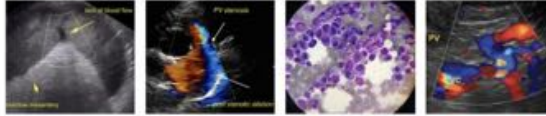


PATIENT
Isabella Kouris

SPECIES
Canine

BREED
German shepherd

SEX
Female, intact

AGE
7/15/2016

WEIGHT
8 lbs.

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

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

HOSPITAL NAME
Flowertown AH

REFERRING VET
Dr. Guffey

INVOICE
14673

DATE
3/1/23

PRESENTING CLINICAL SIGNS

Isabella is a 6.7yo German Shepherd, presents today for vomiting, not eating and diarrhea. O states P is also sometimes vomiting after eating as well. O states P started having diarrhea again last night (dark brown and very watery consistency) and has thrown up 2x since last night . O states P is otherwise doing well. O also states this has happened before and was brought in previously. Dr Guffey is recommending AUS. O understands and will move forward. Chronic GI signs: gas, episodic v/d, thing (No weight gain despite normal eating) Diarrhea since Sunday and vomiting/ lethargy since yesterday.

The dog is currently in heat.

Last bloodwork was show that Albumin levels were slightly low. (1/23/23)

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 (6.68 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 (4.39 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 (0.72 cm at cranial pole) (0.47 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.

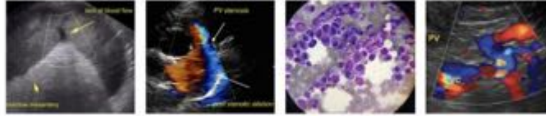
The right adrenal gland is normal size (0.80 cm at cranial pole) (0.47 cm at caudal pole); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (1.86 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



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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 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 minimally to mildly fluid distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is segmentally fluid distended (mild). The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. The lumen of the descending colon is moderately distended with diarrheic stool. No obvious obstructive disease is noted.

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 was no obvious evidence of free fluid. A few prominent mesenteric lymph nodes are visualized, the largest measuring 5.73 cm in length. The nodes are normal in shape and echogenicity. A 1.43 cm medial iliac lymph node is also seen.

Other

The uterus is prominent in size (1.73 cm in width) with a thickened wall. The left and right uterine horns are prominent in width (left 0.54 cm; right 0.86 cm). The ovaries are subjectively normal in size (left 2.65 x 0.94 cm; right 2.66 x 1.10 cm). Both contained follicles within the gland.

A brief echocardiogram reveals no evidence of pericardial effusion or obvious right atrial/auricular mass.

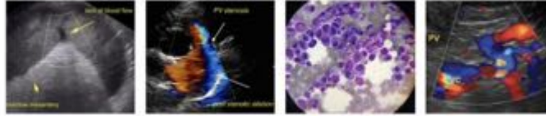
ULTRASONOGRAPHIC FINDINGS

- Diffuse gastrointestinal ileus and diarrheic stool, the cause of which is unclear. Differentials include primary gastrointestinal disease (i.e., motility disorder, food allergy, inflammatory bowel disease, infectious/parasitic disease), underlying metabolic issue, other.
- The ovary and uterine changes are as expected for a patient in heat.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The following diagnostics/treatment recommendations can be considered:

1. Serum cobalamin, folate, PLI and TLI
2. A fecal evaluation for ova/Giardia
3. Prophylactic deworming with Fenbendazole at 50 mg/kg once a day for 5 days is recommended. Repeat above protocol in 3 weeks.



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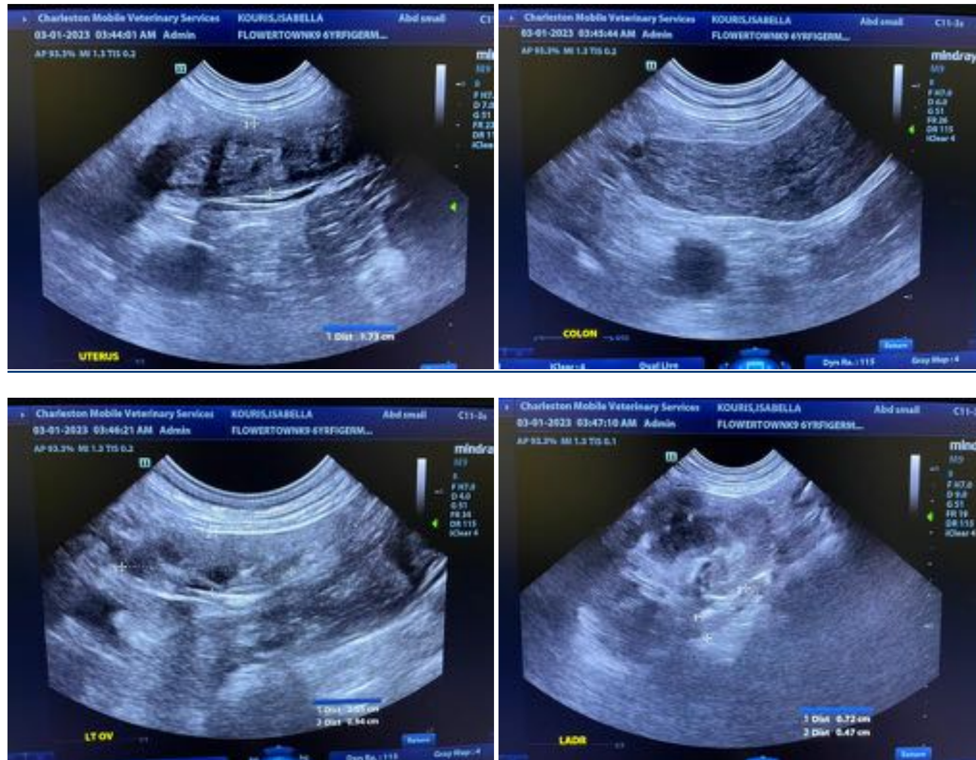
4. A 6-week limited antigen diet trial to assess for food allergies.

5. A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended.

6. Consider a 4-week course of Tylosin as empirical treatment for small intestinal bacterial overgrowth.

7. Initiation of a probiotic and fiber supplement may also prove beneficial.

8. Depending on the results of the above diagnostics/therapeutics, endoscopic or surgical gastrointestinal biopsies may be warranted. Three-view thoracic radiographs should be performed prior to any anesthetic event.



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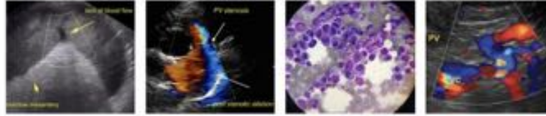

Charleston Mobile Veterinary Services

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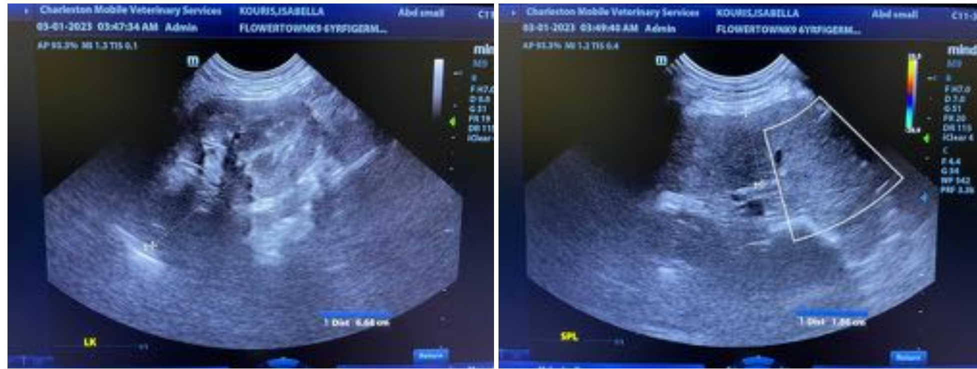

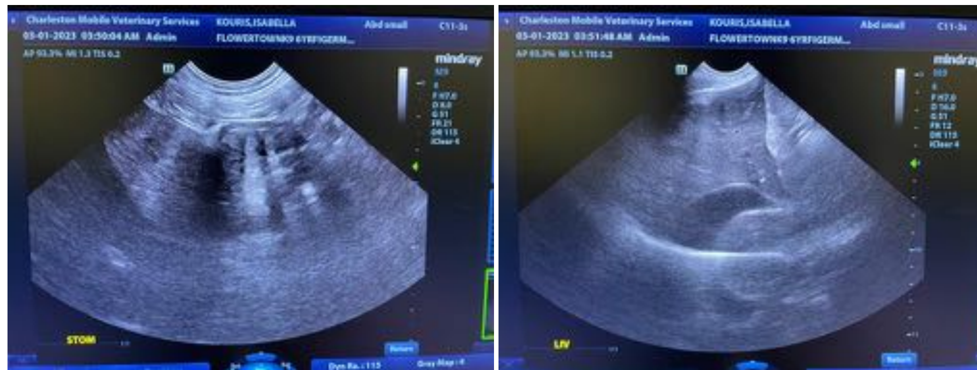

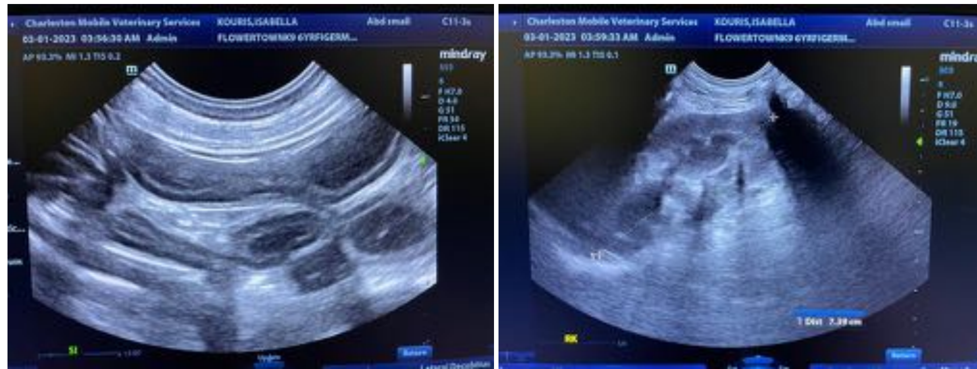

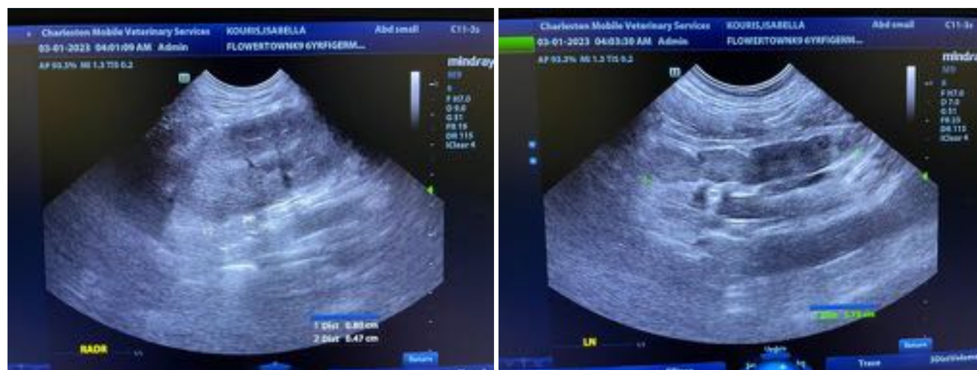

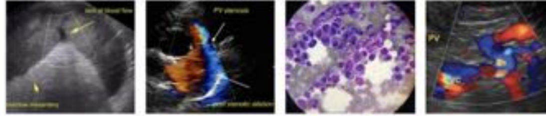

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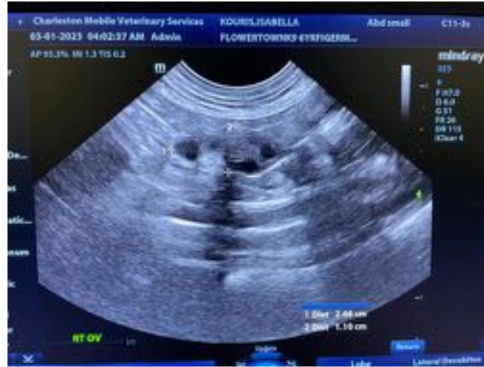

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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