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Clinical Sonography & Telecytology
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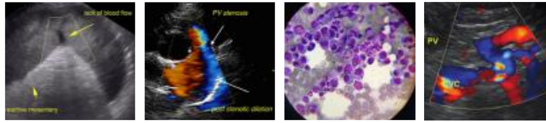


ANIMAL SOUNDS NW
MOBILE VETERINARY ULTRASOUND
IMAGING PERFORMED BY
AnimalSoundsNW.com 541-357-9423

PATIENT

Jewel Cannaday

SPECIES

Canine

BREED

Corgi

SEX

SF

AGE

11 Years

WEIGHT

38 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Sara Hansen

HOSPITAL NAME

VCA Salem AH

REFERRING VET

Dr. Wermuth

INVOICE

14573

DATE

8/11/22

PRESENTING CLINICAL SIGNS

Jewel presented to the ER for vomiting and diarrhea that started a few weeks ago and has progressively increased in frequency. She has now been vomiting and having diarrhea every day for the past couple days. She vomits multiple times per day. Her vomit is mostly grass with phlegm but sometimes it's food. Her stool is formed but loose. Ate at 5am this AM, but vomited everything up. She has a history of shredding toys but not necessarily ingesting them.
Abnormal PE/Chem/CBC/UA Results: CBC completely wnl CHEM ALT 144 (H) otherwise wnl
Radiographic Findings Official report: - Small intestinal findings suggest obstructive ileus associated with regionalized distention; however, the degree of distention is mild and it is possible that this may be due to other, non-obstructive disease, such as focal enteritis or emerging neoplasia. - Decreased serosal peritoneal detail in this area also suggests focal intestinal disease. - Material within the stomach is likely incidental due to recent meal ingestion; however, intermittent obstruction due to retained foreign material may be an alternate possibility. - Other potential causes of vomiting are not ruled out, including gastroenteritis or pancreatitis

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 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 was noted.

The area of the aortic trifurcation was free of pathology.

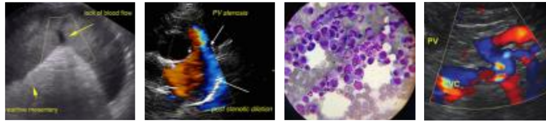
Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and minor loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 5.8 cm in length. The right kidney measured 5.5 cm in length.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 2.1 cm length x 0.61 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 2.4 cm length x 0.64 cm width 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.



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Liver/ Gallbladder

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective minor 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 intact yet mildly prominent wall layering. The lumen of the stomach was primarily empty with minor luminal gas and minor retained anechoic fluid present in the antrum / pylorus. The pylorus wall width measured 0.50 cm. No evidence of mechanical pyloric outflow obstruction or obstructive pyloric mural pathology was noted.

The small intestine presented intact yet generalized mild prominent wall layering owing to propensity for mildly prominent small intestinal mucosa. Intermittent nonspecific jejunal mucosal speckling was noted. No overt evidence of small intestinal mechanical / metabolic ileus or overt foreign material was noted. The small intestinal wall width measured 0.44 cm.

The colon walls presented intact yet prominent wall layering with mild thickened to echogenic submucosa. Semi-formed to soft feces, consistent with reported diarrhea, was present in the colon lumen with lumen dilation. The proximal colon wall width measured 0.40 cm.

Pancreas

The area of the pancreas revealed overtly normal pancreas presentation exhibiting isoechoic parenchyma echogenicity compared to adjacent mild hyperechoic peripancreatic omentum. No sonographic evidence of significant pancreatic pantology or active or acute inflammation.

Free Abdomen

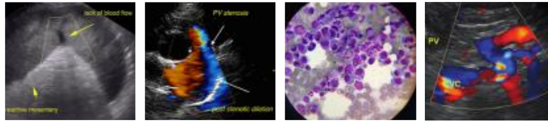
Mild primarily peri intestinal to generalized hyperechoic mesentery was present with no evidence of significant lymphadenopathy or peritoneal free fluid.

ULTRASONOGRAPHIC FINDINGS

- Gastroenterocolitis pattern
- Overtly normal pancreas
- Low-grade hepatopathy
- Mild primarily peri intestinal to generalized hyperechoic mesentery

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No obvious evidence of small intestinal mechanical / metabolic ileus or overt gastrointestinal foreign material was noted. Potential for small amount of passed foreign material in the colon cannot be definitively excluded. Overall, the gastrointestinal tract and colon were suggestive of an acute or



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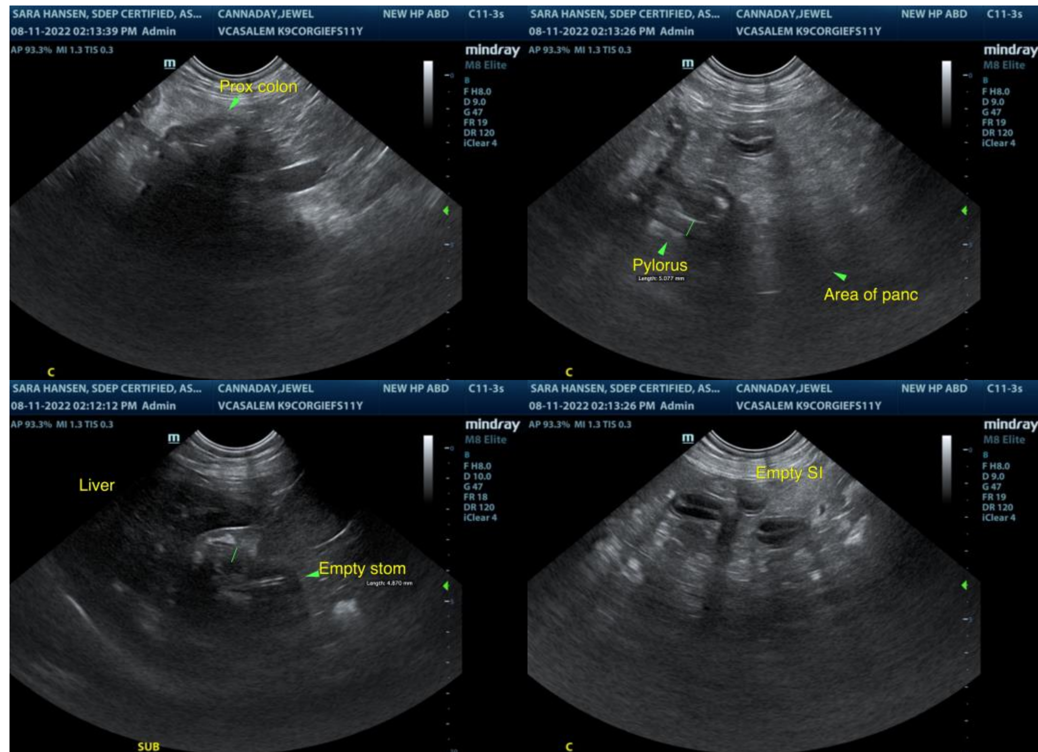
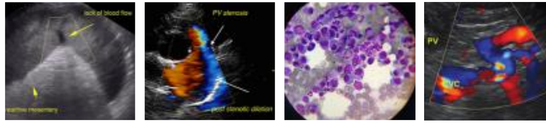
subacute inflammatory process. Considerations may include gastroenterocolitis, inflammatory bowel disease, dietary intolerance / food allergy, gasroenterotoxic insult, and occult parasitism, with occult neoplasia considered a less likely differential diagnosis. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. No overt indication for immediate surgical intervention is evident.

Although considered unlikely given the normal adrenal appearance, resting cortisol level to rule out occult Addison's Disease, could 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 (Proviable or Visbiome), antibiotic trial 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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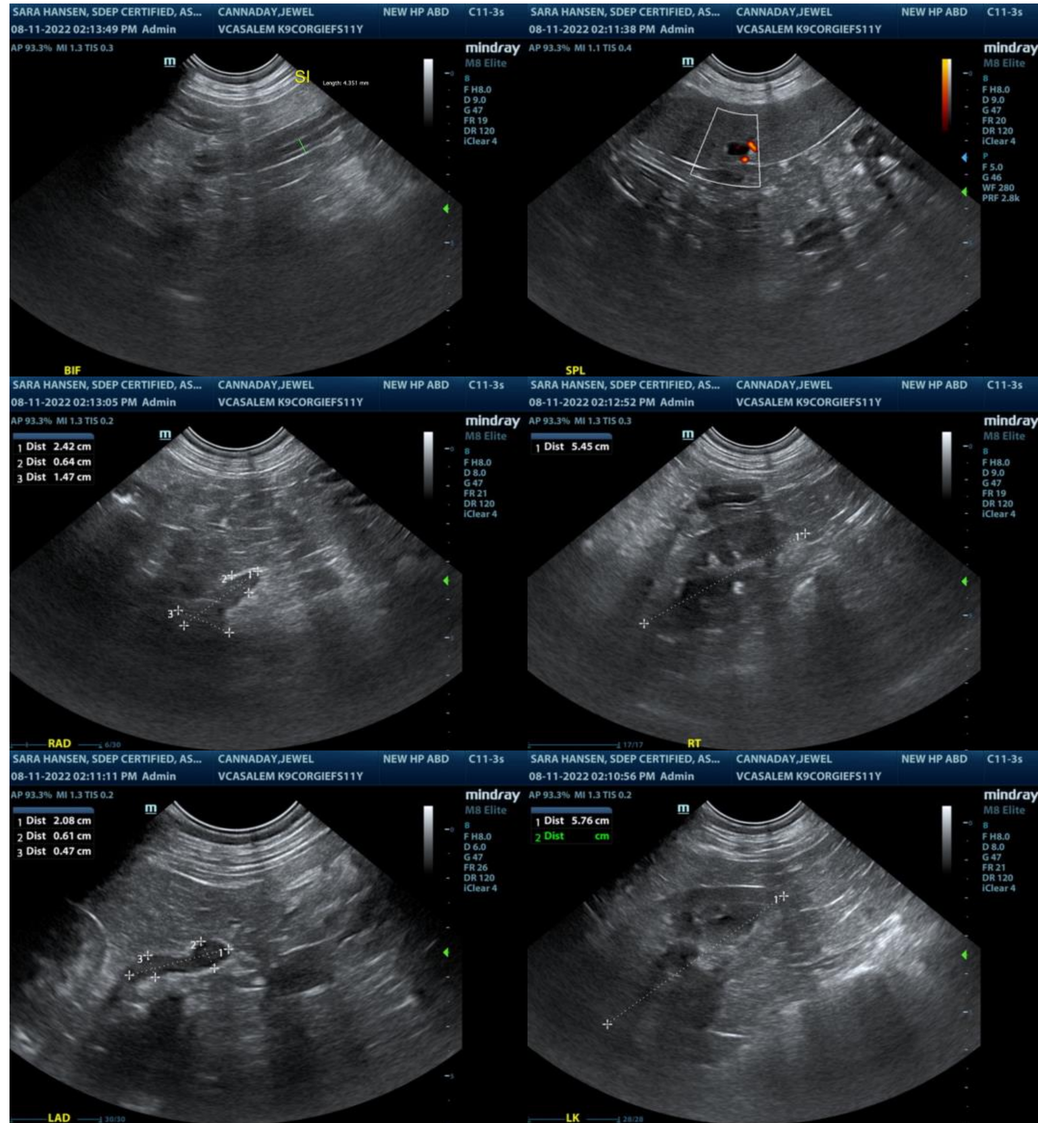

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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