

**PATIENT**

Boo Boo Axley

SPECIES

Canine

BREED

Australian Shepherd

SEX

Neutered Male

AGE

8 Years

WEIGHT

48 Pounds

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

Sarah Pender, CVT

HOSPITAL NAME

SVS Imaging QC

REFERRING VET

Dr. Stacy Kula

INVOICE

17212

DATE

9/8/22

PRESENTING CLINICAL SIGNS

History: Chronic vomiting, bile and water. No food or grass
 Abnormal PE/Chem/CBC/UA Results: Has Cushing's disease, currently on 30mg Vetoryl that is well controlled per ACTH stimulation test. Elevated liver enzymes (expected with disease status) other blood work unremarkable. Right lateral radiograph revealed an enlarged liver but no other obvious issues

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**Urinary System**

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 cm 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.

The area of the residual prostate appeared normal and free of pathology.

The area of the aortic trifurcation was free of pathology.

The left kidney was not definitively visualized.

Normal size and margination were present in the right kidney. 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 7.0 cm in length.

Adrenal Glands

The bilateral adrenal glands were mildly prominent in size. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The left adrenal gland measured 2.7 cm in length x 0.65 cm width in the caudal pole. The right adrenal gland measured 2.8 cm in length x 0.54 cm width in the caudal pole.

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.

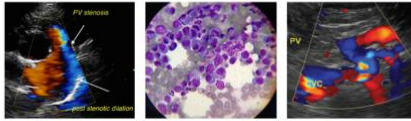
Liver

The liver revealed mild to moderate generalized enlargement with areas of minor capsule asymmetry. Heterogeneous irregular to nodular hepatic parenchyma was present, exhibiting moderate coarse echotexture and mixed parenchyma echogenicity. No masses noted.

The gallbladder was non distended in size with moderate nondependent yet nonorganized mildly hyperechoic debris. The cystic duct and common bile ducts were normal without evidence of dilation. No evidence of gallbladder or peripheral gallbladder inflammation.

Gastrointestinal

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.

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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 formed feces in lumen.

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Pancreas

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

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Free Abdomen

Scant perihepatic free fluid was noted between to the right kidney and caudal caudate liver lobe. No omental masses or lymphadenopathy.

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ULTRASONOGRAPHIC FINDINGS**AGE**

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- Heterogeneous irregular to nodular liver- nonspecific, chronic vacuolar hepatopathy/vacuolar hepatitis, inflammatory/immune mediated disease, nodular hyperplasia, hematopoiesis, benign parenchyma remodeling, fibrosis or other hepatopathy possible. Infiltrative neoplasia is considered unlikely.

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- Gallbladder debris- (non-mucocele)
- Sonographically unremarkable GI tract
- Mild heterogeneous pancreas- patient variant, low grade pancreatitis is considered less likely yet cannot be excluded.

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- Bilateral mildly prominent adrenal glands- consistent with PDH given the patients history. No evidence of adrenal tumors.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**IMAGING PERFORMED BY**

Sarah Pender, CVT

No overt evidence of structural gastrointestinal pathology as a primary or contributing factor to the patients chronic vomiting. Potential low-grade pancreatitis may be suspected if evidence of cranial abdominal or subxiphoid discomfort on palpation. Correlation with a spec CPL or full GI panel to include cobalamin and folate levels to assess for occult pancreatic or intestinal disease. Smaller more frequent feedings with nighttime feeding recommended, if vomiting primarily at night or early morning, along with bland or hydrolyzed diet and gastroprotectant trial may prove beneficial. Three view chest radiographs are suggested to rule out occult thoracic or esophageal pathology as a contributing factor. Screening hepatic FNA cytology could be considered for further assessment. Hepatosupportive medications, including Denamarin and Ursodiol may prove beneficial.

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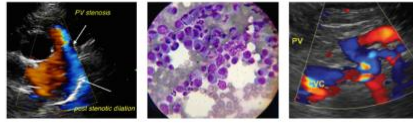
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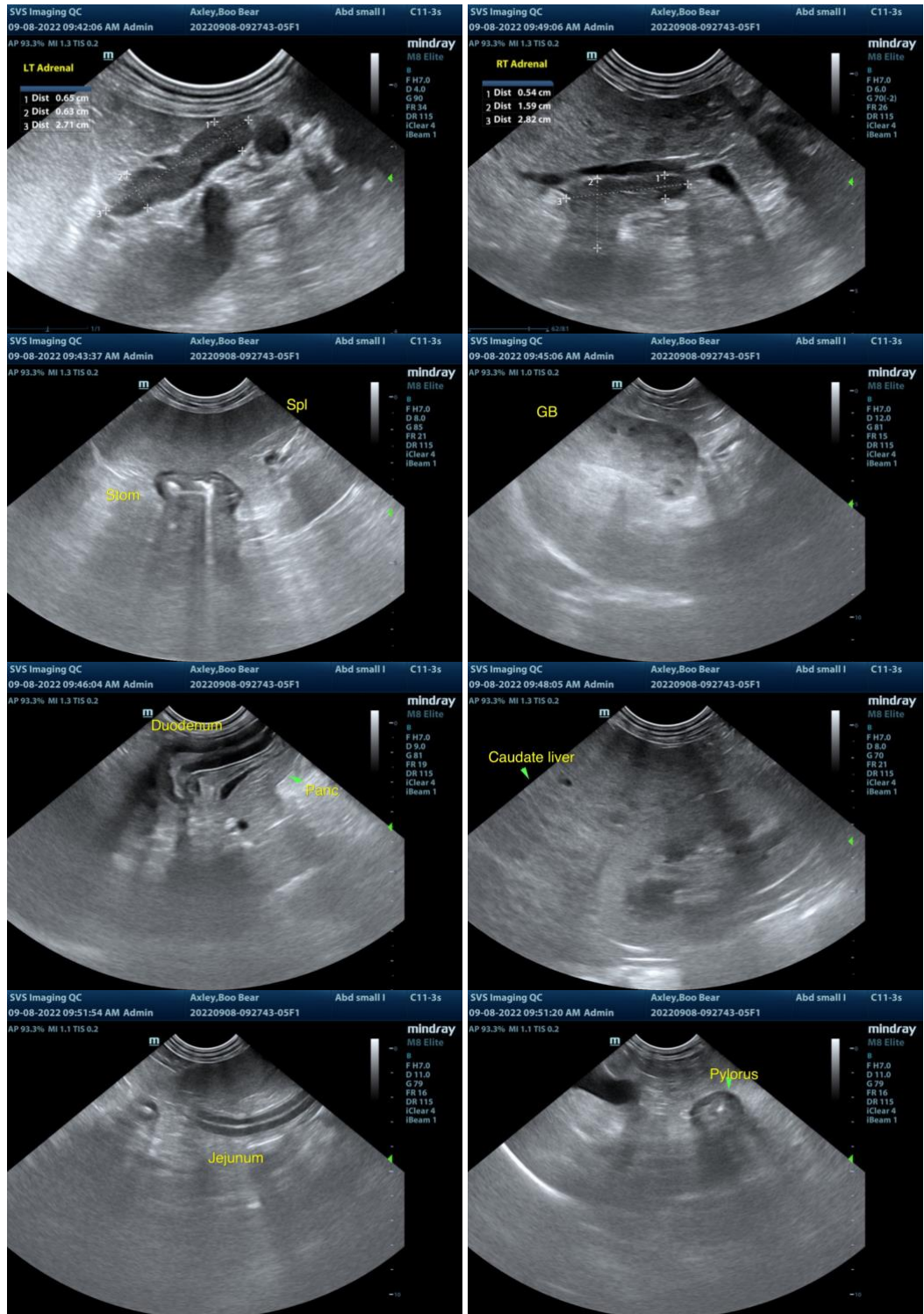
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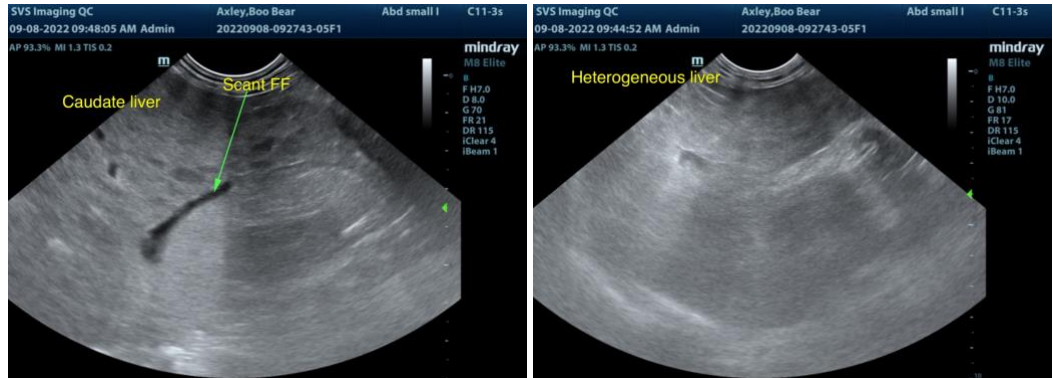
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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