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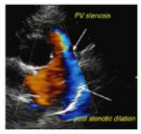
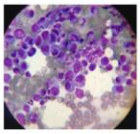
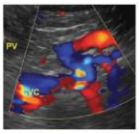

SonoPath
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PATIENT
Chief Engelhart
25751A

SPECIES

Canine

BREED
Anatolian Shepherd Mix

SEX

M/N

AGE

11 yrs 6 months

WEIGHT

36.5 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VET
Madison Veterinary Specialists-Dr. Maller

INVOICE

14921

DATE

9/21/22

PRESENTING CLINICAL SIGNS

Chief became disinterested in food 4 days ago. Since Sunday, he has not eaten at all. He's been lethargic over this time. Early yesterday morning, Chief woke owner up a couple times to go outside and had diarrhea a few times. No blood noticed in the stool. Yesterday afternoon Chief started vomiting. He has vomited ~4 times since. Most instances have been liquid bile w/ some mucous, but some contain what appears to be some bloody substances. Chief drank lots of water last night but vomited it all up soon after. Owners do not think he got into anything inappropriate. Chief has a hx of seizures which have been medically managed for the last 8-9 years. He had CCL tear repaired here and also had Lyme disease as a puppy.
Abnormal PE/Chem/CBC/UA Results: Abdomen: Tense and painful abdomen Blood Pressure 9am 30 mmHg 9:10am 100 mmHg (after fluid bolus) 10:15am 110 mmHg Blood glucose: 9am 79 mg/dL

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and cystourethral junction 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.

No overt pathology associated with the residual prostate was noted.

A solitary, medial iliac lymph node was present. The lymph node was essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). The lymph node measured 2.1 cm x 0.87 cm. This lymph node was not consistent with inflammatory or neoplastic criteria.

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 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 7.4 cm in length. The right kidney measured 7.8 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 0.75 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 0.57 cm width at the caudal pole.

Spleen

The spleen was overtly normal in size with areas of mild capsule asymmetry and generalized mild parenchyma heterogeneity exhibiting Intermittent nondisruptive discrete hypoechoic nodules. An example of a nodule measured 0.65 cm in diameter.

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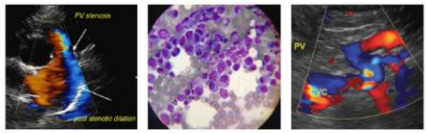

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Liver/ Gallbladder

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 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 containing mild to moderate, dependent to nondependent yet nonorganized gallbladder debris. No evidence of gallbladder or peripheral gallbladder inflammatory criteria was noted. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact yet mildly prominent wall layering. The stomach appeared to be distended with gas. Potential for mild retained ingesta / chyme exhibiting subtle progressive distal acoustic shadowing in the area of the gastric body, antrum, and pylorus is possible. Visualization of the pyloric outflow was somewhat limited owing to the presence of luminal gas and patient size. The gastric body wall width potentially measured up to 0.75 cm.

The intestinal walls demonstrated intact wall layering and maintained 1:3 muscularis / mucosa ratio. The mucosa exhibited mildly decreased echogenicity with occasional mucosal speckling. Segmental, primarily mild jejunal ileus pattern consisting of mild fluid accumulation in the intestinal lumen was present to the level of the ileum without obstruction or foreign material. The ileum appeared to be mildly distended with anechoic fluid to the level of the ileocolic junction. The duodenum wall measured 0.53 cm width. The jejunum wall measured 0.30 cm width.

The colon exhibited intact mildly prominent wall layering. The generalized colon exhibited moderate dilation containing generalized nonformed to liquid fecal matter, consistent with patient history. The cecum appeared to be fluid distended.

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 were evident.

Free Abdomen

No evidence of peritoneal free fluid or overt peritonitis was present. Subtle evidence of peri-intestinal and pericolic hyperechoic mesentery was noted.

ULTRASONOGRAPHIC FINDINGS

- Acute gastroenterocolitis pattern with subjective mild to moderate ileitis / typhlitis
- Heterogeneous to discretely nodular spleen - multiple etiologies including patient / age-related variant, hyperplasia, hematopoiesis, incidental to reactive splenitis, small hematomas, neoplastic criteria thought less likely yet cannot be definitively excluded
- Mild hepatic parenchymal remodeling - subjectively benign
- Gallbladder debris (non-mucocele)

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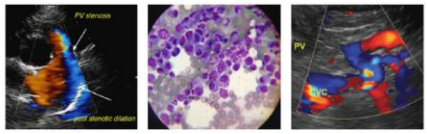

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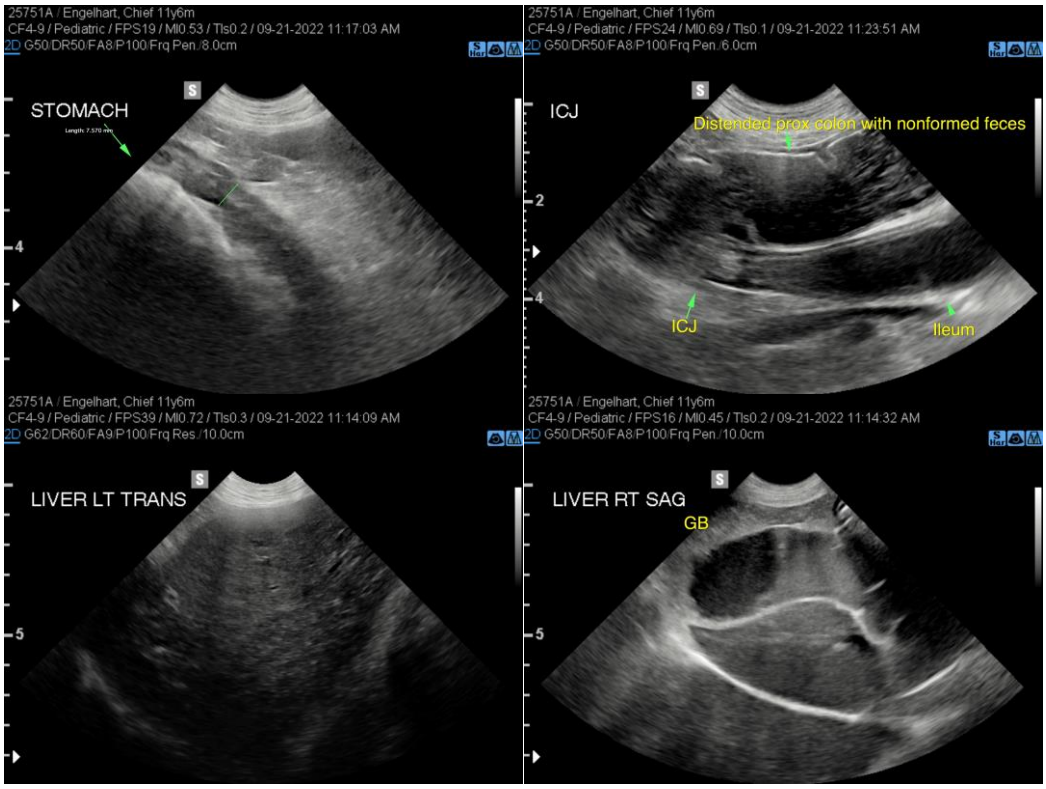
- Mild chronic renal changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No overt evidence of definitive gastrointestinal foreign material or mechanical obstructive pattern was present. Technically, the possibility of a small amount of passing or passed foreign material cannot be definitively excluded. Dietary indiscretion, enterotoxic insult, infectious disease, IBD / dysbiosis, occult parasitism, Addison's Disease, or infiltrative neoplasia are all potentials. Colon torsion is considered a less likely differential diagnosis.

Correlation with abdominal radiographs is recommended. Assessment of serum cobalamin / folate levels, as well as resting cortisol level, may be considered. Hospitalization with aggressive therapy for acute gastroenterocolitis with an assessment of clinical response would be reasonable. Exploratory laparotomy with gastrointestinal biopsies (considered essential), may be indicated if persistent / progressive clinical signs despite supportive care.



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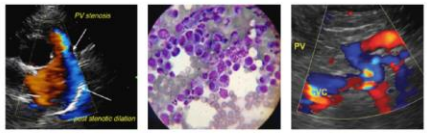

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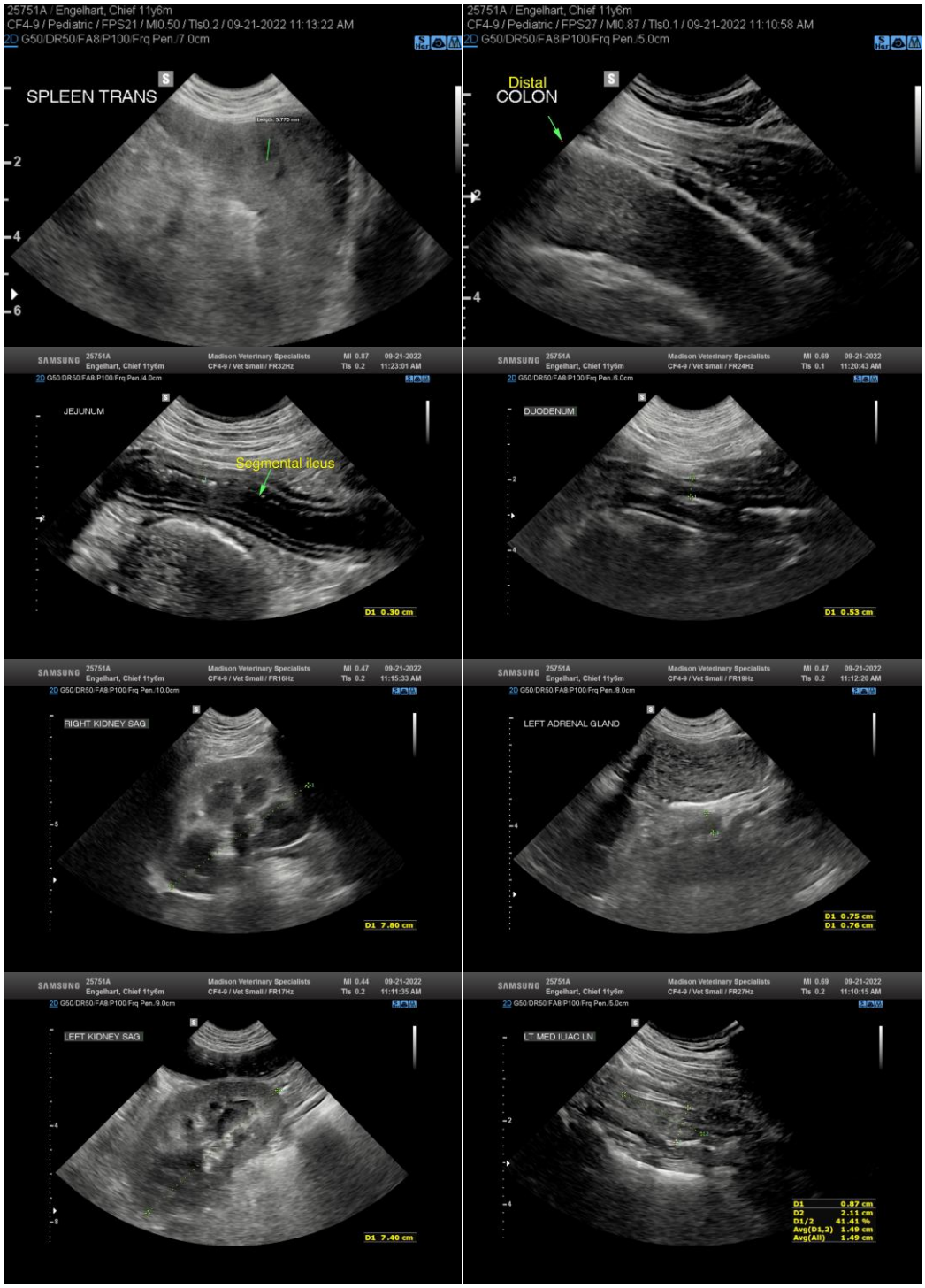

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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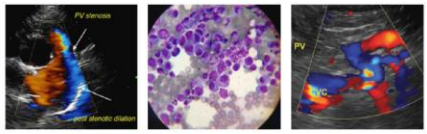

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Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

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