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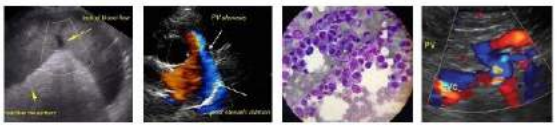


THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT
Biscuit Baxter

SPECIES
Canine

BREED
French Bulldog

SEX
Male Neutered

AGE
3 Years

WEIGHT
13.5 kgs.

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

IMAGING PERFORMED BY
Crystal Hill

HOSPITAL NAME
Grand River Veterinary Hospital

REFERRING VET
Dr. Robinson

INVOICE
11834kk

DATE
9/16/21

PRESENTING CLINICAL SIGNS

History: -Apr 2021- tx for UTI with Clavaseptin, was fed RAW at that time. Recheck u/a at 2wk showed no bacteria but cells to additional 2wk of antibiotics -5/13/2021- switched to Urinary s/o d/t high USG (1.075) at recheck u/a -6/17/2021- switched to Urinary s/o canned since USG still high at 1.036 and struvite crystals present --7/19/2021- started on Zylkene (mild protein) since he was become aggressive with a child 8/16/2021-presented with diarrhea as pruritis- licking feet- interdigital skin quite pink - added Apoquel and metronidazole, and added Trazodone 4 days later- - presented 8/24/21- diarrhea resolved but poor appetite and mild lethargy- bloodwork normal; switched to canned RC Gastro Mod Calories and stopped Apoquel and trazodone, metronidazole finished.- appetite improved but presented 9/15/2021- still poor appetite, some soft stools, vomited for 4 days in a row, lethargic. Some stools over the past month have been tarry black. Seemed to be mild improvement with appetite and demeanor on 5d course of sulcrate last week but relapsed. Cerenia, Famotidine and Sulcrate. Dog was lightly sedated with Dexdomitor and Torb for the procedure.

Abnormal PE/Chem/CBC/UA Results: Mild elevation in ALT 4/21- but normal 8/24/21 -mild elevation in Urea 10.0mmol/L (2.5-9.6) on 8/24/21 but was eating only turkey sausage at that time.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are 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 prostate is normal in size (1.11 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal size (4.87 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 (4.24 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.

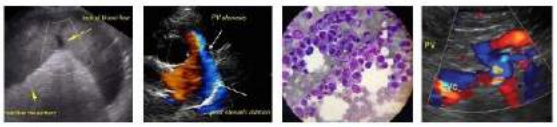
Adrenal Glands

The left adrenal gland is normal size (0.36 cm at cranial pole) (0.44 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.

The right adrenal gland is normal size (1.01 cm at cranial pole) (0.50 cm at caudal pole) (1.86 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 (2.09 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



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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. The portal vein to caudal vena cava ratio is approximately 1:1. 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 not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. In the proximal duodenal wall, there is evidence of mucosal striations. The small intestinal lumen is not dilated. 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. A few prominent mesenteric lymph nodes are observed with the largest measuring 1.11 cm in length. In addition, a 1.31 cm sublumbar lymph node is seen.

ULTRASONOGRAPHIC FINDINGS

- The mucosal striations are suggestive of small intestinal disease, particularly lymphangiectasia.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

1. A malabsorption panel including 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 resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended.
5. Consider initiation of a low-fat, hypoallergenic diet trial.
6. Depending on the results of the above diagnostics/therapeutics, endoscopic or surgical gastrointestinal biopsies may be necessary to get a definitive diagnosis.
7. Three-view thoracic radiographs should be performed prior to any anesthetic event to evaluate cardiopulmonary status.

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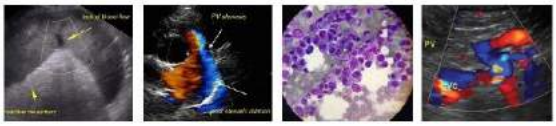

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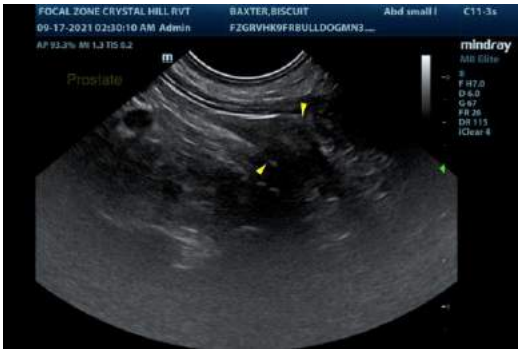

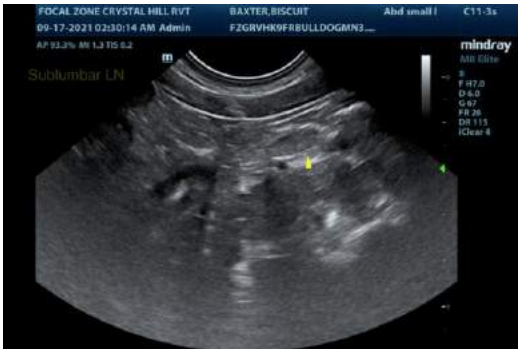

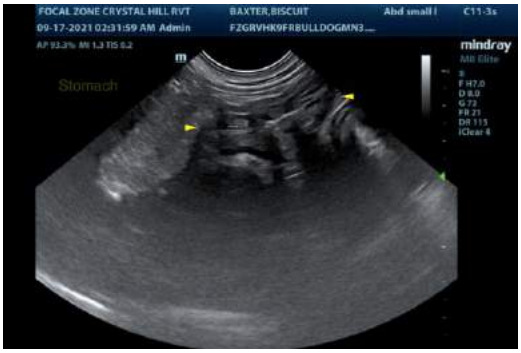

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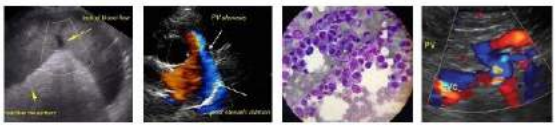

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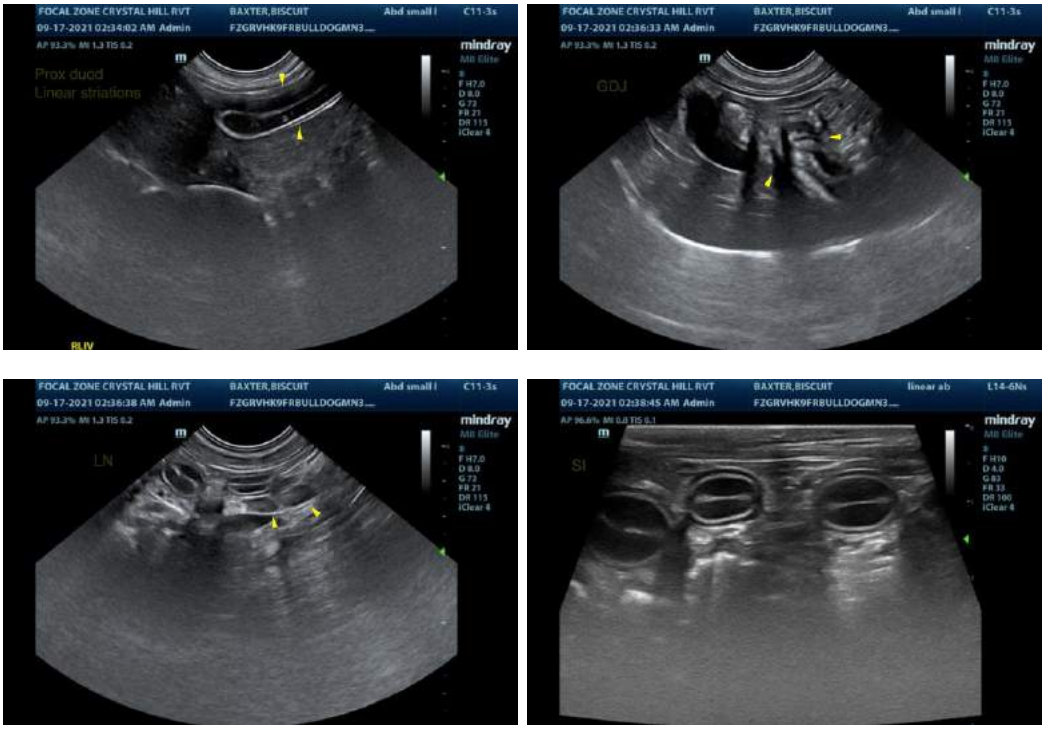

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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