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Clinical Sonography & Telecytology
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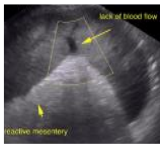
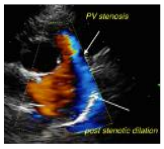
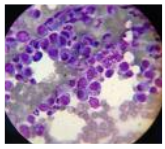
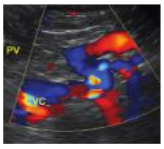





SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

George Benavides

SPECIES

Canine

BREED

Dachshund

SEX

Neutered Male

AGE

9 Years

WEIGHT

15.8 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Kim Liedberg

HOSPITAL NAME

SVS Imaging WI

REFERRING VET

Dr. Teal, Kuenzi Family PH

INVOICE

15921

DATE

6/7/22

PRESENTING CLINICAL SIGNS

History: Presented for not doing right, not eating, diarrhea, occasional vomiting. hospitalized for 1 week for supportive care, Metronidazole, baytril, amoxi, gabapentin, cerenia, IV fluids. still not eating. Good GI sounds ABD and chest radiographs WNL
Abnormal PE/Chem/CBC/UA Results: WBC 38,000

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal thickness and tone. Primarily anechoic urine was present in the lumen. Primarily dependent mild sediment was present, which may indicate cellular debris/protein, crystalline debris or mucus. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural changes were noted.

The residual prostate was symmetrically normal in size with uniform parenchyma and slight coarse echotexture measuring 0.5 cm in diameter. Aortic trifurcation was normal.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and minor loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. Pinpoint areas of medullary mineral were present. The left kidney measured 4.9 cm in length. The right kidney measured 5.2 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 0.65 cm width at the caudal pole and 0.52 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 0.72 cm width at the caudal pole and 0.62 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.

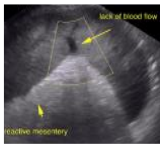
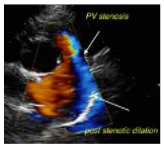
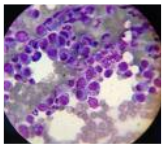
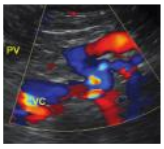
Liver

The liver was normal in size. Minor hepatic parenchymal remodeling noted. The hepatic and portal vasculature were normal in appearance without signs of congestion.

The gallbladder was non distended in size with mild gallbladder debris. 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 was empty with minor luminal gas. No evidence of gastric distention with retained ingesta, fluid or foreign material. Ventral gastric body wall measured 0.28 cm.

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The upper to mid duodenum exhibited intact wall layering and maintained 1:3 muscularis to mucosa ratio. In the area of the subjective distal duodenum, moderate to variable thickened intestinal walls were noted, exhibiting decreased mural echogenicity and loss of discernable wall layering, along with focal suspected mural cratering with concurrent gas artifact, measuring potential 5.0 cm in length x 2.0 cm in width with ventral intestinal wall potentially measuring 1.3 cm in width. By comparison, normal appearing duodenum measured 0.40 cm in width and normal appearing jejunum measured 0.32 cm in width. Intact and overtly normal intestine exiting the caudal aspect of the segmentally thickened intestine in the area of the duodenum was present with visualized maintained intact and sonographically unremarkable intestinal wall layering to the approximate level of the colon. No evidence of mechanical/metabolic small intestinal ileus pattern.

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

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

Mild regional periintestinal hyperechoic mesentery around the abnormally thickened intestine in the area of the distal duodenum. No evidence of overt or significant lymphadenopathy as well as no evidence of peritoneal free fluid.

ULTRASONOGRAPHIC FINDINGS

- Intestinal mural mass in the area of the distal duodenum, suspect potential mural cratering or ulceration with associated mural gas artifact
- Mild associated reactive to possible mild inflamed periintestinal mesentery
- Mild primarily dependent urinary bladder sediment
- Minor age-related renal changes
- Minor hepatic parenchymal remodeling-benign
- Mild gallbladder debris (non-mucocele-likely incidental, potentially secondary to inappetence)

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The primary finding of the intestinal mural mass may indicate significant segmental inflammation or neoplastic criteria, necrotic granuloma, intestinal mural abscess or other unspecified necrosis. The possibility of previously penetrating foreign body is considered less likely given the lack of overt regional peritonitis. No evidence of obvious regional metastasis associated with the intestinal mural mass. Subjectively the intestinal mural mass appears to be amendable to surgical resection, given its size.

Assuming no evidence of pathology on three-view chest radiographs, exploratory laparotomy with potential resection anastomosis and/or biopsy based on gross inspection would be warranted. Surgical consult could be considered prior to potential surgical options.

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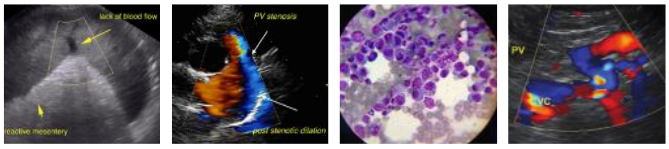

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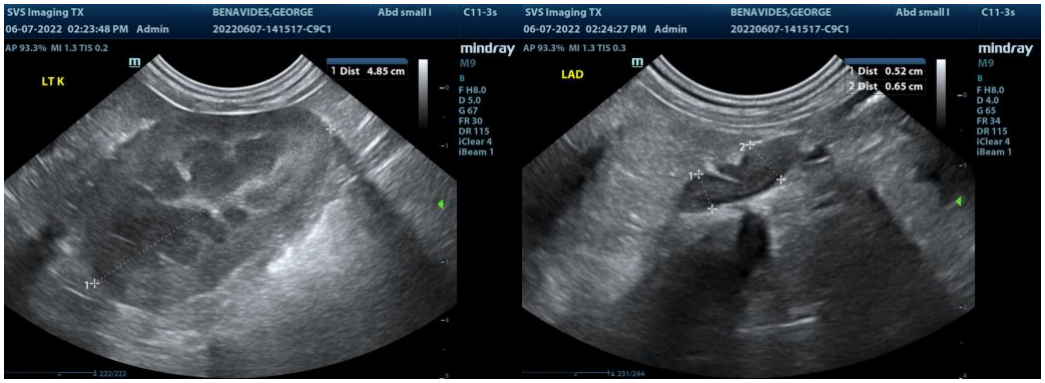

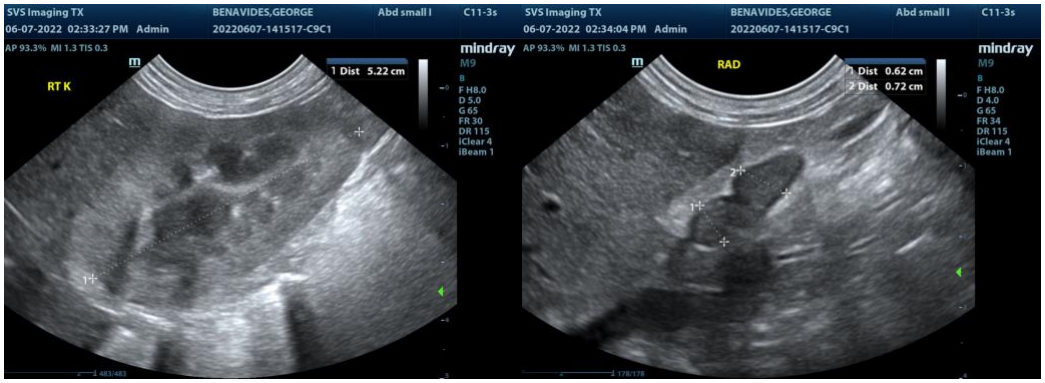

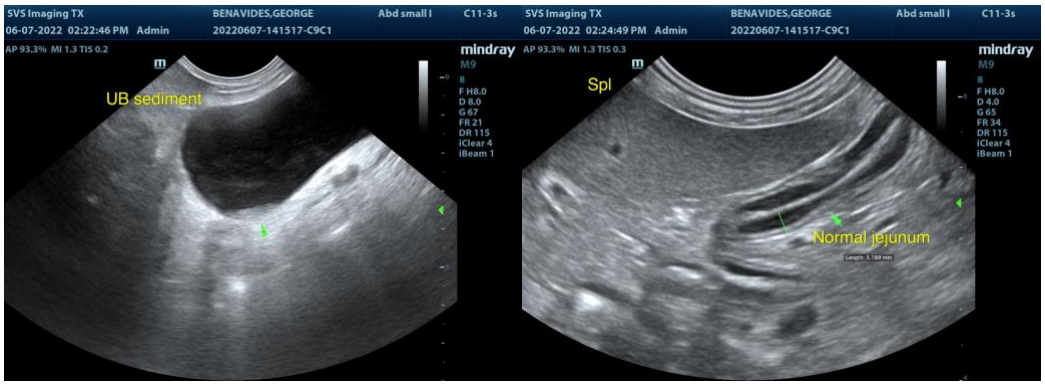

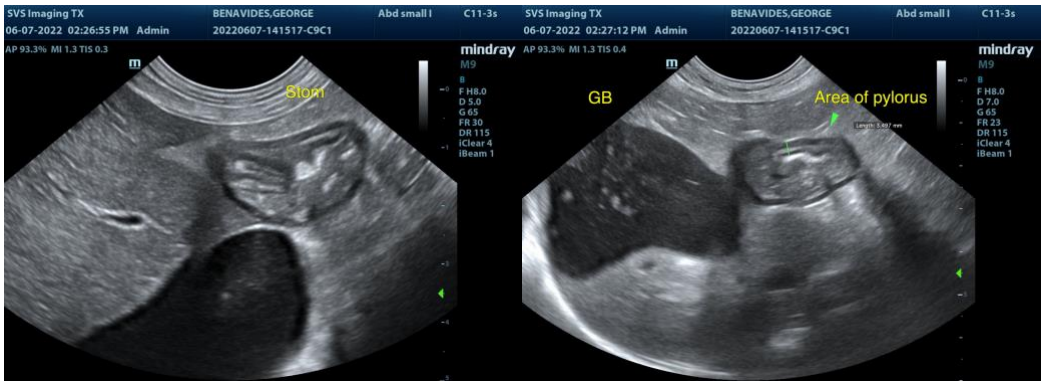

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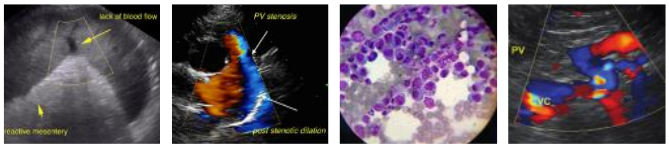

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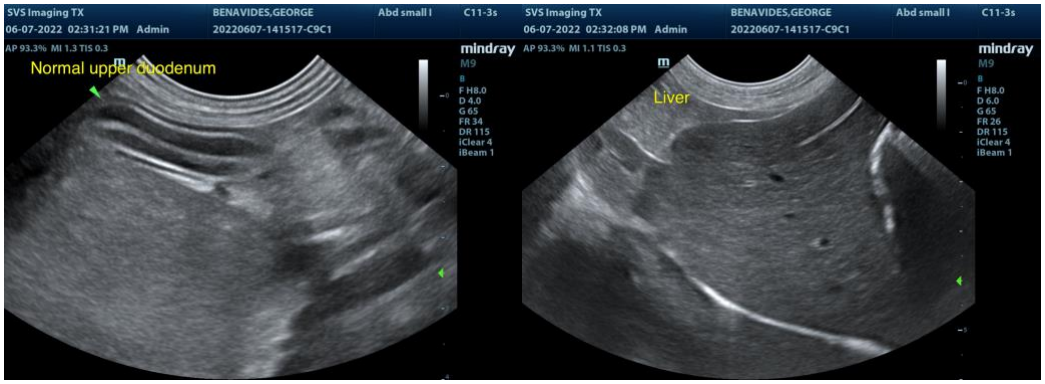

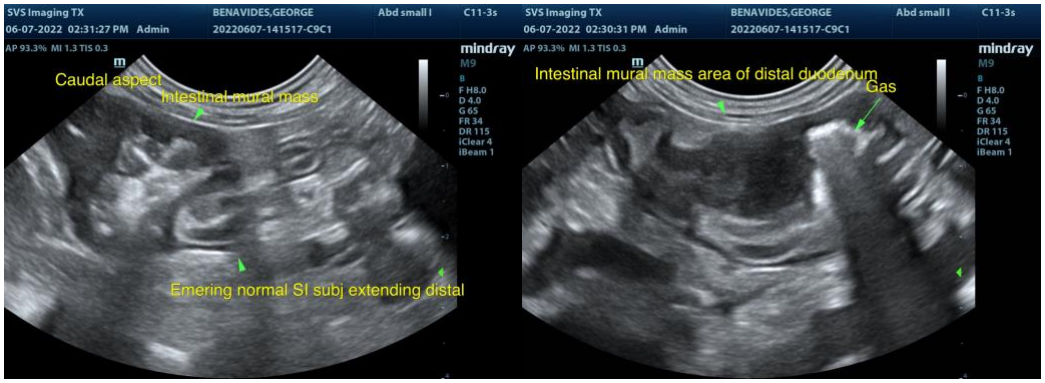

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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