES/EARS: OU WNL. AD mild dry hyperplastic skin, slightly narrow canal N/T: No nasal discharge, no sneezing, no cough on tracheal palpation. ORAL: dental calculus 2/4 HEART/LUNGS: no murmurs nor arrhythmias, synchronous pulses, Lungs clear, No coughing. LN: peripheral LNs are normal in size, shape, consistency. GI/UG: soft non-painful on abdominal palpation, eating and defecating normally. no vomiting. M/S: no lameness nor abnormalities appreciated. NEURO: appropriate mentation, no deficits appreciated, nor spinal pain.

Abnormal PE/Chem/CBC/UA Results: March was last blood work - positive cPL snap, - chemistry panel wnl, - CBC with normal WBC count, low Lymphocyte count 0.9 K/uL, high Neutrophil differential 84.8%, and low eosinophil differential 0.2% - negative fecal float Current Medications trazodone PO this AM

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. 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. Aortic trifurcation was normal.

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 4.3 cm in length. The right kidney measured 4.3 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 2.0 cm in length x 0.53 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 1.9 cm in length x 0.46 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



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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. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material. The stomach wall measured 0.32 cm.

The small intestine presented intact yet subjective prominent wall layering with primarily maintained 1:3 muscularis/mucosa ratio with segmental propensity for mildly prominent muscularis layer. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material. The duodenum wall measured 0.42 cm. The jejunum wall measured 0.35 cm.

The colon exhibited intact yet subjective prominent wall layering with the descending colon presenting empty with subjective formed to semi-formed feces noted in the distal colon at the level of the urinary bladder. The descending colon wall measured up to 0.44 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 was evident.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Intact yet subjective mild prominent small bowel and colon wall layering
- Sonographically unremarkable pancreas

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The small intestine and colon exhibited subtle to mild subjective mural changes, which could be a normal variant for this patient, yet are suggestive of an underlying inflammatory process, i.e., possible IBD. In general, potential etiologies in patients exhibiting recurrent gastrointestinal signs may include low grade to mild pancreatitis, which may present as sonographically normal, dietary intolerance/food allergy, recurrent colitis, given the noted blood in the stool, IBD or other enterocolonopathy.

If patient is currently doing well on current gastrointestinal food and supportive care, continued monitoring would be reasonable. Potential diet rotation or long-term hydrolyzed diet trial, high colony count probiotic and as needed gastrointestinal support could be considered if recurrent gastrointestinal signs. A GI panel to include PLI/TLI/Cobalamin/Folate may be considered, if clinically indicated.

No evidence of intraabdominal or gastrointestinal neoplastic criteria.



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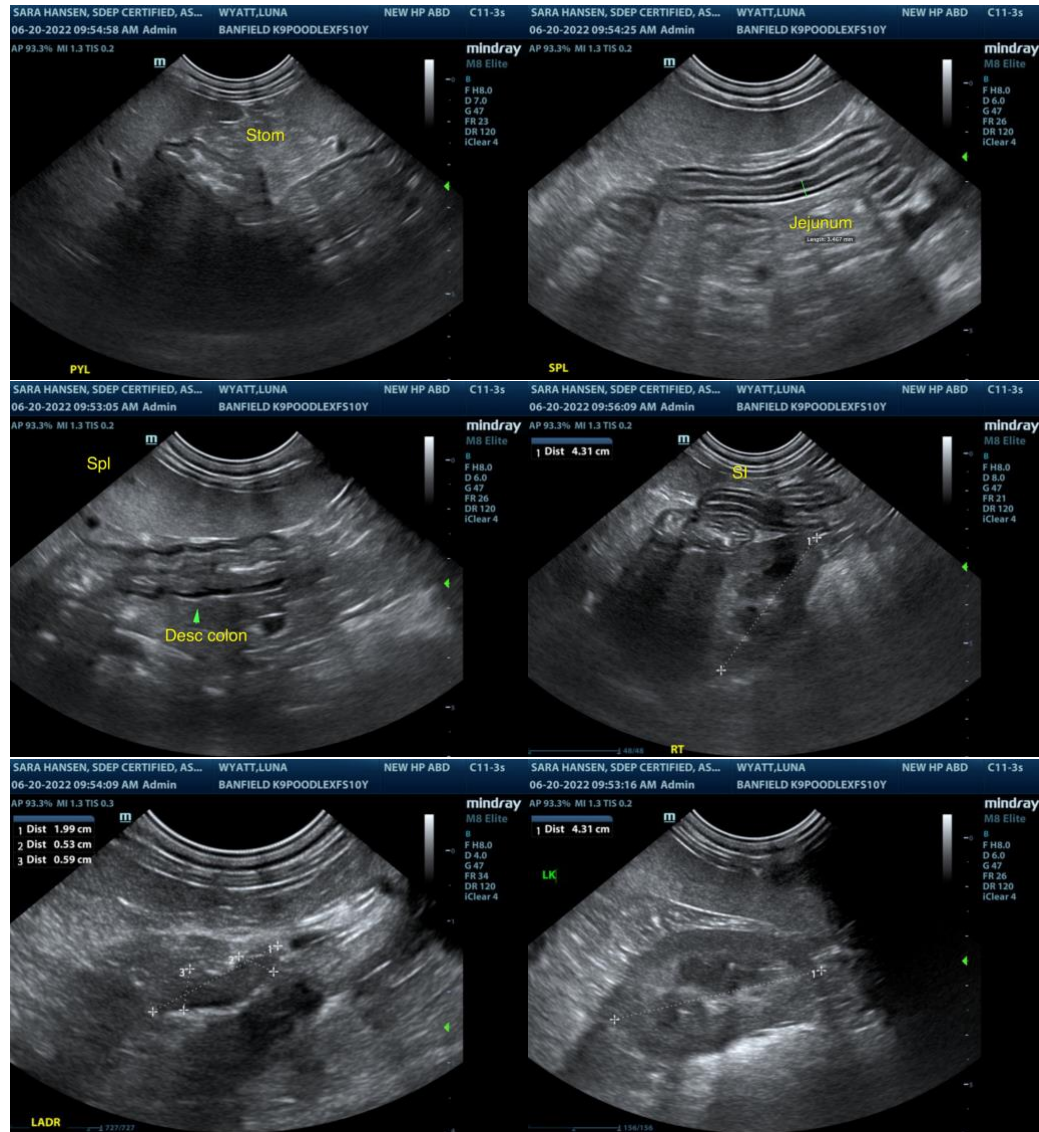
Dr. Wright

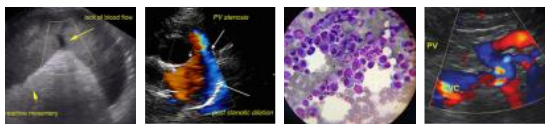
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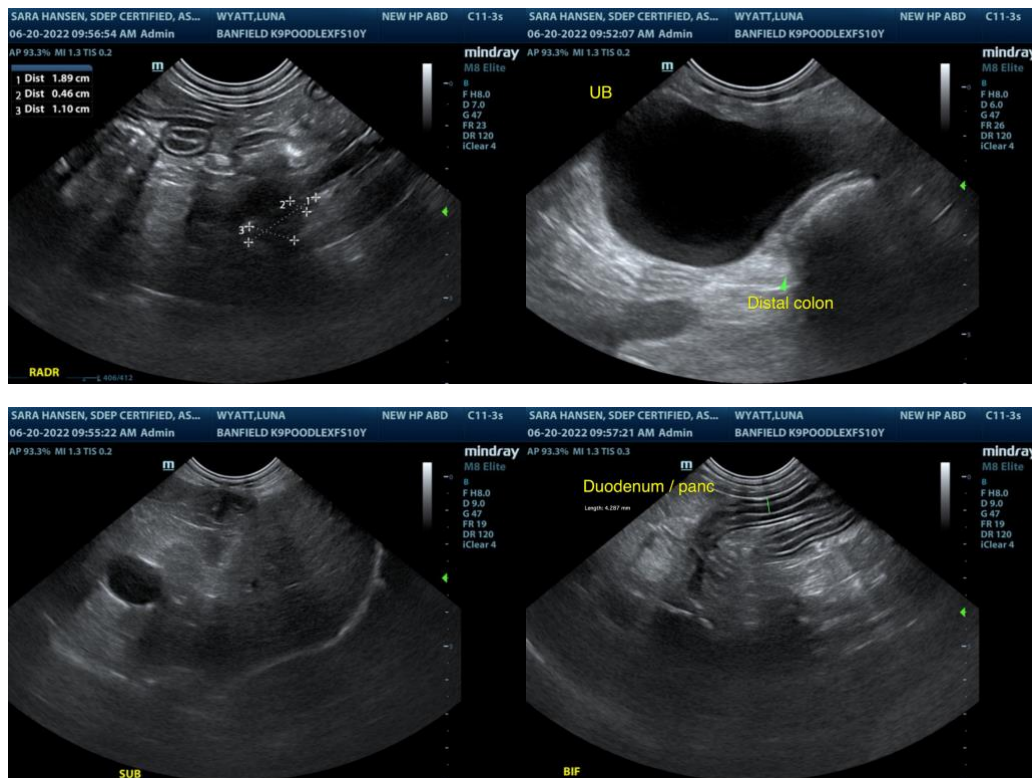
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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