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Clinical Sonography & Telecytology
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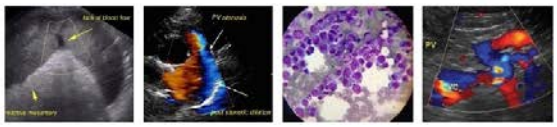


THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Zack Jack

SPECIES

Canine

BREED

Poodle X

SEX

Neutered Male

AGE

8 Years

WEIGHT

3.7 kg

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

BPH Stoney Creek

REFERRING VET

Dr. Mellish

INVOICE

44616

DATE

1/30/23

PRESENTING CLINICAL SIGNS

Presented 01/25 for anorexia, shaking, drinking a lot, inappropriate urination and not having a BM NSF on PE and P ate treats in exam room Sent home with antibiotic and anti-inflammatory. Presented again on 01/27 for blood from hind end and still anorexic Ruptured anal gland on PE and spot check BG is 2.6 P was admitted to hospital for hypoglycemia and ruptured anal gland. P has been on Dextrose CRI, will eat cooked chicken only (has always been picky with food), and has been mildly hypothermic for most of his stay and has been on heat support. A few hours ago, P was taken off heat support and is currently maintaining temperature, attempted to wean off Dextrose CRI but BG dropped to 2.9 and it was re-started. Current Medications Dextrose, Baytril, Gabapentin

Abnormal PE/Chem/CBC/UA Results: K 3.3, HCT 4.38, PCV 35, HGB 11.2, WBC 16.8, NEUT 13.58, PLT 142, MPV 14.4 Random cortisol was normal Radiographs: No lesion is detected in the thorax. No lesion is identified in the abdomen. However, significant intra-abdominal organ lesions or dysfunctions could be underestimated based on survey radiographs due to limited sensitivity. There is intervertebral disc disease from L2-L5 and possibly at L5-6. However, survey radiographs often have limited accuracy to determine if or where spinal cord or nerve root compression is present. Additionally, other spinal lesions such as intradural or intramedullary lesions cannot be excluded based on survey radiographs.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The area of the prostate is examined without evident prostatic pathology noted.

The right kidney is normal in size (3.71 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal in size (3.56 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

The right adrenal gland is normal in size (1.38 cm long x 0.94 cm at the cranial pole and 0.41 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

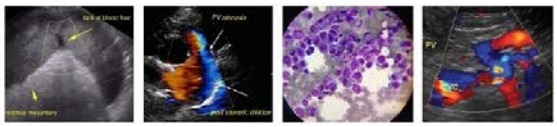
The left adrenal gland is normal in size (1.45 cm long x 0.44 cm at the cranial pole and 0.41 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and



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homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is moderately distended with anechoic bile as well as mild suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The pancreatic parenchyma is appropriately isoechoic to surrounding tissue. Visible capsule is smooth and normal in contour. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is no evidence of free peritoneal effusion noted in these images.

There is no apparent lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- **Mild gallbladder debris -** Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is no ultrasonographically definitive reason for this patient's reported hypoglycemia.

Given the patient's signalment/size, hypoglycemia could simply be the result of prolonged anorexia, in which case appetite stimulants and/or even a feeding tube placement may be necessary while figuring out the underlying cause for anorexia. However, if hypoglycemia is persisting beyond resuming normal appetite, recommendations include bile acids for further assessment of liver function as well as a paired insulin to glucose ratio at a time not on Dextrose supplementation when the blood glucose is <50 if possible.

Additionally, in the meantime, empirical deworming with a 5-day course of Panacur is recommended. If there is any other indication of sepsis from the anal gland abscess that could be resulting in hypoglycemia, more aggressive management of the abscess, including potentially an anal gland removal, may be warranted.

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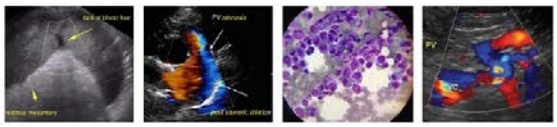

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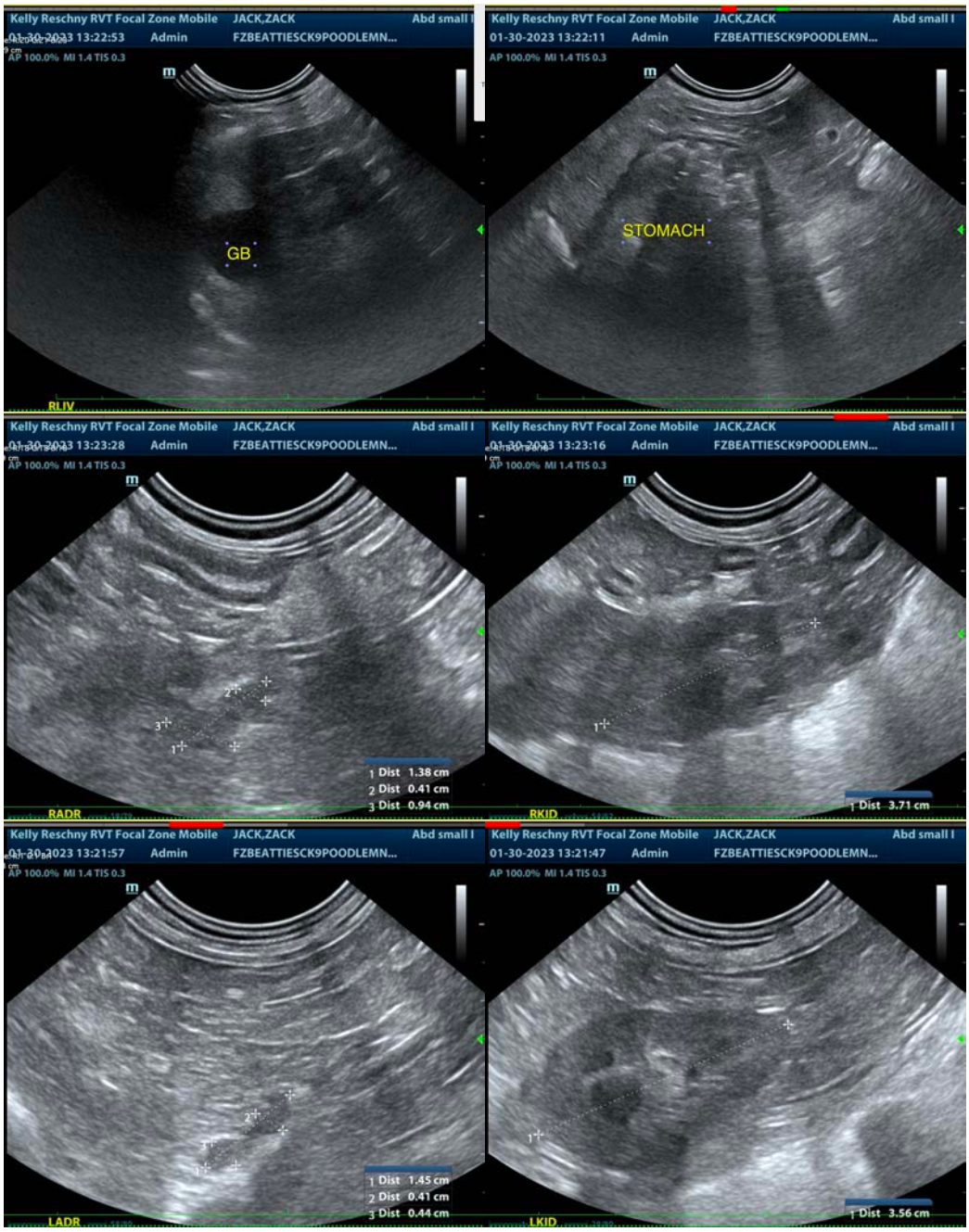

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM
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