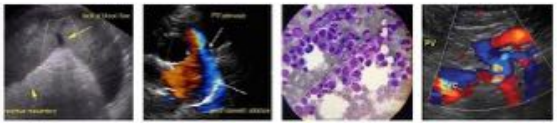


PATIENT

Rose Kanalas

SPECIES

Canine

BREED

Canine

SEX

Female, intact

AGE

4 Yrs.

WEIGHT

7 kg.

INTERPRETED BY

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

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Beatties PH Stoney Creek

REFERRING VET

Mellish/Ruggieri

DATE

13871

PRESENTING CLINICAL SIGNS

History: QAR, CRT<2S, MM pale pink, tacky gums Vomiting after E/D anything since last week. Unable to keep down a meal. O has to give small amount of water otherwise P will vomit afterwards. Confirmed vomiting and not regurgitation according to what O described Was at regular DVM last Monday for diarrhea. O mentioned seeing black tarry stools before seeing rDVM. Started about 2 weeks ago. Diarrhea has since resolved and no further melena seen rDVM gave an injection on Monday for pain/inflammation, asked if it was Metacam, O thinks so. O said since seeing rDVM, P got worse. Vomiting and not eating started afterwards P is intact female. Last heat cycle was in December according to O Moderate muscle wastage along spine, hips. Underweight Urinary/Reproductive: No discharge from vulva. Confirmed with Tech that she has not eaten today prior to scan. Mirtazapine 15mg PO SID Sucralfate 1.25ml PO BID, Cerenia inj, IVF.
Abnormal PE/Chem/CBC/UA Results: CBC: Mod. non-regenerative anemia (HCT 24.7%, RBC 5.29, HGB 9.7), mild neutrophilia (12.71) Electrolytes, Chem: Mild azotemia (creat 206, Urea 18.9), hyponatremia (130), hypokalemia (3.4), hypochloremia (88) cPLI: Normal Urine analysis: SG 1.016

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 mostly anechoic urine. No masses, inflammatory changes or calculi are observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The left kidney is normal size (4.69 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 (4.94 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 (0.44 cm at cranial pole) (0.42 cm at caudal pole) (1.63 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.

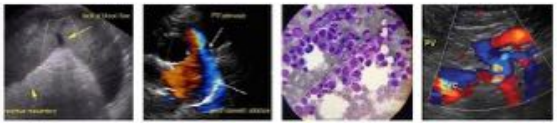
The right adrenal gland is normal size (0.52 cm at cranial pole) (0.53 cm at caudal pole) (2.33 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (1.07 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 gallbladder 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.

Gastrointestinal

The gastric lumen is not distended. The gastric wall thickness is difficult to determine due to excessive rugal folds. The pylorus is mildly thickened (up to 0.77 cm) with retention of the normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. The colonic wall is normal. No 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 is no evidence of free fluid. The abdominal lymph nodes are normal/not visible.

Other

The uterine body is visible and is normal in size (0.63 cm in width). No obvious pathology is seen.

The left ovary measures 0.91 x 0.66 cm and is subjectively normal in size and shape with homogeneous parenchyma. No obvious pathology is observed.

ULTRASONOGRAPHIC FINDINGS

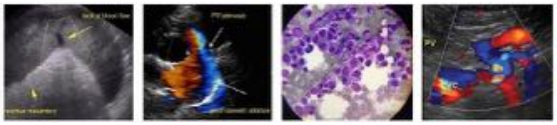
- The pyloric thickening may be secondary to inflammation, hypertrophy or less likely, emerging neoplasia.

*An obvious cause for the patient's clinical signs is not identified in this study. Considerations include microscopic gastrointestinal disease (i.e., dietary indiscretion/gastroenteritis, infectious/parasitic disease, food allergy/intolerance, inflammatory bowel disease), underlying metabolic issue (i.e., hypoadrenocorticism), mild pancreatitis, other.

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



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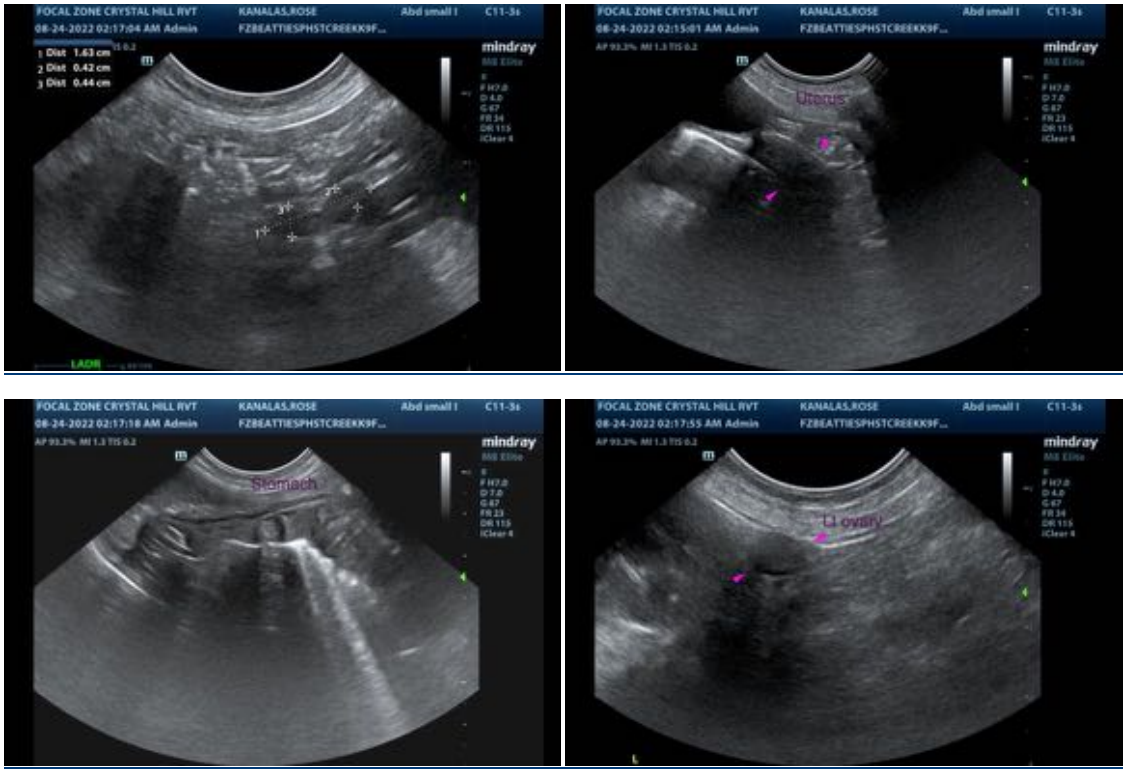
5. Consider a 4-week course of Tylosin as empirical treatment for small intestinal bacterial overgrowth.
6. A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended.
7. Also consider three-view thoracic radiographs to assess for occult esophageal disease.
8. Depending on the results of the above diagnostics/therapeutics, endoscopic or surgical gastrointestinal biopsies may be warranted. Endoscopy may be preferred in that the upper GI tract can be evaluated for evidence of ulceration.

- Empirical treatment for gastric ulceration (i.e., proton pump inhibitor, Sucralfate for 10-14 days) is recommended while awaiting test results.
- Serial monitoring of the patient's PCV is also recommended to evaluate for worsening anemia.



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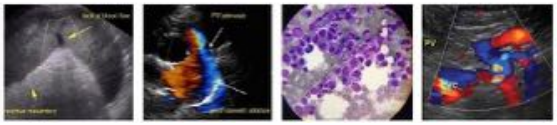

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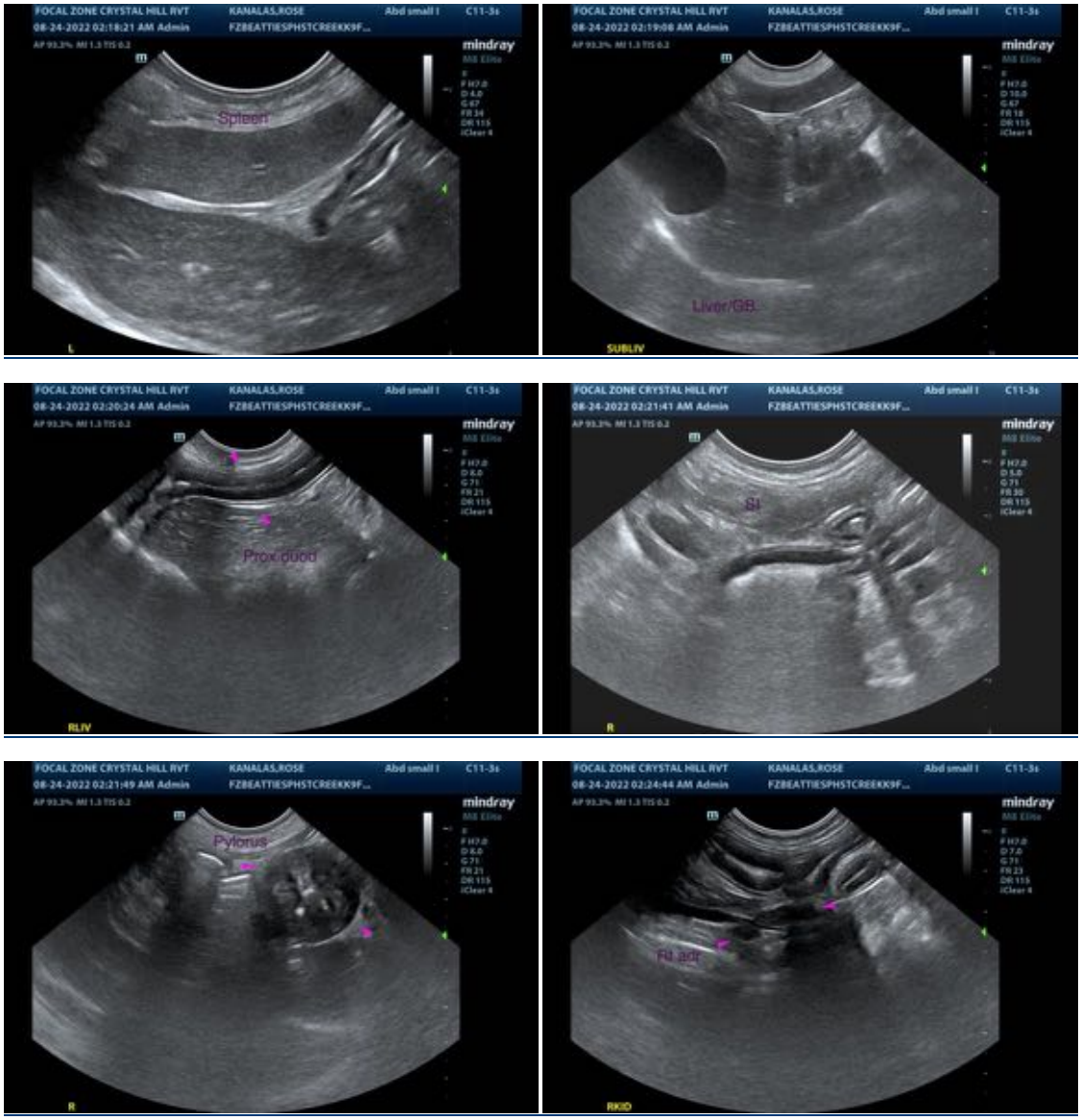

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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