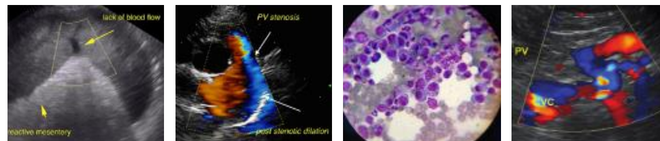

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1-800-838-4268 info@sonopath.com

PATIENT

Ruby Abelson-Gertler

SPECIES

Canine

BREED

Goldendoodle

SEX

FS

AGE

6yr

WEIGHT

33kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Patti Mayfield DVM

HOSPITAL NAME

Bend Animal Emergency and Specialty Center

REFERRING VET

Dr. Kitagaki

INVOICE

11157ag

DATE

07/25/2022

PRESENTING CLINICAL SIGNS

History: - P has been very lethargic since going on a run yesterday. - P also runs off leash in the forest while on runs with O, and could have gotten into anything. O said they also have some rat poison/bait in the garage but it is contained. O also said they have a potential gas leak in their house that they noticed today, which P was inside of for 15 minutes. - O is also concerned it could be related to P's paw hurting, as P has recently been slightly favoring right paw. P has not been drinking much water, so O gave P a little bit of Pedialyte and bone broth which P drank a small amount of. - P also has a decreased appetite, but is having normal stool - 24 hours of vomiting - P may have gained access to a corn cob 2 days ago.

Abnormal PE/Chem/CBC/UA Results: PE: - ~ 5-7% dehydration with acute abdominal pain. Blood work: CBC: Leukocytosis with mature neutrophilia CHEM: WNL Abdominal rads: - Moderate amount of ingesta within the stomach, but no obvious gastric FB or obstruction. - Mild fluid dilation of the duodenum with a possible FB in the distal duodenum with gas filling defects that could correlate with a corn cob FB. Significant volume of feces within the transverse and distal colon.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3 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 6.4 cm in length. The right kidney measured 7.2 cm in length.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

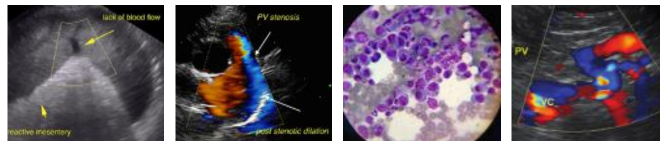
The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.69 cm width at the caudal pole and 2.8 cm length. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.76 cm width at the caudal pole and 3.2 cm length.

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. The cystic and common bile ducts were normal.



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Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained mild to moderate primarily nonshadowing ingesta with subtle focal areas of mild distal acoustic shadowing. No evidence of mechanical pyloric outflow obstruction was present.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was primarily empty with mild retained nonshadowing chyme in the upper GI tract involving the duodenum and likely the upper jejunum.

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

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Overtly normal GI tract with mild to moderate potentially retained gastric and segmental upper SI ingesta/chyme
- Normal colon with formed fecal matter
- Sonographically unremarkable pancreas

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is no overt evidence of GI obstructive pattern or obvious foreign material in this scan.
Technically given the reported inappetence the possibility of a small amount of nonobstructive gastric and/or passing upper intestinal foreign material cannot be definitively excluded. The potential upper GI ileus in this patient is suspected to be metabolic potentially owing to GI insult or structurally insignificant inflammatory GI process. Given the lack of definitive obstructive pattern no overt indication for immediate surgical intervention at this time.
Supportive care for gastroenteritis or low grade pancreatitis which may present sonographically normal would be reasonable. Monitoring of gastric emptying over the 12-24 hours is suggested.
Recheck sonogram primarily to reassess the stomach and upper GI tract would be recommended if evidence of persistent retained gastric ingesta or if persistent/progressive GI signs.
Although considered unlikely given the sonographically normal appearance of the bilateral adrenal glands, a resting cortisol to rule out occult Addison's disease may be considered.

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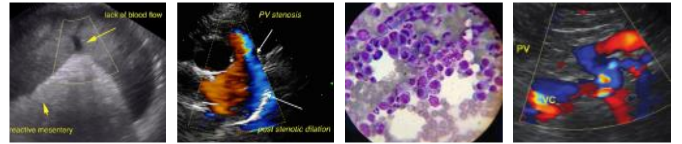

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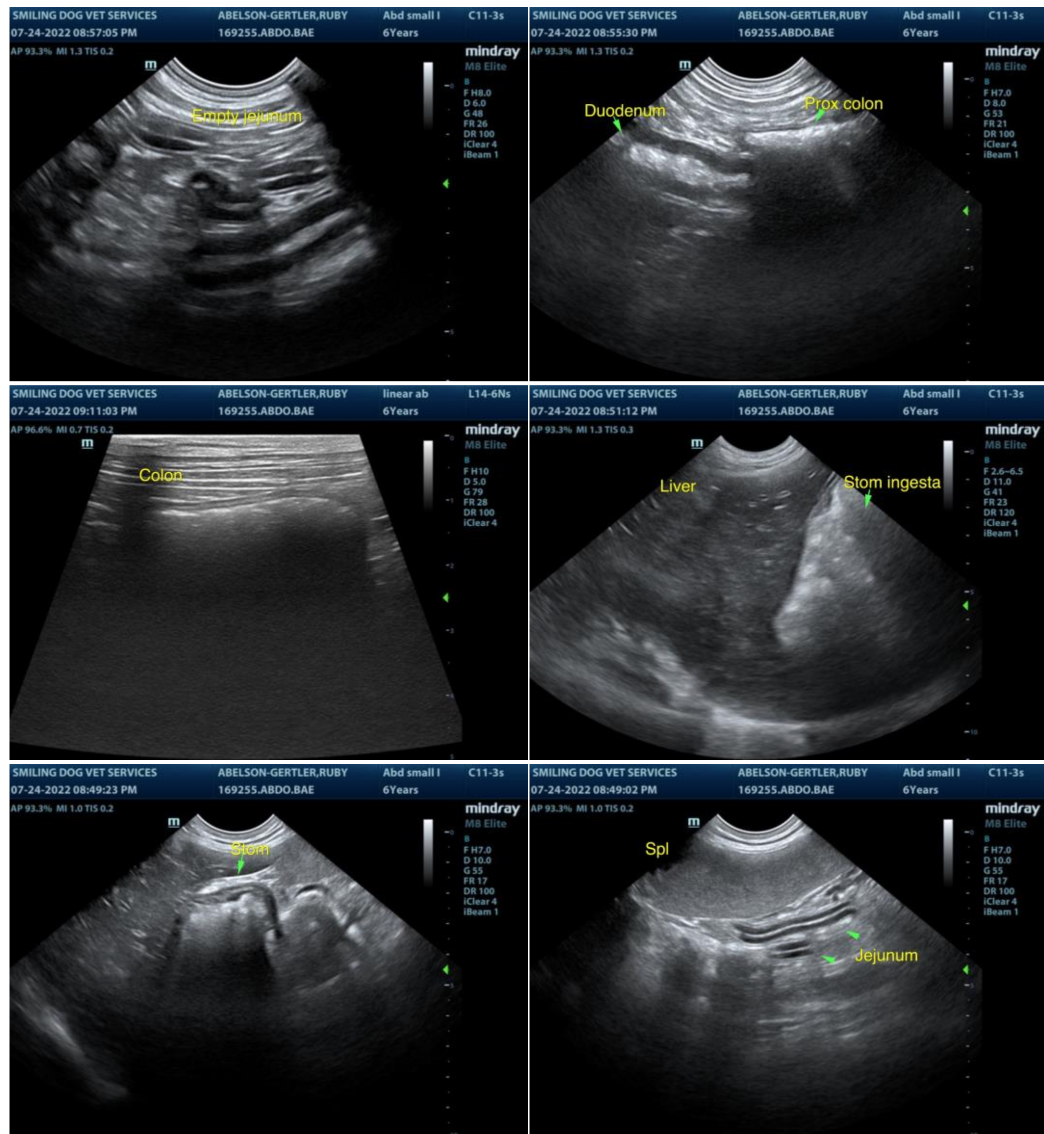

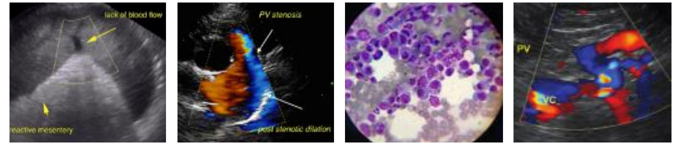

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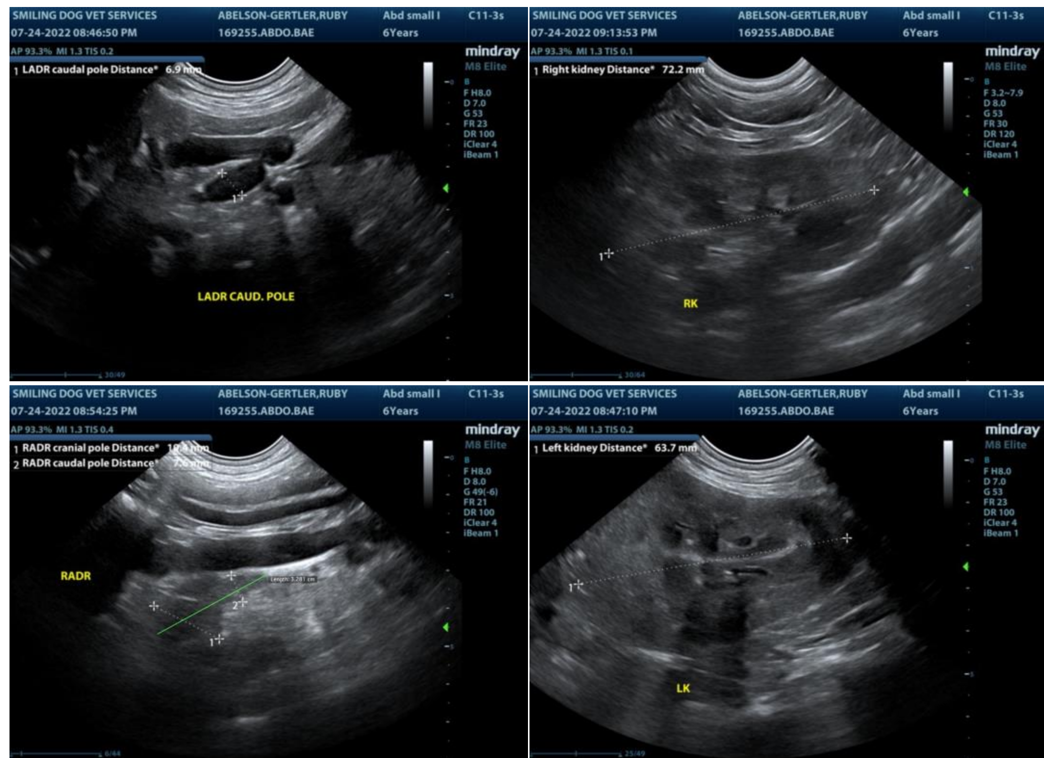

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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