



PATIENT

Timber Hager

SPECIES

Canine

BREED

Border Collie mix

SEX

Female, spayed

AGE

9 Yrs. 6 months

WEIGHT

19.8 kg.

INTERPRETED BY

Andrea Nicastro, DVM,
Diplomate ACVIM
(Small Animal Internal
Medicine)

IMAGING PERFORMED BY

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VET

Dr. Patton

INVOICE

14590

DATE

2/14/23

PRESENTING CLINICAL SIGNS

History: Timber presented to the MVS Emergency Service on Feb 13, 2023, at 7:18pm, for evaluation of vomiting, diarrhea, lethargy, and weight loss. Owner came home from work to find 10 piles of clear, mucousy liquid vomit with what appeared to be small blood clots in also. Timber has been lethargic and not acting like herself for the last couple of weeks. Stools have been on/off diarrhea with blood in stool for an unknown duration and has been having urinary accidents in house. Timber has been loosing weight despite having an increase in appetite and continues to have the nasal discharge as she did when seen here previously. Owners have also noted a couple new lumps but think they are fatty lumps. Timber was diagnosed with chronic rhinitis in September 2022 and is currently being treated with methylprednisone.

Abnormal PE/Chem/CBC/UA Results: Presented in hypovolemic shock. Has since resolved. ALT 692 ALP 426 T. Bili 1.6 Cl 106

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder lumen is moderately distended with anechoic urine. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal size (6.50 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney is normal size (6.51 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.52 cm at cranial pole) (0.96 cm at caudal pole) with a slightly irregular shape and a prominent caudal pole. The glandular echogenicity and detail are unremarkable. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (1.09 cm at cranial pole) (0.59 cm at caudal pole); normal shape; 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 (1.18 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. No pathological hepatic lymphadenopathy observed. The gall bladder lumen is moderately



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distended. The wall is mildly thickened (up to 0.38 cm) and hypoechoic with a “double-walled” effect. Luminal contents are mostly anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

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The gastric lumen is moderate to severely fluid distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract appears patent. The small intestinal lumen is not dilated. The small intestinal wall thickness with retention of the normal layering pattern. There is slight disruption in the normal 1:3 muscularis: mucosal ratio in several segments. Discreet masses are not identified. The ileocecolic junction and colonic wall are normal. No obvious obstructive disease is noted.

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Pancreas

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A portion of the pancreas is obscured by the gastric distention. In the visualized portion, the pancreatic size and peripheral margins appear normal. The parenchyma is mildly hypoechoic relative to surrounding omental fat. No focal lesions are observed. The adjacent mesentery is mildly hyperechoic.

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Free Abdomen

Trace free fluid is observed. A few prominent mesenteric lymph nodes are visualized, the largest measuring 3.06 cm in length.

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ULTRASONOGRAPHIC FINDINGS

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Andrea Nicastro, DVM,
Diplomate ACVIM
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Medicine*)

Primary Findings:

- The pancreatic changes could be consistent with mild acute or chronic active pancreatitis. Mild adjacent peritonitis is present.
- The bowel pattern is suggestive of any inflammatory process (i.e., inflammatory bowel disease) with some potential for emerging lymphoma.
- Gastric ileus, suspected to be functional as there was no obvious evidence of a pyloric outflow tract obstruction.

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Secondary Findings:

- Mild left adrenomegaly could be consistent with early hyperplastic change or may be a normal variant for this patient.
- The “double-walled” gallbladder could be consistent with low oncotic pressure, increased hydrostatic pressure (i.e., due to fluid overload, right sided congestive heart failure), cholecystitis, anaphylaxis, immune mediated hemolytic anemia (less likely), sedation (if Dexdomitor was used during the study), other.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Supportive care for pancreatitis is recommended including IV fluid therapy, gastric protectants, antiemetics, pain medication as needed, +/- fresh frozen plasma.
- Given the bowel changes, consider the following:
 - A fecal evaluation for ova/Giardia.
 - Malabsorption panel including serum cobalamin, folate, TLI and PLI.
 - If the patient's GI signs are chronic, consider the canine CE-IBD assay +/- a hypoallergenic or hydrolyzed protein diet trial (if the patient is eating).
 - Ultimately, GI biopsies may be necessary to get a definitive diagnosis. Thoracic radiographs should be performed prior to any anesthetic event.
 - In the meantime, consider initiation of a probiotic.





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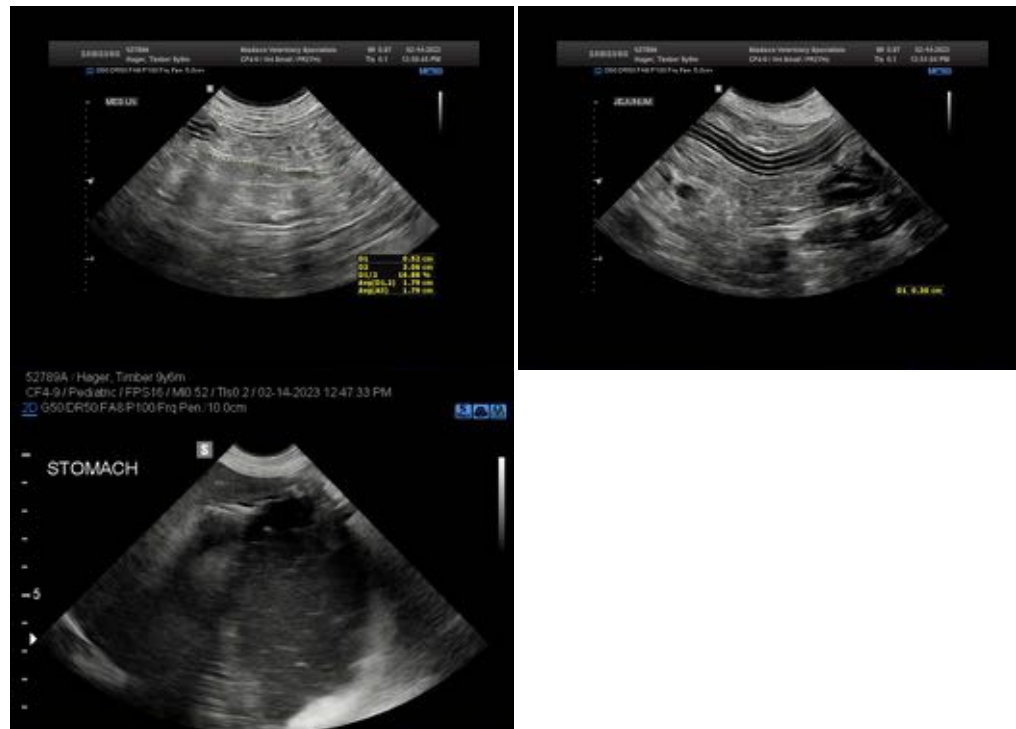
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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