**PATIENT**

Lilly Wessel

SPECIES

Canine

BREED

Maltese

SEX

FS

AGE

11yr

WEIGHT

6lb

INTERPRETED BYR. McKenzie Daniel,
DVM, DABVP
(Canine and Feline)**IMAGING
PERFORMED BY**

Sarah Pender CVT

HOSPITAL NAME

SVS Imaging QC

REFERRING VET

Dr. Doerscher

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08/29/2022

PRESENTING CLINICAL SIGNS

Presented 8/8 for shaking and diarrhea that had been occurring for a few days. DX GE and tx w/bland diet, AmoxiClav & Proviab. That resolved but quickly turned into polyuria, up many times throughout the night. Presented 1 week later 8/15 for symptoms consistent with UTI, although UA WNL and rads unremarkable. TX w/Meloxicam & trazodone b/c P was up overnight every 90 mins. BW was unremarkable, did grow some bacteria on in-house urine culture but O declined sending in for sensitivity. We increased her dose of AmoxiClav to treat for UTI. 8/19-22 P not eating well and still NFW. Cerenia not helpful for appetite. Had O stop AmoxiClav, gave Convenia injection and collected free-catch U and set up another culture. Did grow bacteria and sent it in, grew Pantoea agglomerans, environmental pathogen. As of 8/26, P was slightly improved w/appetite and polyuria but still having symptoms so O opted for US. Did V over this past weekend and stools are back to loose. Ate a small amount this morning.

Abnormal PE/Chem/CBC/UA Results: Generally WNL - SDMA 16 PE generally unremarkable - Good BCS, grade 2 dental dz Pantoea agglomerans on urine culture last week

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**Urinary System**

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra 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 3.9 cm in length. The right kidney measured 4.2 cm in length.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

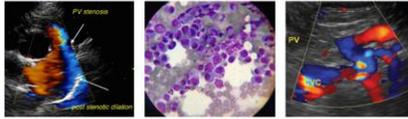
The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.46 cm width at the caudal pole and 1.6 cm length. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.49 cm width at the caudal pole and 1.5 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

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 non-shadowing ingesta/chyme with no signs of ileus, obstruction or foreign material.

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The small intestine presented intact wall layering with mildly prominent generalized mucosa layer to the level of the ileum. The ileum to the ileocolic junction exhibited moderate wall thickening with subjective discernable ileum and ileocolic wall layer detail. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material.

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Normal visible colon wall layers were present with apparent soft formed feces in the lumen extending to the descending colon.

Pancreas**SEX**

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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.

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Free Abdomen

No overt lymphadenopathy was present.

Small pockets of scant primarily peri-ileocolic free fluid were noted.

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ULTRASONOGRAPHIC FINDINGS

- Moderate thickened ileum/ileocolic junction exhibiting altered yet intact wall layering
- Intact duodenojejunal wall layering with propensity for prominent mucosa layer
- Sonographically unremarkable stomach containing mild potentially retained ingesta/chyme
- Sonographically unremarkable bilateral kidneys/urinary bladder

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The primary cause of the patient's clinical signs is suspected to be related to distal small intestinal disease specifically involving the ileum and the ileocolic junction. This may indicate moderate ileitis although the possibility of emerging infiltrative neoplasia cannot be excluded. Potential for generalized small intestine disease cannot be definitively excluded.

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Biopsies of the ileum/ileocolic junction with small intestinal biopsies for histopathology are required for definitive diagnosis. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended to assess for decreased cobalamin levels given the distal small intestinal disease. A surgical consultation could be considered in case potential resection and anastomosis of the ileum/ileocolic junction is required.

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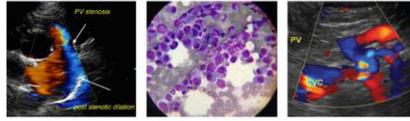
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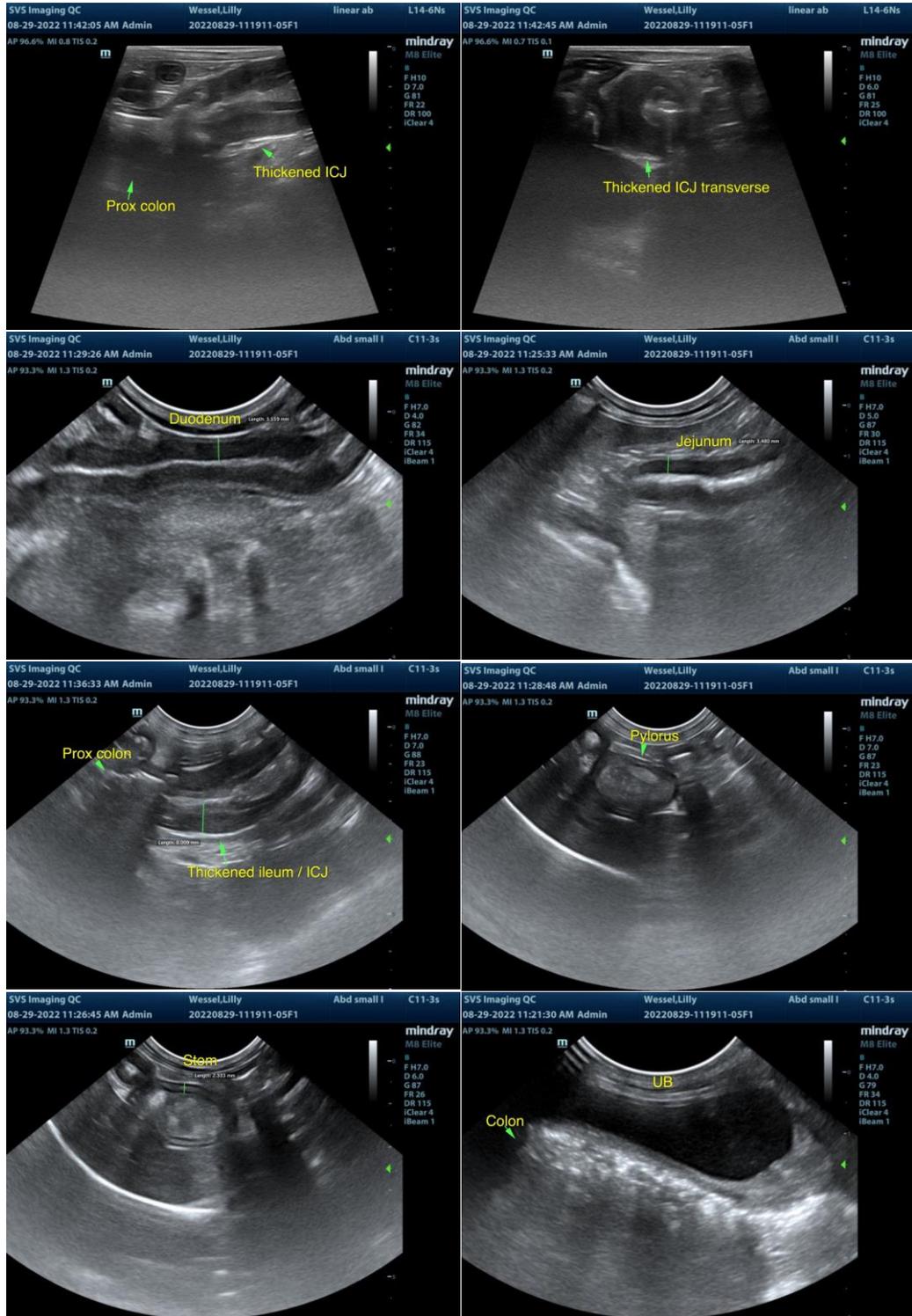
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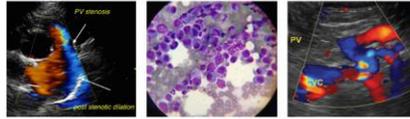
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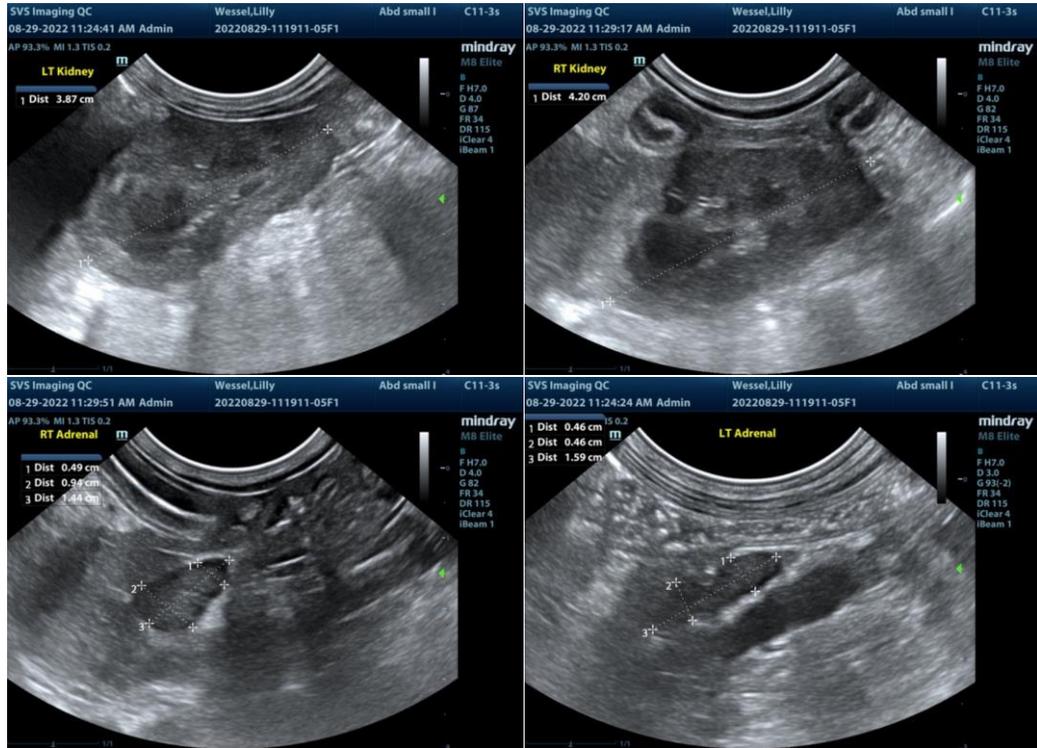
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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