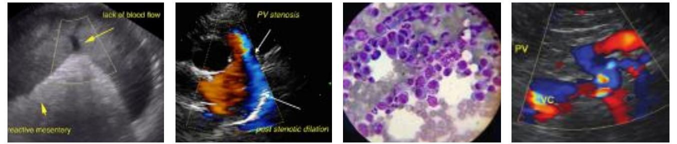


SonoPath.com™
1-800-838-4268 info@sonopath.com

PATIENT

Penny Coughlin

SPECIES

Canine

BREED

Labrador Mix

SEX

FS

AGE

9.5

WEIGHT

60.3

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Sharkaway

HOSPITAL NAME

Kew Gardens Animal Hospital

REFERRING VET

Dr. Sharkaway

INVOICE

11084ag

DATE

07/09/2022

PRESENTING CLINICAL SIGNS

WEIGHT LOSS, LOST 20 LBS OVER 2 MONTHS HISTORY OF DM FOR 2 YEARS DIARRHEA

Abnormal PE/Chem/CBC/UA Results: BLOOD WORK -PENDING FECAL- PENDING

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 was 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. Bilateral areas of medullary mineral were present. The left kidney measured 8.3 cm in length. The right kidney measured 7.4 cm in length.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

The left and right adrenal glands were not definitively visualized.

Spleen

The spleen was indistinctly visualized potentially owing to volume contraction and displacement secondary to mild volume peritoneal free fluid.

Liver

The liver was subjectively enlarged in size, structure, and contour. The liver exhibited generalized parenchymal remodeling. 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

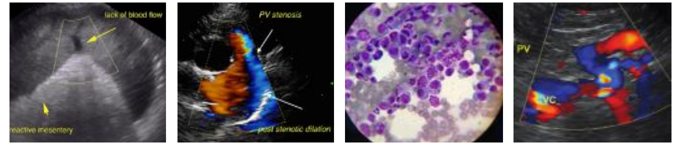
The stomach presented variable wall thickening exhibiting subjective decreased mural echogenicity and loss of wall layer detail. The gastric body wall measured up to 1.4 cm in width. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material.

The small intestine presented intact yet prominent to mildly thickened wall layering due to a prominent mucosa layer. Intermittent areas of nonspecific mucosal speckling were present. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material. The small intestinal wall measured 0.66 cm in width.

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

Pancreas

The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.



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Free Abdomen

Generalized peri intestinal hyperechoic mesentery with mild volume peritoneal fluid was present.

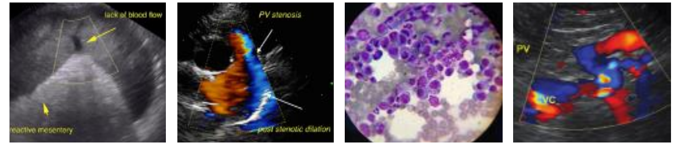
Transdiaphragmatic view of the caudal thorax revealed concurrent mild to moderate volume pleural free fluid. Obvious evidence of pericardial free fluid was nor definitively evident.

ULTRASONOGRAPHIC FINDINGS

- Variably thickened stomach with decreased wall echogenicity and loss of wall layer detail
- Diffuse mildly thickened yet intact small bowel walls with nonspecific mucosal speckling
- Mild hepatomegaly-nonspecific
- Pleural and peritoneal free fluid with generalized hyperechoic mesentery
- Minor pancreatic remodeling-nonspecific, sonographically not overtly suggestive of significant pancreatic inflammation or neoplastic criteria
- Bilateral chronic renal changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Considerations for the GI tract may include inflammatory criteria i.e. gastroenteritis or IBD, PLE if concurrent hypoalbuminemia or panhypoproteinemia, infiltrative GI neoplasia or other. Correlation with pending lab work as well as pleural and peritoneal effusion analysis for cytology +/- C/S is suggested. Three view chest radiographs are suggested with ideally a full echocardiographic workup to rule out cardiogenic cause of cavitary effusion. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended.



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Thickened stomach

Minor peritoneal FF
GB
Normal hepatic vasculature
Pleural effusion

RK

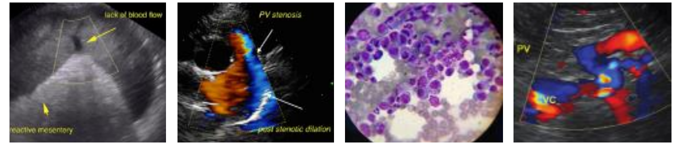
Area of panc base

SI
Minor FF

GB
Pleural effusion

SI

UB



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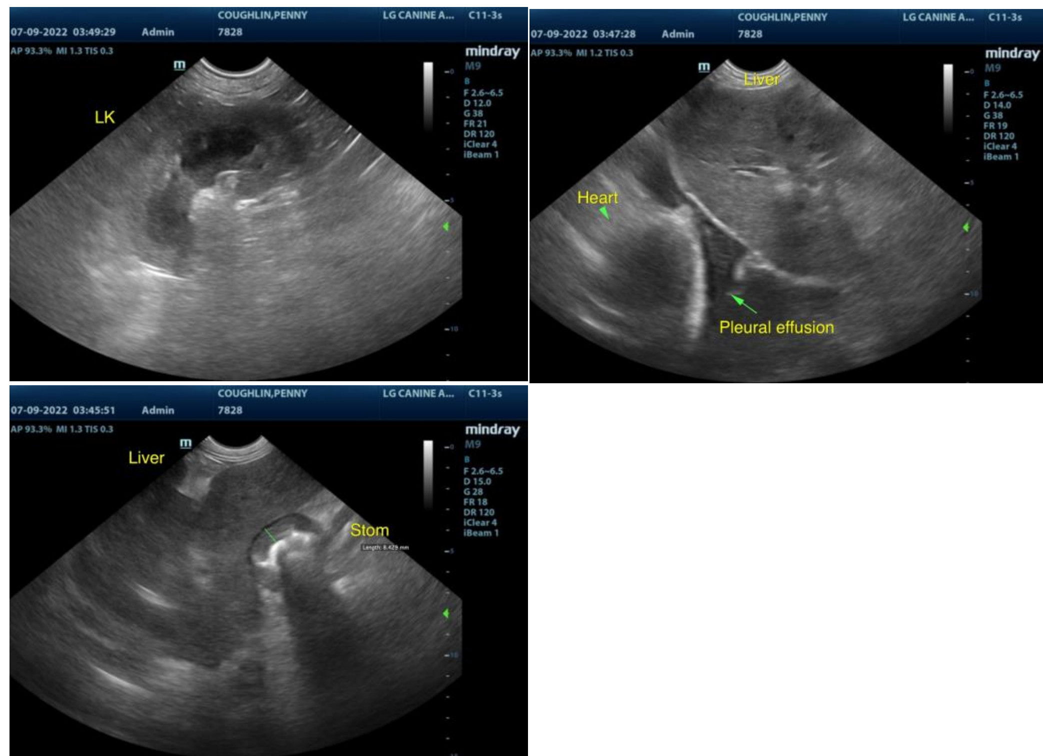

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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