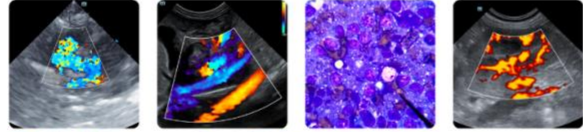
Charleston Mobile Veterinary Services
IN PARTNERSHIP WITH SONOPATH VETERINARY ULTRASOUND



Clinical Sonography & Telecytology
Educational Teleconsultation Services™

SonoPath
FOSTERING THE ART OF VETERINARY MEDICINE™
www.charlestonmobile.net
info@charlestonmobile.net
800.403.5408

PATIENT
Harlow Buxton

SPECIES
Canine

BREED
Great Dane

SEX
Female Spayed

AGE
10/28/2018

WEIGHT
43.7kg

INTERPRETED BY
Andrea Nicastro DVM
Diplomate
ACVIM
(Sm Animal Internal Med)

IMAGING PERFORMED BY
Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

HOSPITAL NAME
BluePearl MP ER

REFERRING VET
Dr Libby

INVOICE
22206

DATE
12-1-25

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: Harlow is a 7y FS Great Dane presenting for anorexia, lethargy, and vomiting. O states Harlow has had no interest in eating for the past few days. Harlow will drink water however, immediately vomits right after. O has not noticed any diarrhea or defecation the past few days as well. Harlow has been drooling excessively, and O is concerned she may have a FB. Harlow does not normally get into things however, O had company in town for the holidays.

Further Hx: The owner states that anorexia began Friday evening or Saturday morning and has continued. Harlow started vomiting on Saturday and that has continued and the fluid vomitus has now become blood tinged as of this morning. The owner has not observed diarrhea, but noted that Harlow was straining to defecate yesterday with no production. The owner was informed that Harlow has bloody liquid diarrhea on rectal exam this morning. The owner noted that Harlow was 105# in March at the pDVM's, but this morning she was 97.8#. The owner notes that Harlow had a gastropexy when she was spayed.
The owner is not aware of any history of dietary indiscretion (but notes that a lot of family members were in for Thanksgiving), foreign body ingestion, toxin ingestion, or any other pertinent history associated with the onset of Harlow's symptoms.

PE: Eyes: pupils are equal and responsive with intact menace OU. Oral: excessive drooling/ptyalism. MM are moist, pink, CRT 1.5 sec. Non-compliant for full oral exam. No lesions or masses visualized. Could not assess sublingual space for linear FB. LNs: no PLN enlargement palpable. Ears: clear canals AU. H/L: anxious during exam. Tachycardic at 130 bpm. No overt murmur or arrhythmia appreciated. Pulses were strong and synchronous. Lung sounds were clear with no crackles or wheezes. Abdomen: not splinting, but resistant to deep abdominal palpation. Anxious. Challenging to palpate individual organs. M/S: ambulatory x 4. BCS 5/9. No localized pain/lameness. Neuro: no deficits noted. Skin/coat: increased skin tent. Moderate dehydration. Mild erythema around the perivulvar region. GI: bloody liquid diarrhea on rectal exam. Nausea, drooling, vomiting blood-tinged mucoid fluid. Urogenital: recessed vulva. Some dermal erythema and staining (urine/moisture/saliva) in the perivulvar region.

Abnormal lab-work values - Update/Diagnostic results:
CBC revealed hemoconcentration with a HCT of 70.6%, elevated reticulocyte count of 112.6K, normal WBC count of 10.55K and a normal PLT count of 202K.
Chemistry profile revealed an elevated Cl of 124, decreased GLB that was likely relative to an increased/concentrated ALB level of 3.8. CHOL, AMYL and LIPA did not read and will be rechecked.
Urinalysis: S.G. >1.050, 500 mg/dL urine protein, bilirubin 3, urobilinogen 4, WBCs 1/hpf, RBCs 15/hpf, no bacteria and no crystals observed.

Current Medications: Cerenia, Protonix, Metronidazole
Radiographic Findings - Update/Diagnostic results:
CBC revealed hemoconcentration with a HCT of 70.6%, elevated reticulocyte count of 112.6K, normal WBC count of 10.55K and a normal PLT count of 202K.
Chemistry profile revealed an elevated Cl of 124, decreased GLB that was likely relative to an increased/concentrated ALB level of 3.8. CHOL, AMYL and LIPA did not read and will be rechecked.
Urinalysis: S.G. >1.050, 500 mg/dL urine protein, bilirubin 3, urobilinogen 4, WBCs 1/hpf, RBCs 15/hpf, no bacteria and no crystals observed.

Pancreatitis snap test: normal.
3-view abdominal radiographs: pending.

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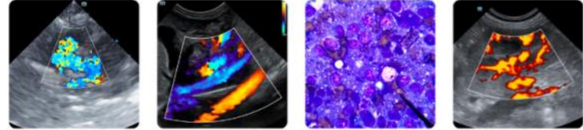

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ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness. The mucosal surface is smooth. The bladder is moderately distended. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone and visible portion of the proximal urethra are normal.

The left kidney is normal in size (7.98 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (7.83 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is subjectively normal in length (0.59 cm at cranial pole) (0.49 cm at caudal pole) with a slightly flattened contour. Glandular echogenicity and detail are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal in size (1.31 cm at cranial pole) (0.59 cm at caudal pole) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (2.71 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative, or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1: 1.

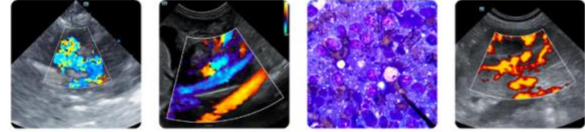
The gallbladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is mildly to moderately fluid-distended and hypomotile. The gastric wall is normal to borderline thickened (up to 0.41 cm) with retention of the normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is diffusely fluid-distended (mild). The small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. The colonic lumen is diffusely distended with liquid-appearing fecal material. There is no obvious evidence of an obstructive pattern.

Pancreas

A portion of the pancreas is obscured by the gastric distention. In the visualized portion no obvious abnormalities are seen.



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Lymph Nodes

A few prominent mesenteric lymph nodes are visualized (one measuring 4.21 x 0.70 cm). At least one prominent medial iliac lymph node is also seen (measuring 2.04 x 0.66 cm).

Free Abdomen

There is no obvious evidence of free fluid.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

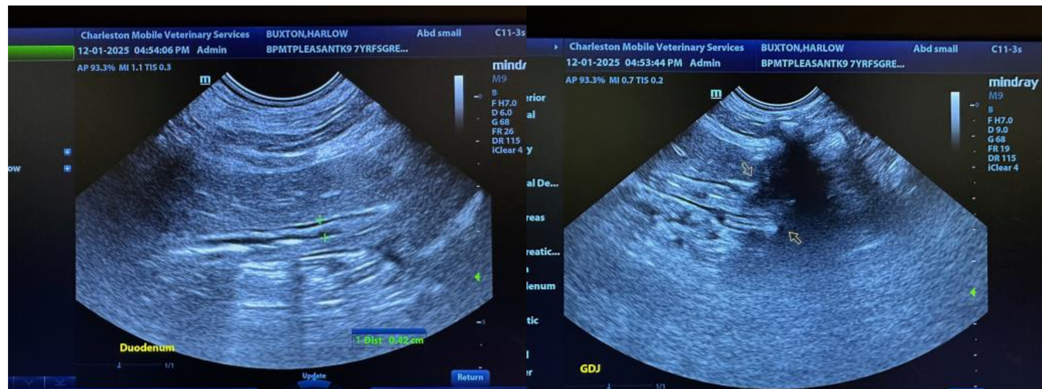
- Diffuse gastrointestinal ileus, the cause of which is unclear. Considerations include dietary indiscretion, toxicity, food allergy/intolerance, inflammatory bowel disease, infectious/parasitic disease, underlying metabolic issue, other.

Secondary Findings

- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- Mild bilateral nonspecific age-related renal changes
- The flattened left adrenal gland may be a normal variant for this patient or could be secondary to atrophy (i.e., resulting from hypoadrenocorticism if applicable).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Fecal evaluation for ova and Giardia along with a fecal GI infectious disease panel are recommended. Also consider prophylactic deworming with fenbendazole.
- A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended.
- Consider three-view thoracic radiographs to assess for occult aspiration pneumonia.
- Supportive care for acute gastroenteritis is recommended, including a probiotic, fiber supplement, and bland diet.
- If clinical signs persist despite medical management, further work-up (i.e., GI panel, endoscopic or surgical GI biopsies) may be indicated.



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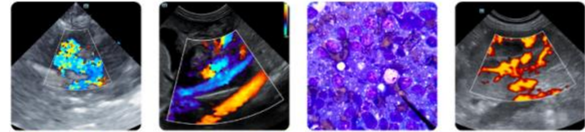

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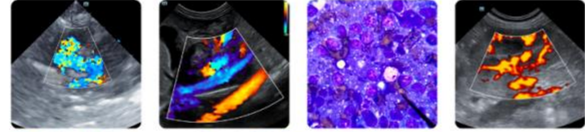

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com