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Clinical Sonography & Telecytology
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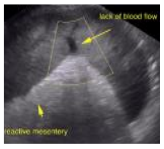
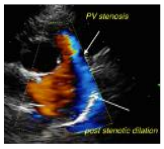
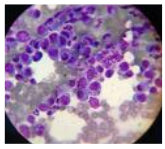
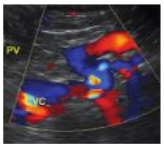

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Sophie Johnson

SPECIES

Canine

BREED

Pitbull X

SEX

Spayed Female

AGE

8 Years

WEIGHT

25.8 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Sarah Barthelemy

HOSPITAL NAME

Cranston VH

REFERRING VET

Cranston VH

INVOICE

23867

DATE

8/10/23

PRESENTING CLINICAL SIGNS

History: 1 month history of hyporexia with intermittent vomiting and soft stools. Labs unremarkable. No weight loss.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 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.

The area of the aortic trifurcation was free of pathology.

Both kidneys were normal in size and margination with mildly indistinct corticomedullary border demarcation. Pinpoint areas of medullary mineral were present. Both kidneys exhibited focal lateral cortical infarcts. The left kidney measured 5.6 cm in length. The right kidney measured 6.6 cm in length.

Adrenal Glands

Both adrenal glands were overtly normal in size, position and shape. The left adrenal gland measured 0.43 cm at the cranial pole and 0.49 cm at the caudal pole. The right adrenal gland measured 0.42 cm at the caudal 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 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.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no evidence of retained ingesta, fluid or foreign material.

The small intestine presented generalized intact wall layering with segmental to generalized propensity for mildly prominent to hyperechoic submucosa layer, as well as mildly prominent muscularis layer. The lumen of the small intestine was empty with no evidence of loss of intestinal wall layering, obstructive pattern or intestinal masses. Duodenum wall measured 0.47 cm. Jejunum wall measured 0.41 cm.

Normal visible colon wall layers were present. The colon contained semi-formed to soft fecal matter.

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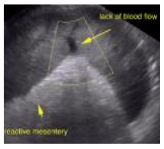
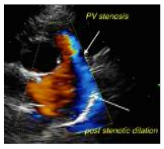
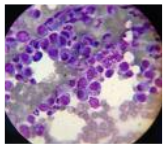
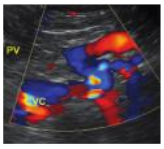

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Pancreas

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

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Enteropathy- suspect inflammatory enteropathy/IBD intestinal pattern
- Normal colon containing semi-formed/soft fecal matter.
- Heterogenous pancreas

Secondary Findings

- Early age-related renal changes, exhibiting pinpoint medullary mineral and cortical infarcts.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Although nonspecific, the small intestine exhibited subtle mural changes, specifically, mildly hyperechoic to prominent submucosa layer, which may be associated with inflammatory enteropathy or inflammatory bowel disease. Potential contributing factors may include dietary intolerance/food hypersensitivity, dysbiosis, chronic pancreatitis, which may be suspected if cranial abdominal or subxiphoid discomfort on palpation, occult parasitism, occult Addisons disease or other enteropathy.

Further assessment may include a GI panel to include PLI/TLI/Cobalamin/Folate and screening resting cortisol level.

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 (Proviable or Visbiome), potential antibiotic trial, if clinical concern for dysbiosis or infectious disease with consideration for potential adverse effects on normal gastrointestinal flora, with as needed gastrointestinal support and assessment of clinical response may prove beneficial. Intestinal biopsies may be indicated if GI signs continue despite empirical therapy and pending additional diagnostics.

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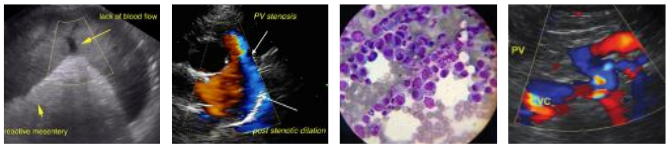

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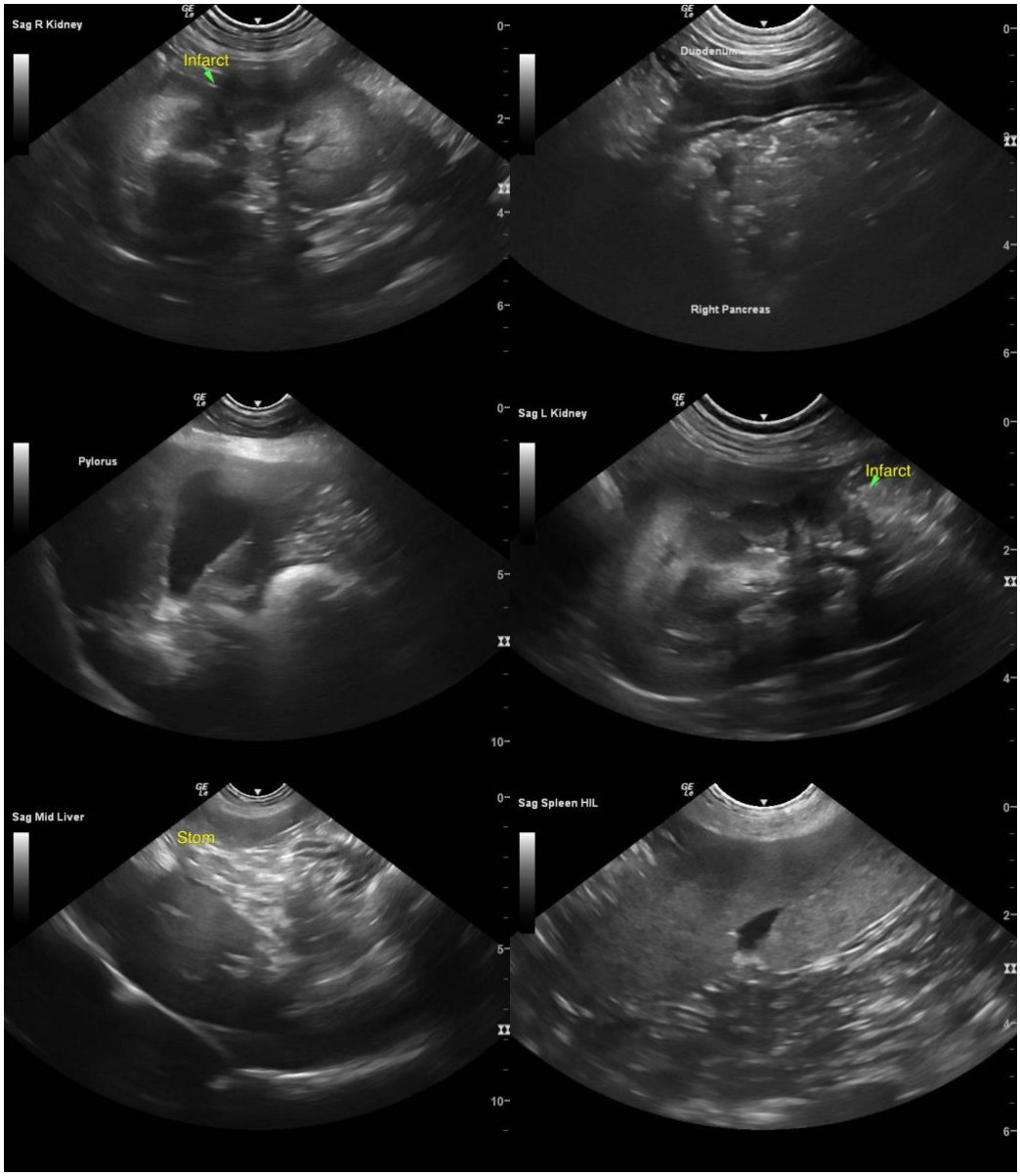

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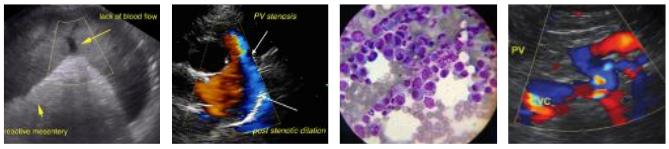

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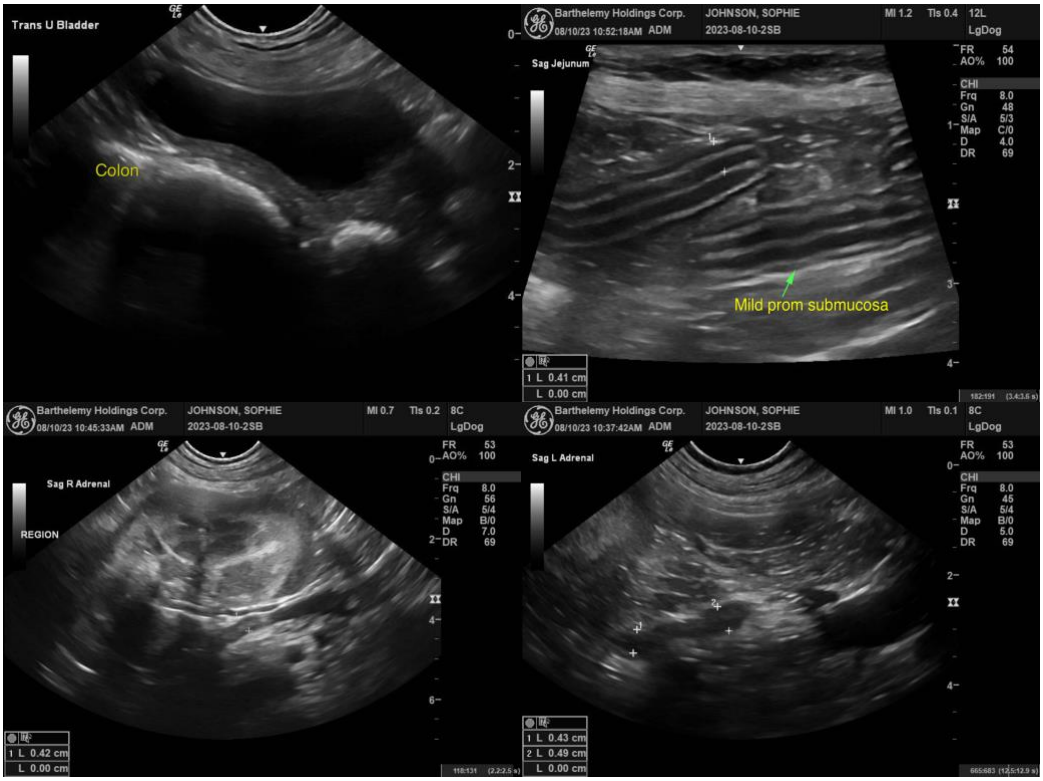

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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