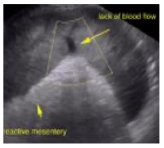
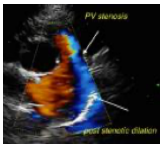
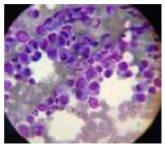
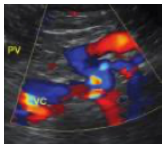
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

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PATIENT
Roxy Lindsley

SPECIES
Canine

BREED
Shepherd Mix

SEX
Spayed Female

AGE
12 years

WEIGHT
62.4 lbs

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

IMAGING PERFORMED BY
Dr. Maggiulli

HOSPITAL NAME
Willamette VH

REFERRING VET
Dr. Maggiulli

INVOICE
11380

DATE
8.11.22

PRESENTING CLINICAL SIGNS

History: Diarrhea for 4 days (starting 8/6) progressing to hematochezia on 8/9. Vomited once on Sunday 8/7. Anorexia started on Monday 8/8. Still drinking water. Lethargy progressive over that time.
Two other dogs in the house, 1 had diarrhea last week that resolved with bland diet. No known exposure to dog parks, hikes, or bodies of water. No recent diet changes or dietary indiscretion. Weight loss since March ~5lbs.

Abnormal PE/Chem/CBC/UA Results: EPOC = K 3.3(L), Na 138 (L), Lac 1.94, PCO2 23.3 mmHg (L), pH 7.465, PO2 55.2 (H), TCO2 16.7 (L)
Interpretation: mild hypokalemia, mild hyponatremia- likely secondary from ongoing diarrhea and episode of vomiting. alkalosis
Direct fecal - suspect ova
Abdominal x-rays: Diffuse gastroenteritis, no obvious obstruction or mass
urinalysis--> hold due to unremarkable chem

Moderate dental disease, complex crown fracture to 204, MM moderately tacky, CRT 2s
mildly opaque lens OU, moderate clear mucoid discharge OU, clear corneas, palpebral and menace intact OU, excessive shedding, soft/non-painful abdomen, no obvious masses or organomegaly
Normal bronchovesicular sounds, no crackles or wheezes noted. NSR, No murmur, strong and synchronous femoral pulses, CRT 2s. ambulatory x4

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 distended with anechoic urine. No masses, inflammatory changes or calculi are observed. The region of the trigone is normal.

The **left kidney** is normal size (6.65 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The **right kidney** is normal size (6.80 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with 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 normal size (0.58 cm at cranial pole) (0.62 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.

The region of the **right adrenal gland** is evaluated. No obvious pathology is observed.

Spleen

The **spleen** is normal in size (2.17 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 curvilinear peripheral contours. The parenchyma is slightly mottled in appearance. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion

The **gall bladder** is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The **gastric lumen** is not distended. The gastric wall is normal in thickness with a normal layering pattern. The small intestinal lumen is segmentally 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 colonic wall is normal. There is no evidence of an obstructive pattern.

Pancreas

The region of the **pancreas** is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional inflammation or effusion.

Free Abdomen

The **peritoneal cavity** is normal. There is no evidence of inflammation or effusion. The abdominal **lymph nodes** are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Bowel changes suggestive of enteritis, +/- mild ileus.

*An obvious cause for the patient's clinical signs is not identified in this study. Considerations include acute hemorrhagic gastroenteritis, dietary indiscretion, food allergy/intolerance, infectious/parasitic disease, other primary GI issue, underlying metabolic disease, mild pancreatitis, other.

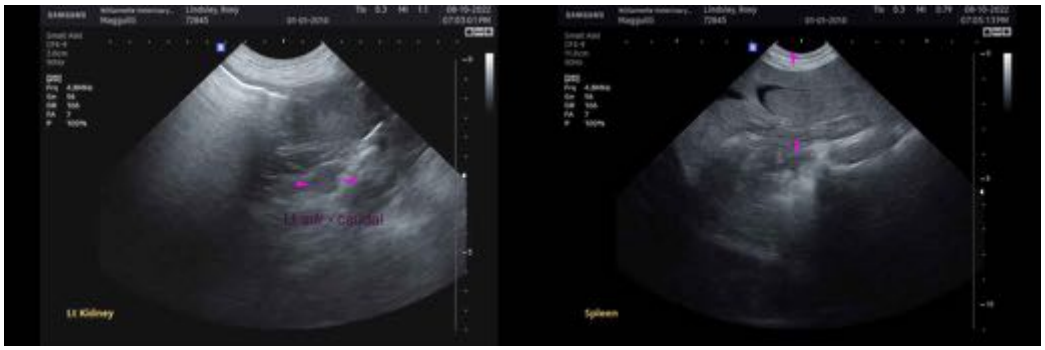
Secondary Findings

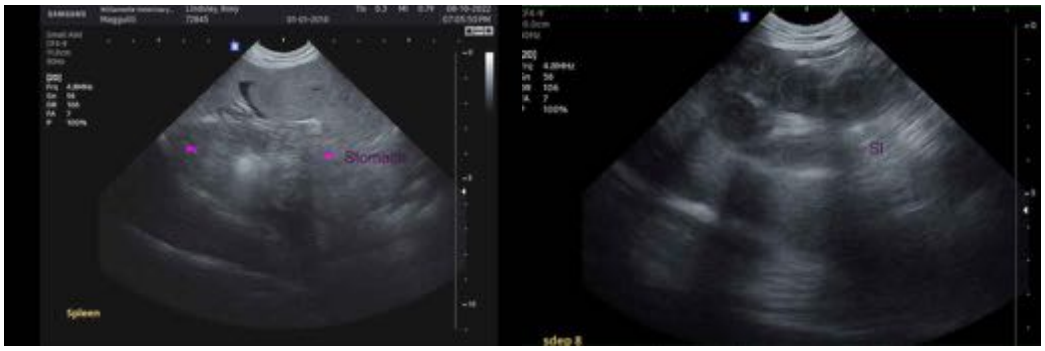
- The hepatic changes are consistent with age-related parenchymal remodeling and are not considered clinically significant at this time.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given the weight loss, three-view thoracic radiographs are recommended to assess for occult neoplasia and aspiration pneumonia.
- A fecal evaluation for ova and Giardia as well as fecal sedimentation (to assess for *Nanophyetus salmincola)* is recommended, if not already performed.
- Consider prophylactic deworming with Fenbendazole.
- Malabsorption panel, including serum cobalamin and folate, TLI and PLI
- A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test
- Continued supportive care for acute hemorrhagic gastroenteritis is recommended, including fluid therapy, gastric protectants, antiemetics, and pain medication as needed. Broad-spectrum antibiotic therapy should also be considered to help prevent bacterial translocation. Also consider initiation of a tetracycline antibiotic if the clinical suspicion for salmon poisoning is high.

- If the patient's clinical signs do not improve and the above diagnostics are inconclusive, a more advanced GI work-up (i.e., endoscopic or surgical GI biopsies) may be warranted.





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