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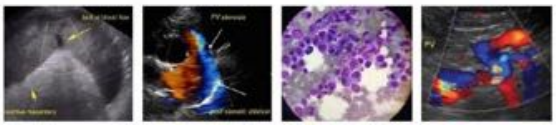

THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Luna Roman

SPECIES

Canine

BREED

Bloodhound X

SEX

Spayed Female

AGE

4 years

WEIGHT

20 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

Beattie PH Burlington

REFERRING VET

Dr. Murota

INVOICE

11321

DATE

8.3.22

PRESENTING CLINICAL SIGNS

History: JULY 27TH - been about 5 days, started soft and now is liquid and bloody Diarrhea with fresh blood (seen starting Sunday) since Monday V+ , Monday was morning, today during walk has vomited 3 times, good energy level, JULY 31ST- :Blood on rectal thermometer. P comfortable on abdominal palpation but tense/nervous Dysentery, Vomiting, Inappetence, Lethargy. Eating less, but still eating. Will only eat rice and chicken Drinking well O said been giving meds as prescribed at last appointment. No improvement. Seems more like regurgitation now vs vomiting meds: metronidazole, tylosin, maropitant, cerenia, sulcrate, fortiflora

Abnormal PE/Chem/CBC/UA Results: Electrolytes, Chem: nsf cPLI: Normal Urine analysis: Unable to collect

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. The cystourethral junction and the visible portion of the proximal urethra are normal.

The **left kidney** is normal size (5.78 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The **right kidney** is normal size (5.23 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal 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 (0.56 cm at cranial pole) (0.57 cm at caudal pole) (2.42 cm in length); 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 **right adrenal gland** is normal size (1.20 cm at cranial pole) (0.58 cm at caudal pole) (1.84 cm in length); 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 (2.22 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 portal vein to caudal vena cava ratio is approximately 1: 1.

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

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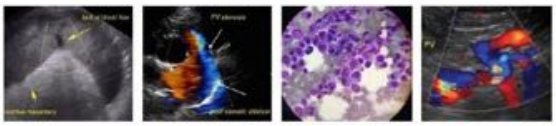

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Gastrointestinal

The **gastric lumen** is mildly fluid distended. The gastric wall is normal in thickness with a normal layering pattern. The small intestinal lumen is not dilated. The small intestinal wall is normal in thickness with retention of the normal layering pattern. There is disruption in the normal 1:3 muscularis: mucosal ratio and thickening of the submucosal layer in most segments. Discreet masses are not identified. The wall of the distal descending colon is thickened (up to 0.75 cm) with retention of the normal layering pattern. There is no obvious 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

There is no evidence of free fluid. At least 2 prominent mesenteric **lymph nodes** are visualized, the largest measuring 0.95 cm in length. A few prominent lymph nodes are also visualized at the aortic trifurcation, the largest measuring 1.27 cm in length.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The small intestinal wall changes are suggestive of an inflammatory process (i.e., enteritis/inflammatory bowel disease). The colonic wall changes are also consistent with inflammation, with a lower possibility of emerging neoplasia.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- *An obvious cause for the patient's clinical signs is not identified in this study. Considerations include dietary indiscretion, acute hemorrhagic gastroenteritis, infectious/parasitic disease, food allergy/intolerance, inflammatory bowel disease, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Fecal evaluation for ova and Giardia, if not already performed
- Consider prophylactic deworming with fenbendazole
- Also consider a fecal PCR infectious disease panel.
- A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dl, an ACTH stimulation test is recommended.
- Given the recent history of regurgitation, consider thoracic radiographs to assess for esophageal disease and occult aspiration pneumonia.
- If the patient's clinical signs do not improve with aggressive supportive care, and the above diagnostics are inconclusive, GI biopsies (i.e., endoscopic, or surgical) may be necessary to get a definitive diagnosis.

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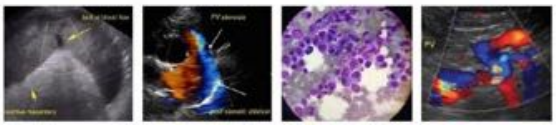

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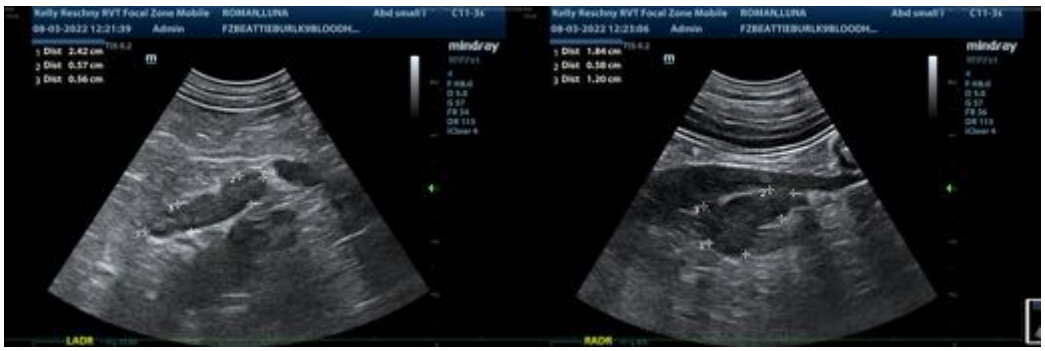

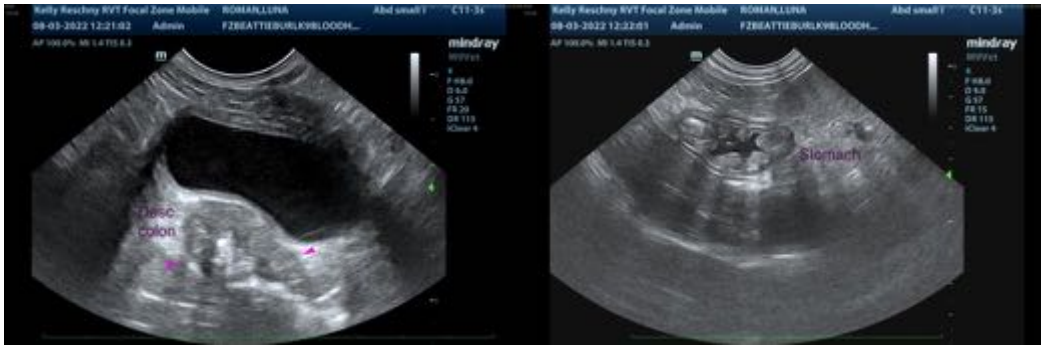

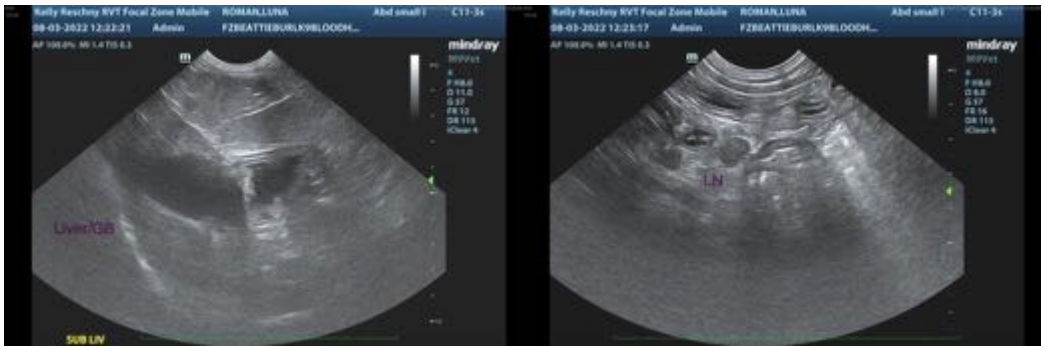

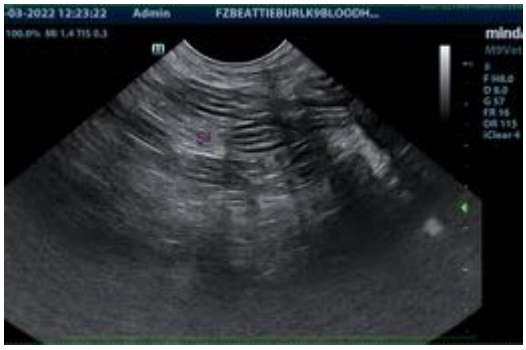

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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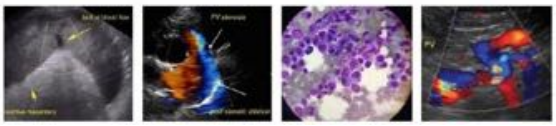

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