



PATIENT	PRESENTING CLINICAL SIGNS
Savannah Haeffele	<p>Patient has been treated for >2.5 months for chronic diarrhea (malodorous) and hyporexia with minimal response to therapy. Current meds: -- Interceptor -- Galliprant -- Phycox -- Metronidazole 250 mg: 1.5 tab PO BID -- Cerenia 24 mg: 1 tab PO q 24 hours x 4 -- Hills Low Fat and bland diet</p> <p>Abnormal PE/Chem/CBC/UA Results: 7/13/23 PE: -- Grade 1/4 PD disease, all else unremarkable</p> <p>K9 Essential with UA (idexx): -- Creatinine 1.5 mg/dL -- BUN 42 mg/dL -- Creatine Kinase 229 U/L UA: -</p> <p>- 0-1 HPF Calcium Oxalate crystals Fecal O&P/giardia: -- NEG for all Radiographs performed 9/2022 prior to onset of diarrhea: -- Right lateral abdomen - FNA = golf ball sized lipoma Right stifle - OA, some flattening of femoral head</p>
SPECIES	
Canine	
BREED	
Goldendoodle	
SEX	ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN
FS	Urinary System
AGE	The urinary bladder, trigone, and cystourethral junction 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.
13 years	
WEIGHT	No evidence of pathology in the area of the aortic trifurcation.
16.7 kg	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 mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. Pinpoint medullary mineral was noted in both kidneys. The left kidney measured 4.3 cm in length. The right kidney measured 4.6 cm in length.
INTERPRETED BY	Adrenal Glands
R. McKenzie Daniel, DVM, DABVP (Canine and Feline)	The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 1.5 cm length x 0.55 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 1.8 cm length x 0.91 cm width at the caudal pole.
IMAGING PERFORMED BY	Spleen
Patti Mayfield DVM	The spleen exhibited primarily finely textured parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Mild generalized parenchyma heterogeneity was present without evidence of nodular changes. 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. The parenchymal heterogeneity is likely consistent with benign changes such as extramedullary hematopoiesis or age-related remodeling with minor potential for inflammatory or neoplastic disease.
HOSPITAL NAME	Liver/ Gallbladder
Broken Top Veterinary Clinic	The liver was subjectively normal in size and structure with a maintained symmetrical contour. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion. Normal liver volume was present. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.
REFERRING VET	
Jessica Herrig DVM	
INVOICE	
17295	
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Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. Minor retained anechoic pyloric fluid was noted with signs of obstruction or foreign material.

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.

Normal visible colon wall layers were present with apparent semi-formed to possible soft fecal matter, consistent with patient history.

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 were evident.

Free Abdomen

No omental masses, lymphadenopathy, or evidence of peritoneal free fluid were noted. Possible incidental small intrabdominal lipomas were noted.

ULTRASONOGRAPHIC FINDINGS

- Sonographically unremarkable gastrointestinal tract with minor retained pyloric fluid
- Normal colon containing semi-formed / soft fecal matter
- Minor hepatic parenchymal remodeling
- Mild chronic renal changes with pinpoint medullary mineral

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Sonographically, there was no evidence of significant visceral pathology, specifically no evidence of gastroenterocolic mural pathology or active pancreatitis.

At times, the gastroenterocolic appearance may not correlate with a history of chronic gastrointestinal signs. Considerations may include dietary intolerance / food hypersensitivity, dysbiosis, structurally insignificant inflammatory bowel or low-grade pancreatitis, both of which may present as sonographically normal, occult parasitism, occult Addison's Disease, infiltrative intestinal neoplasia (less likely), or other.

Further assessment may include a GI panel to include PLI/TLI/Cobalamin/Folate. Although considered less likely, given the normal adrenal presentation, resting cortisol level to rule out occult Addison's Disease may be considered.

Empirically, a limited antigen or hydrolyzed diet trial with potential long-term dietary therapy, prophylactic deworming (Panacur 50 mg/kg SID x 5 consecutive days with repeat protocol in 3 weeks even if fecal testing is negative), high colony count probiotic (Provable or Visbiome), antibiotic trial (Tylosin may prove more effective given nonresponse to Metronidazole) and as needed gastrointestinal support with assessment of clinical response may prove beneficial. Intestinal biopsies may be indicated if GI signs continue despite empirical therapy.



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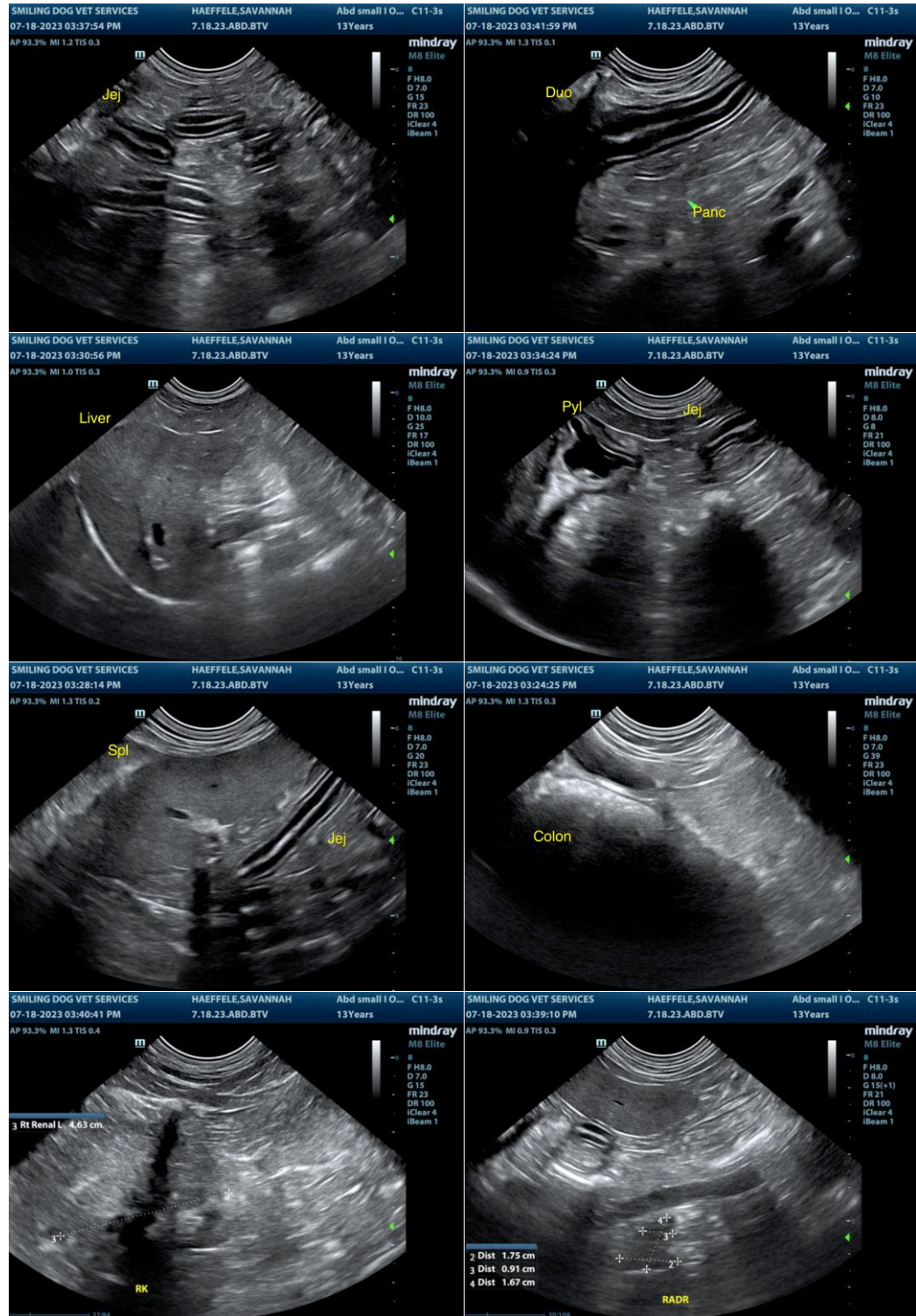
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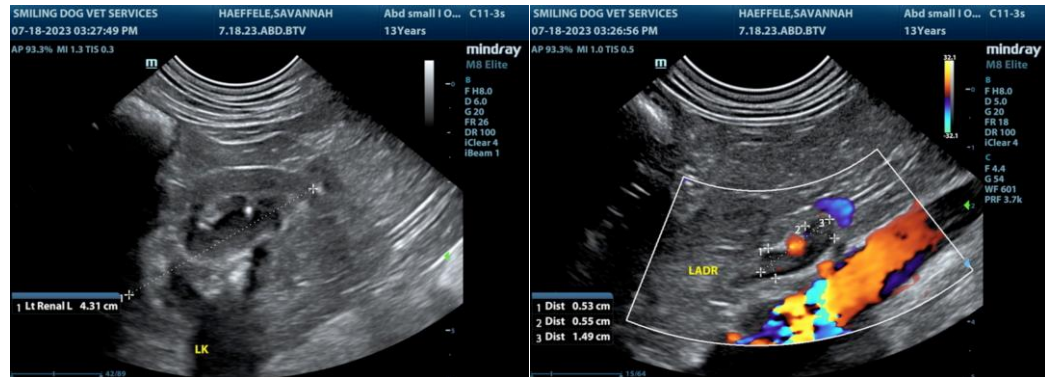
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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