



PATIENT

Greyboy Kullik

SPECIES

Canine

BREED

DSH

SEX

Neutered Male

AGE

9 Years

WEIGHT

7.6 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT
LVT

HOSPITAL NAME

Brighton Greens VH

REFERRING VET

Dr. Robin Janeway

INVOICE

17124

DATE

9/1/22

PRESENTING CLINICAL SIGNS

History: History: Chronic vomiting (more than 6 months), vomits once daily in the morning bile and white foam, not wanting to eat much now Physical exam findings: severe periodontal disease, otitis externa AD only with likely polyp, mild intestinal thickening on palpation but no abdominal pain observed BW and UA: pending Radiograph Findings(email radiographs if available): Radiographic Findings: Whole body radiographs except the cranial thorax on the VD view are provided. Cardiovascular and pulmonary structures are within normal limits. Abdominal detail is satisfactory. The stomach contains mild gas, possibly a small amount of soft tissue opacity ingesta, but otherwise appears contracted and empty. There is mild rugal fold prominence. The small bowel contains scattered disorganized gas and liquid content with no pathologic distension seen. The colon contains mild gas and moderate formed feces of normal character. Radiopaque G.I. foreign material is not identified. The kidneys and other visceral features are within normal limits. Conclusion Unremarkable cardiopulmonary structures. Impression of a gastroenteritis. Radiopaque G.I. foreign material is not defined and there are no convincing features of gastric outflow obstruction, small bowel obstruction or bowel plication. Other abdominal viscera are of normal character. Reason for Ultrasound: chronic vomiting, pancreatitis? IBD? Triaditis, other

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. Primarily anechoic urine was present in the lumen. Mild to moderate nondependent particulate to pinpoint hyperechoic sediment was present without evidence of calculus formation. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural changes were noted.

Aortic trifurcation was normal.

Normal renal size with asymmetrical margination was present in both kidneys. The renal cortex presented uniformly increased in echogenicity with uniform echotexture. The renal cortex appeared to be hypertrophied resulting in an altered cortex: medulla ratio. Mild loss of corticomodullary distinction was also present. The renal medullary volume was subjectively reduced. The left kidney measured 3.6 cm in length. The right kidney measured 3.6 cm in length.

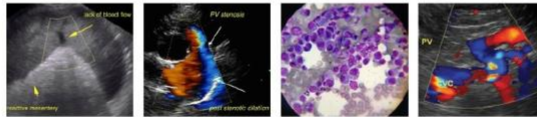
Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.50 cm.

The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.40 cm.

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. The spleen measured 0.84 cm in width.



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Liver

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 mild to benign parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion. A solitary nonhomogeneous to cystic macronodule to small mass was present in the ventral liver, measuring 2.0 cm in diameter.

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Gastrointestinal

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The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material. The gastric body wall measured 0.26 cm.

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The small intestine exhibited intact wall layering with segmental propensity for prominent muscularis layer. No evidence of loss of intestinal wall layering or intestinal masses. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material. The duodenum wall measured 0.29 cm. The jejunum wall measured up to 0.31 cm in wall width. The ileocolic wall measured 0.27 cm.

WEIGHT

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

Pancreas

The pancreas was normal in size with areas of minor capsule asymmetry. Mildly nonhomogeneous to subtly hypoechoic parenchyma was noted, compared to adjacent nonreactive omentum.

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Free Abdomen

Intermittent, mildly prominent to enlarged colic lymph 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 of lymph node size measured 0.40 cm width. No effusion noted.

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT
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ULTRASONOGRAPHIC FINDINGS

- Urinary bladder sediment
- Nonspecific bilateral chronic renal changes
- Probable inflammatory bowel disease
- Possible concurrent low grade chronic to chronic active pancreatitis
- Nonspecific yet suspect benign cystic liver nodule to small mass- probable cystic biliary adenoma
- Mild, subjectively benign/reactive colic lymph nodes

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS



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The urinary bladder sediment may suggest cellular / crystalline debris or mucus. Cystocentesis for UA +/- C/S if evidence of inflammatory cells is recommended.

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The small intestine exhibited mild mural changes, specifically, segmental prominent muscularis layer, which although potential for patients variant, suggestive of inflammatory enteropathy/IBD pattern. Potential for low grade to chronic pancreatitis would be suspected, if evidence of cranial abdominal or subxiphoid discomfort on palpation. Further assessment may include a GI panel to include PLI/TLI/Cobalamin/Folate. Full thickness intestinal biopsies are required for a definitive diagnosis. Triaditis could be considered in this patient, if previous or current hepatic enzyme elevations.

BREED

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Empirically, a hydrolyzed diet trial, as needed gastrointestinal support +/- prednisolone trial (at lowest effective dose to control clinical signs) and cobalamin supplementation, pending GI panel, and assessment of clinical response would be reasonable.

SEX

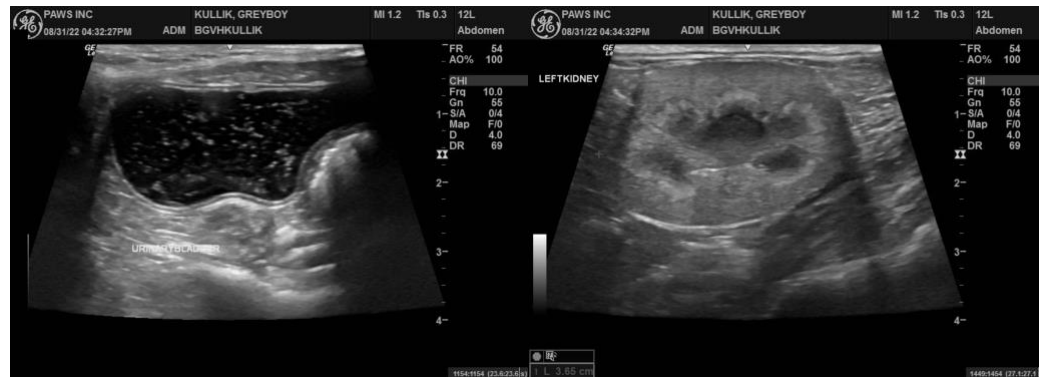
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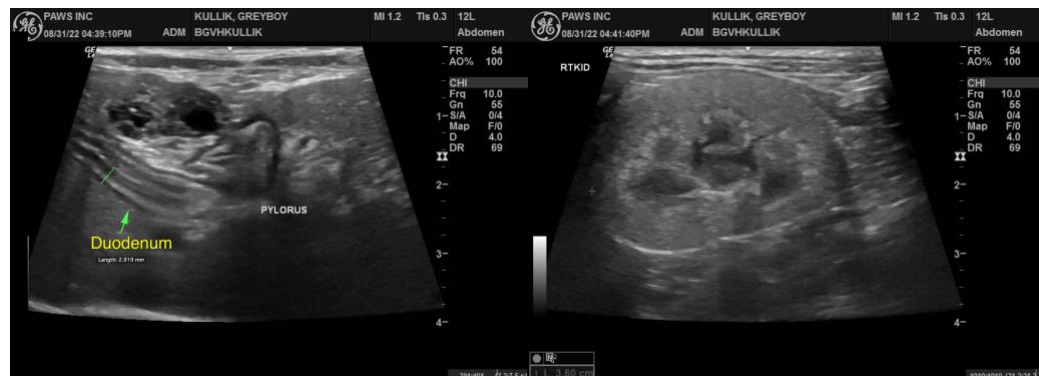


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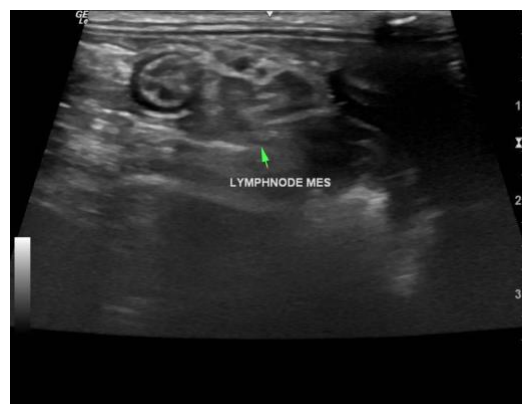
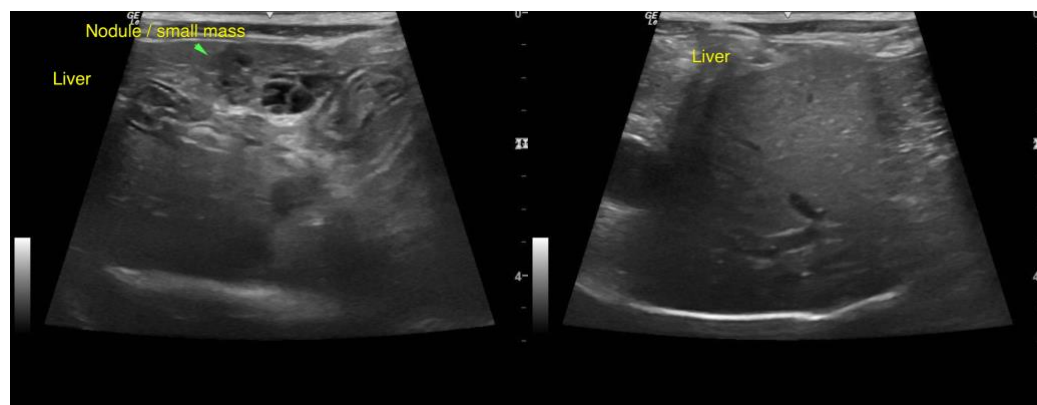
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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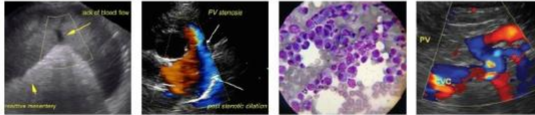
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Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

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info@SonoPath.com

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