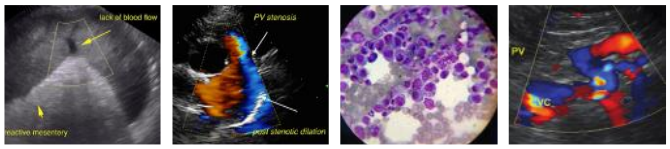
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Mitch Entz

SPECIES
Canine

BREED
Yorkshire Terrier

SEX
MN

AGE
12yr

WEIGHT
3.6kg

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

IMAGING PERFORMED BY
Dr. Belan

HOSPITAL NAME
Cranston Vet Clinic

REFERRING VET
Dr. Nielsen

INVOICE
11669ag

DATE
09/19/2022

PRESENTING CLINICAL SIGNS

Vomiting and soft stools. Has responded to omeprazole and sucralfate in the past and is presently on same meds.

Abnormal PE/Chem/CBC/UA Results: Non diagnostic

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 was 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 mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 3.4 cm in length. The right kidney measured 3.5 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 0.41 cm width at the caudal pole and 0.33 cm width at the cranial pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.23 cm width at the caudal pole and 0.4 cm width at the cranial pole.

Spleen

The spleen exhibited mild generalized parenchyma heterogeneity with a solitary discrete perihilar nodule consistent with benign myelolipoma measuring 0.67 cm in diameter. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis.

Liver

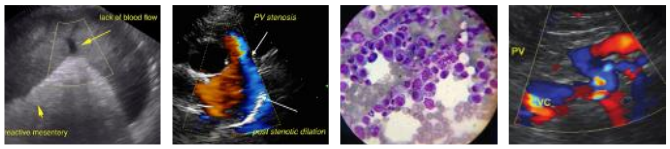
The liver was subjectively normal in size, structure, and contour. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to benign parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion.

The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content with mild dependent to non-dependent non-organized hyperechoic luminal debris. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact mildly prominent wall layering with a normal wall layer ratio. The lumen of the stomach contained moderate retained anechoic fluid with no signs of ileus, obstruction or foreign material. The pylorus wall measured 0.32 cm in width.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. Segmental mildly prominent duodenojejunal mucosa and submucosa layers were present. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material.



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The colon walls presented intact yet prominent wall layering with mild thickened to echogenic submucosa. Nonformed to liquid fecal matter was present in the colon lumen with lumen dilation.

Pancreas

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

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

Focal, 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 0.33 cm in diameter.

ULTRASONOGRAPHIC FINDINGS

Primary

- Gastroenterocolitis pattern-suspect inflammatory bowel
- Intermittent prominent benign/reactive mesenteric lymph nodes
- Heterogeneous to hyperechoic pancreas-patient/age related variant, remodeling or minor fibrosis owing to previous inflammation, low grade to chronic pancreatitis possible
- Mild congealed gallbladder debris (non-mucocele)
- Mild chronic renal changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Potential for low grade to chronic pancreatitis may be suspected if evidence of cranial abdominal or subxiphoid discomfort on palpation. Correlation with a spec cPL could be considered. Dietary intolerance / food hypersensitivity, occult parasitism, inflammatory bowel disease, dysbiosis, low grade to mild pancreatitis are possible with early infiltrative neoplasia less likely. A GI panel to include PLI/TLI/Cobalamin/Folate, fresh fecal analysis to assess for parasitic ova / Giardia and resting cortisol to rule out occult Addison's Disease is warranted.

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. Ursodiol therapy may be considered if evidence of cholestasis arises.

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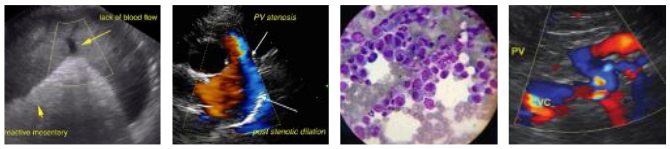

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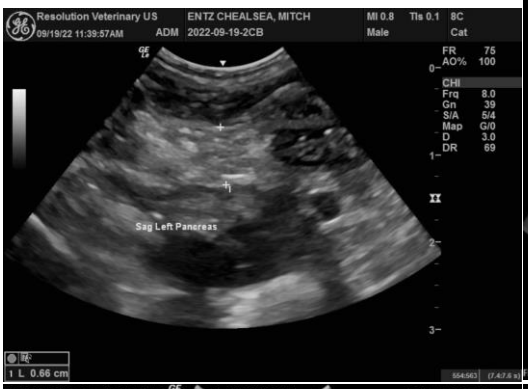

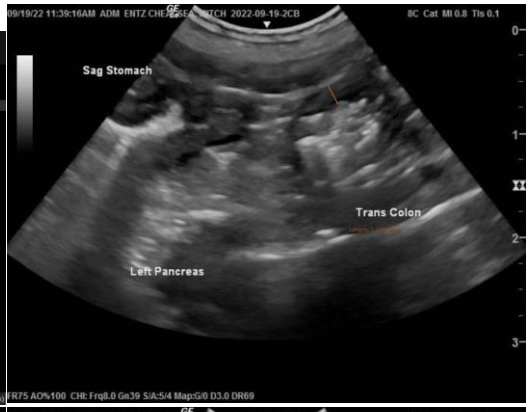

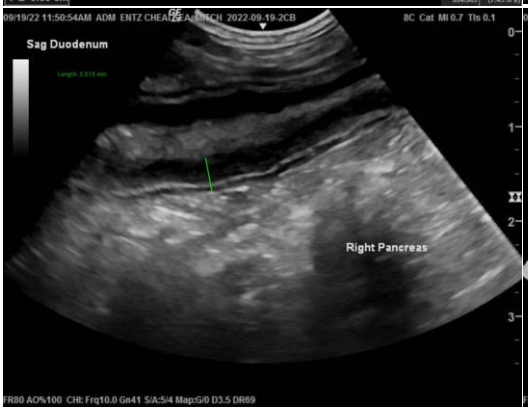

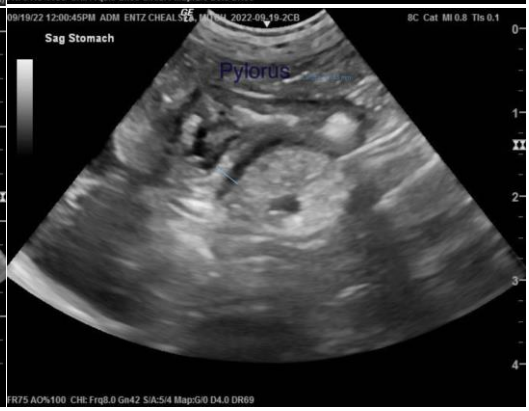

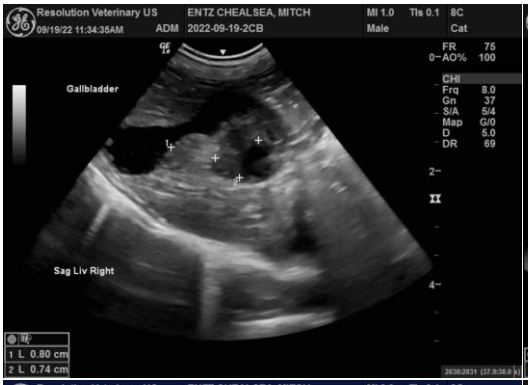

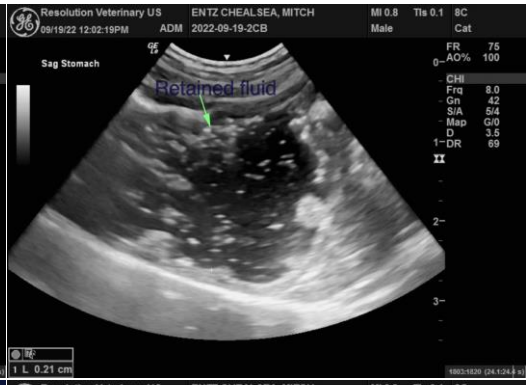

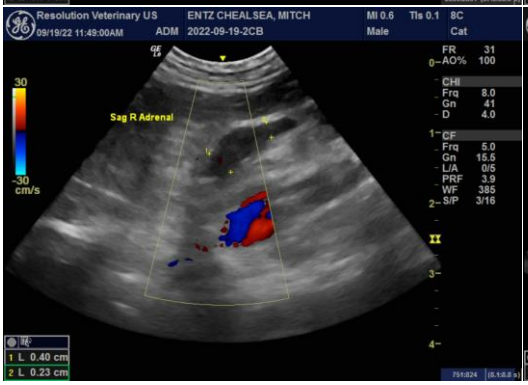

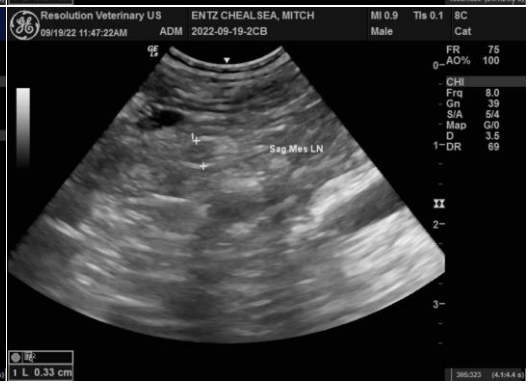

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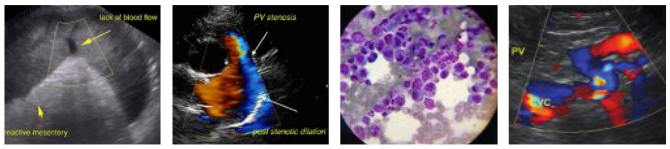

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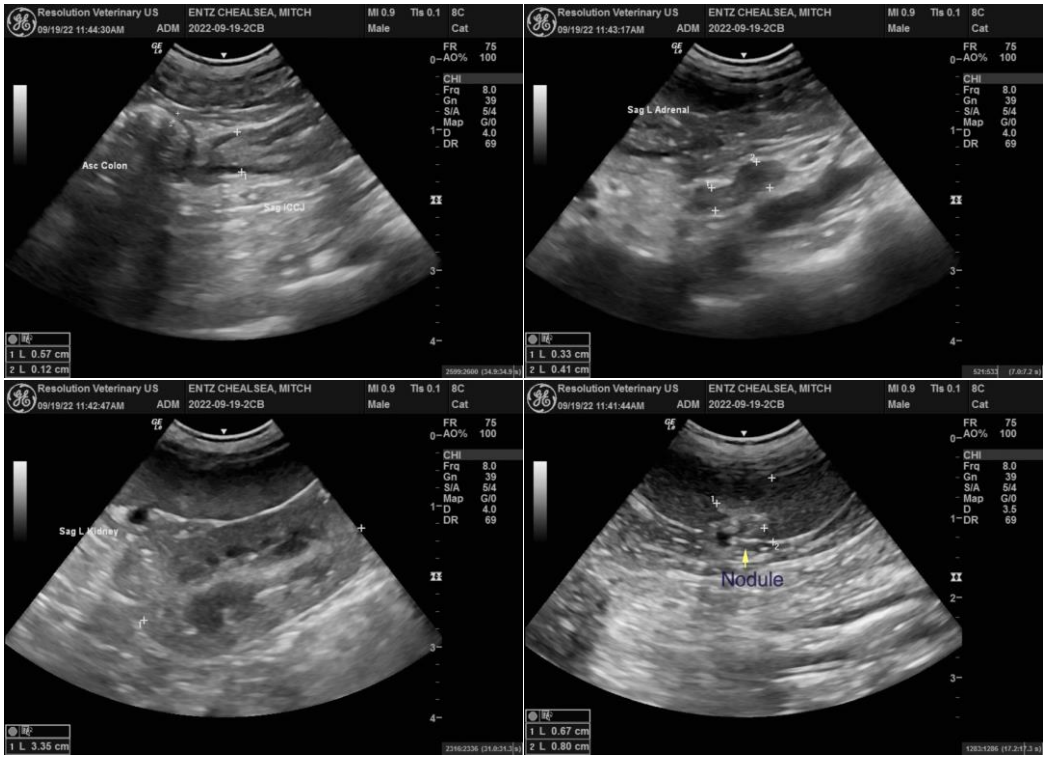

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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