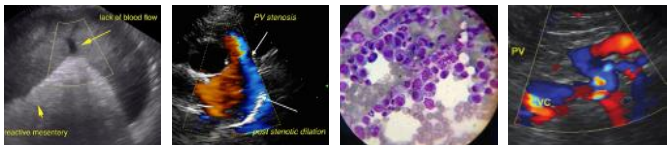
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Harry Smith

SPECIES

Canine

BREED

German Shepherd Dog

SEX

MN

AGE

6 yr

WEIGHT

71

INTERPRETED BY

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

IMAGING PERFORMED BY

Amy

HOSPITAL NAME

Long Valley Animal Hospital

REFERRING VET

Dr. Earl

INVOICE

11130ag

DATE

07/12/2022

PRESENTING CLINICAL SIGNS

History: Anorexia/Vomiting/Diarrhea. Weight loss. Owner reports PU/PD Current Medications: Cerenia

Abnormal PE/Chem/CBC/UA Results: HCT= 60.7 TP= 8.8 ALB 4.2 Glob= 4.6 Urine Specific Gravity 1.007

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2 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.

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 6.5 cm in length. The right kidney measured 7.2 cm in length.

The area of the aortic trifurcation was free of pathology.

No overt pathology in the area of the residual prostate.

Adrenal Glands

The left adrenal gland exhibited potential for mild subnormal size. The left adrenal gland measured 0.38 cm width at the caudal pole and 0.47 cm width at the cranial pole. The right adrenal gland was not definitively visualized.

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.

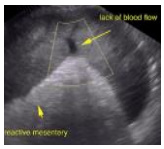
Liver

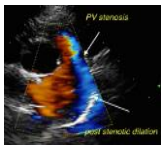
The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content with minor debris-likely incidental, potentially secondary to fasting. The cystic and common bile ducts were normal.

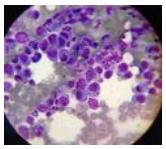
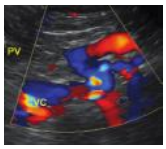
Gastrointestinal

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 gastric body wall measured 0.45 cm in width.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio, the duodenum exhibited minor nonobstructive ileus. The duodenum wall measured 0.52 cm in width. The jejunum and





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ileum to the level of the colon were sonographically normal. The jejunum wall measured 0.42 cm in width.

Normal visible colon wall layers were present. The descending colon exhibited mild distention with apparent non 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

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Subnormal left adrenal gland-nonspecific
- Gastroenterocolitis pattern

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No overt evidence of gastroenterocolic structural pathology with subjective inflammatory changes present. In patients with chronic or recurring GI signs and weight loss considerations may include dysbiosis, dietary intolerance, occult parasitism, inflammatory bowel or low grade to chronic pancreatitis with occult gastrointestinal neoplasia a less likely differential diagnosis. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. A fresh fecal analysis to rule out parasitic ova/giardia as well as a resting cortisol level to rule out occult Addison's disease with a full ACTH stim suggested if resting cortisol level is <2.0.

Three view chest radiographs are suggested to rule out occult thoracic pathology as a contributing factor to the weight loss.

Pending additional diagnostics, a hydrolyzed diet trial, prophylactic deworming, high colony count probiotic, antibiotic trial i.e. metronidazole or tylosin with as needed GI support would be reasonable. GI biopsies may be required for further assessment.

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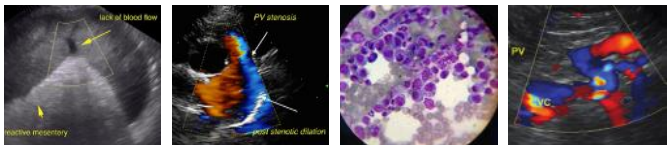

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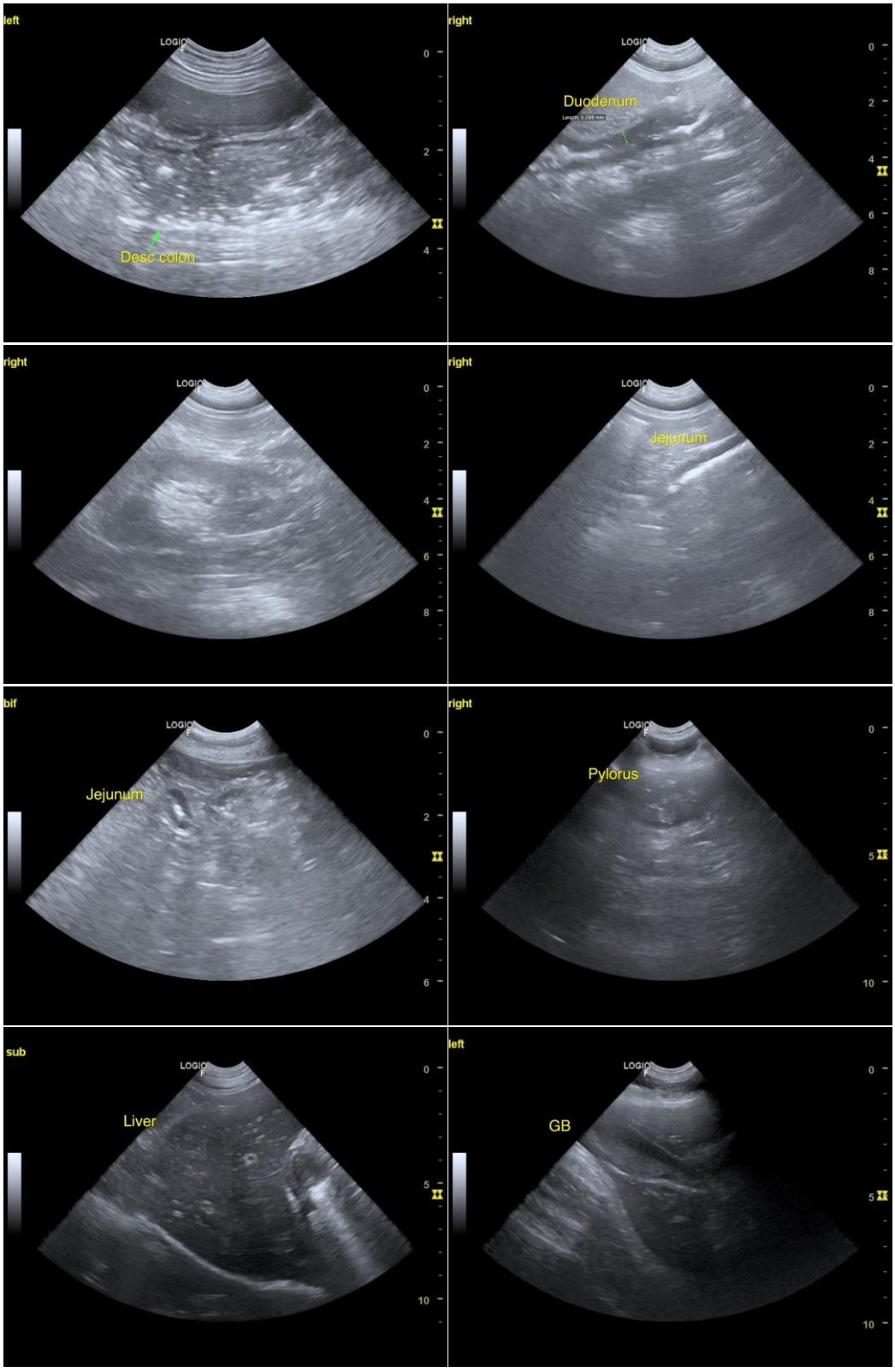

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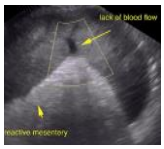
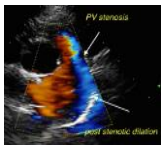
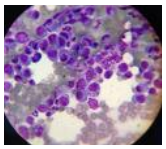
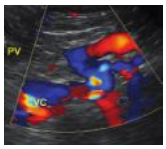

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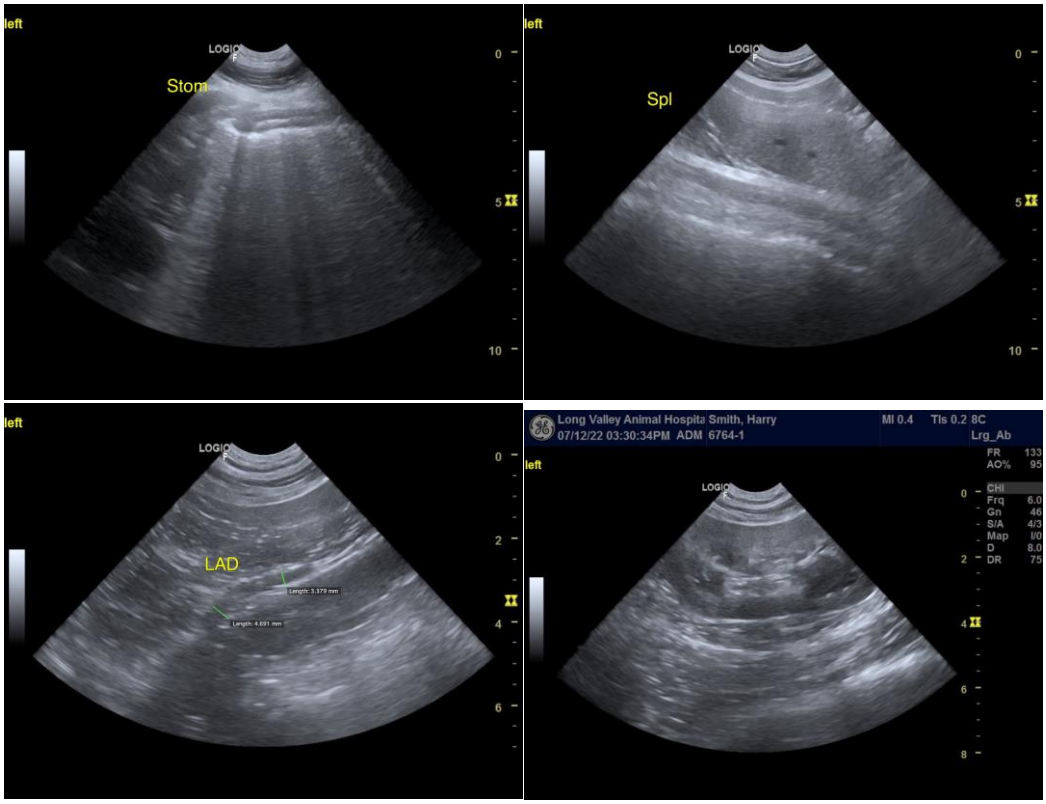

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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