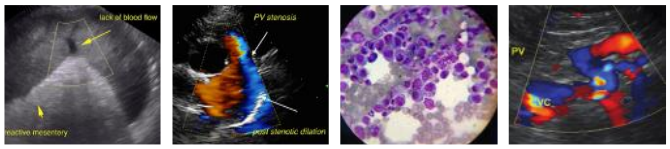
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Malkovich Garcia

SPECIES
Canine

BREED
Great Dane

SEX
MN

AGE
9yr

WEIGHT
127.6lb

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

IMAGING PERFORMED BY
A. Rodriguez

HOSPITAL NAME
Foxfield Veterinary Services

REFERRING VET
A. Rodriguez

INVOICE
14679ag

DATE
08/21/2023

PRESENTING CLINICAL SIGNS

Chronic diarrhea and wt loss

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder was subnormal in size owing to lack of urine distension which prohibited full evaluation of the urinary bladder walls. The trigone, cystourethral junction, and visible pelvic urethra exhibited normal thickness and tone. Mild 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 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 8.4 cm in length. The right kidney measured 8.9 cm in length.

The area of the aortic trifurcation was free of pathology.

The area of the residual prostate appeared normal and 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 0.85 cm width at the caudal pole and 4.3 cm length. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.87 cm width at the caudal pole and 4.5 cm length.

Spleen

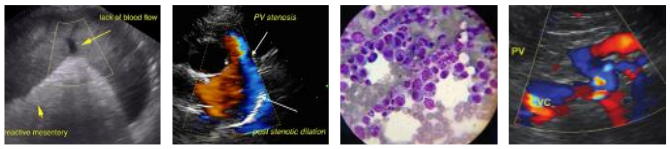
The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver/Gallbladder

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. Normal vascular volume. 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 contained minor retained non-shadowing echogenic fluid/chyme with no signs of ileus, obstruction or foreign material.



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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 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 omental masses or peritoneal effusion was present.

Intermittent mildly prominent to enlarged mesenteric nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). An example measured 3.4 cm x 0.81 cm.

ULTRASONOGRAPHIC FINDINGS

- Sonographically unremarkable GI tract.
- Normal colon with semi formed feces.
- Mild age related renal changes.
- Intermittent minor benign/reactive mesenteric lymph nodes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Overall, there is no overt evidence of significant abdominal visceral, specifically GI or pancreatic pathology as a definitive cause of the patient's clinical signs. At times the sonographic presentation of the gastrointestinal tract may not correlate with reported gastrointestinal signs.

In patients with ongoing GI signs, considerations including dietary intolerance / food hypersensitivity, occult parasitism, dysbiosis, malassimilation/maldigestive disorder, infectious disease, occult Addison's disease, inflammatory bowel disease, infiltrative neoplastic disease (thought unlikely) or other are possible. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. Although considered unlikely considering normal adrenal presentation, a resting cortisol level to rule out occult Addison's disease is recommended.

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), cobalamin supplementation pending assessment of B12 levels, +/- antibiotic trial i.e., Metronidazole or Tylosin with consideration for possible adverse effects on normal GI flora and as needed gastrointestinal support with assessment of clinical response may prove beneficial. Intestinal biopsies may be considered if GI signs continue/progress despite empirical therapy and pending additional diagnostics.

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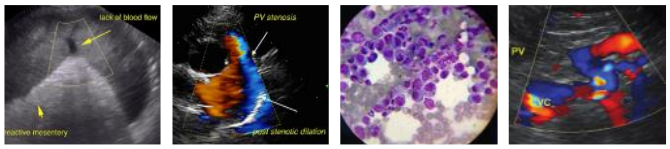

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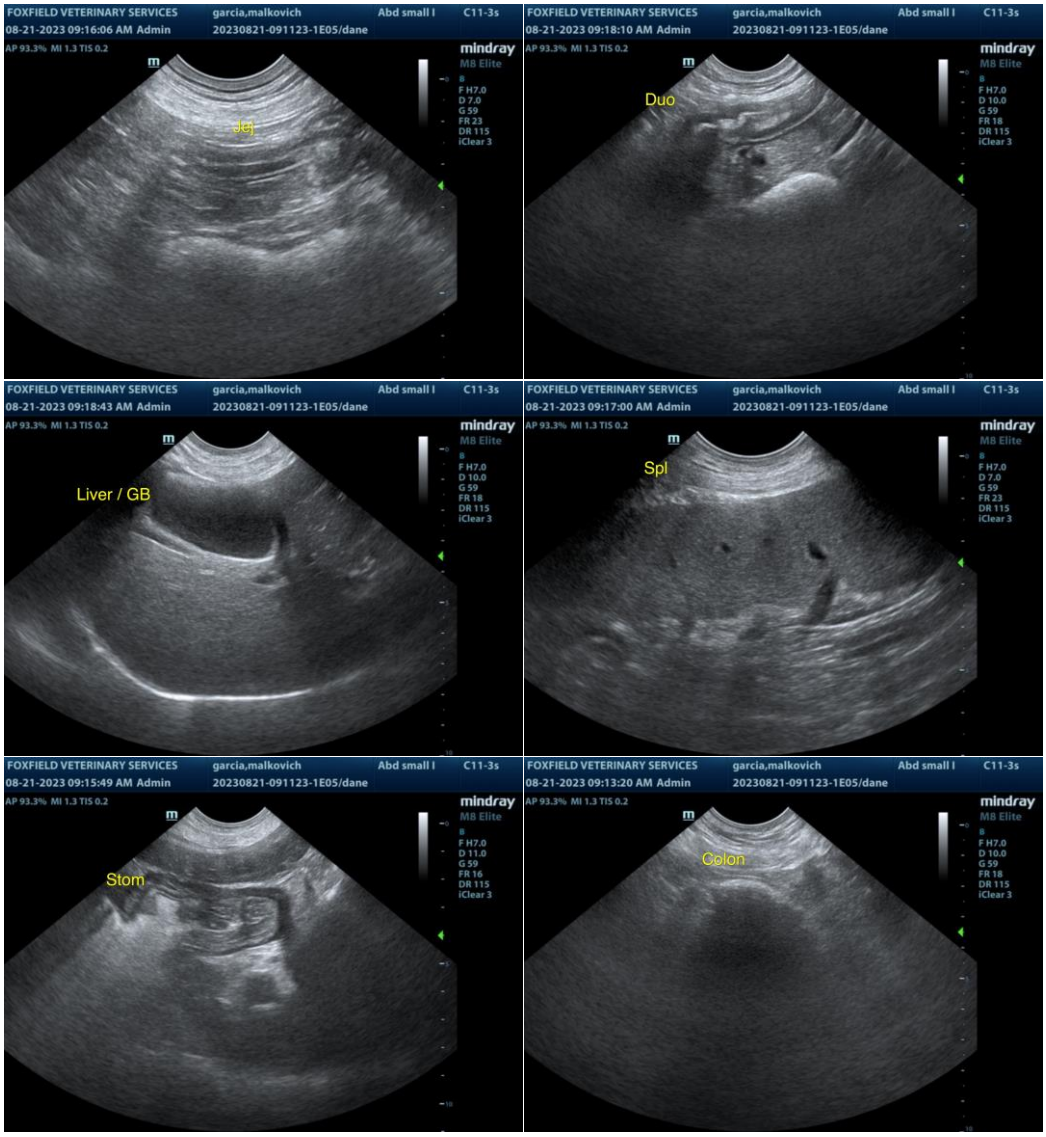

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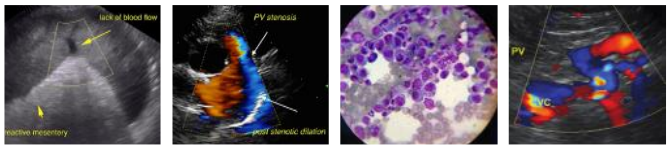

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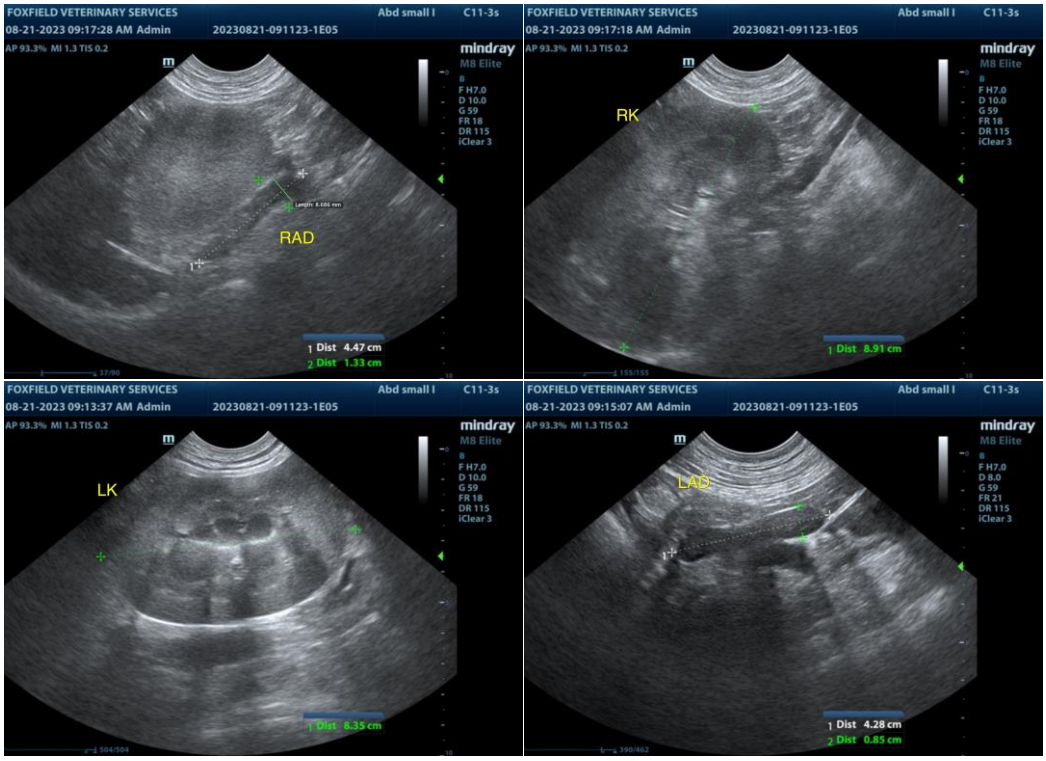

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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