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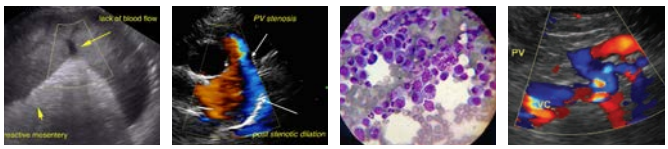

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1-800-838-4268 info@sonopath.com

PATIENT
Phoebe Namniuk

SPECIES
Canine

BREED
Shih Tzu/Maltese

SEX
Spayed Female

AGE
10 Years

WEIGHT
15.8 Pounds

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Dr. Jessie Evoniuk

HOSPITAL NAME
State Ave Vet Clinic

REFERRING VET
Dr. Jessie Evoniuk

INVOICE
44695

DATE
2/2/23

PRESENTING CLINICAL SIGNS

Phoebe was normal earlier this afternoon; when O got home from work she was hacking some; she threw up; there was still some food from the day before; O took for a walk; she passed normal feces; then she seemed to be posturing and some liquid came out; she sounds like she is wheezing; after coming back from her walk she seemed to be using her hind end and abd to gag; she did eat supper; able to swallow normally; she drank water and then she hacked and regurgitated the water; no meds; no travel Hx; groomed 2 weeks ago; no C/S; no changes in food BAR; p/m mm; CRT 1-2s; no mur/arrh; upper resp stridor/congestion; hard to auscult lungs; no cough or abns on laryngeal or tracheal palpation; grunting on abd palp; tense on abd palp; T-102.7F; ears, LNs WNL; pulled blood; adm cerenia SQ, buprenorphine SQ, dexamethasone IM Return visit: Was a bit loopy after Buprenorphine but improved thru the night. Upper airway noise resolved. Didn't offer treats as would normally. No further gagging/vomiting. Seems more comfortable in the abdomen. PE Eyes mild mucoid discharge. Ears clear. Teeth G2. Tongue out as normal. H.L WNL. T 102. And full but no overt grunt or pain. Soft airway noise with palpitation of the throat/laryngeal area. DIsc resolution. RO reflux/gag vs pancreatitis vs other. Hx of bladder stones.

Abnormal PE/Chem/CBC/UA Results: WBC 17.76, NEU 14.34, RBC 8.97, HGB 23.1, HCT 60.73, MCH 25.7, ALT 248

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended with primarily anechoic contents and occasional echogenic non-shadowing debris. Some of the debris is mineral in appearance. There is at least one small cystoliths that measures 0.26 cm. Apical urinary bladder wall is diffusely thick (0.58 cm). Mucosa is hyperechoic and irregular. No masses observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface.

The right kidney is normal in size (4.37 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 or infarcts observed. Small non-obstructive nephroliths noted.

The left kidney is normal in size (4.1 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 or infarcts observed. Small non-obstructive nephroliths noted.

Adrenal Glands

The caudal pole of the right adrenal gland is normal in size (0.44 cm). The cranial pole is not able to visualized in these images.

The left adrenal gland is normal in size (0.41 cm at the caudal pole and 0.50 cm at the cranial pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

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). Multifocal well-demarcated hyperechoic homogenous nodules are noted. Splenic vasculature appears normal.

Liver

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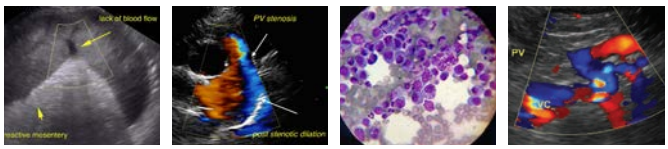

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The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. 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 stomach is moderately distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. However, given the reported history of fasting, delayed gastric emptying could be considered. Soft (cloth) fluid absorbing foreign material is considered less likely but cannot be definitively ruled out. If clinical signs are consistent (vomiting, etc.), recommendations include supportive medical care, 24 hours fasting and re-image.

The visible small intestines are normal in wall thickness and layering (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with 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

- Urinary bladder debris and at least one small cystoliths
- Small non-obstructive nephroliths bilaterally
- **Hyperechoic splenic nodules –** most consistent with benign myelolipomas. Other differentials such as fibrosis or calcification caused by old hematomas or infarcts, chronic inflammation, granulomatous disease or metastatic disease cannot be ruled out, but are considered less likely.
- **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.

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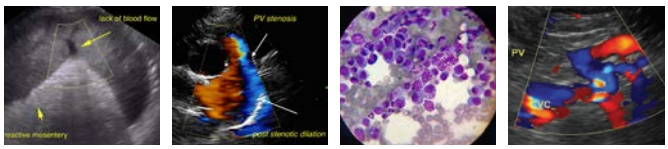

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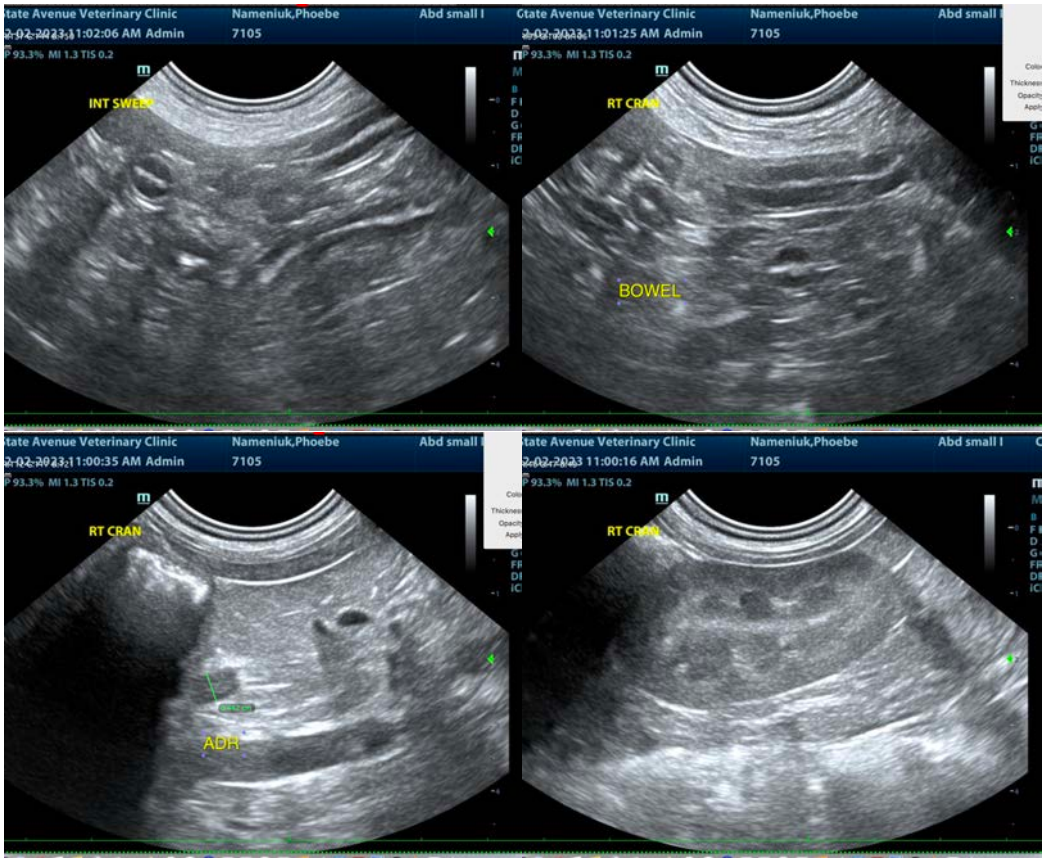
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is not an ultrasonographically obvious explanation for this patient's reported gastrointestinal signs in these images. Given the patient's improvement in clinical signs, recommendations include continued supportive/symptomatic medical management until the patient is back to normal, followed by recheck bloodwork at that time. If liver enzymes are still increased, testing for Leptospirosis would be indicated +/- liver sampling, beginning with a fine needle aspirate of the liver if patient's coagulation status is appropriate, depending on how high the ALT is.

If gastrointestinal signs return and/or become chronic, a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

In the meantime, empirical deworming with a 5-day course of Panacur is recommended if not already in place, in addition to the supportive care being administered.



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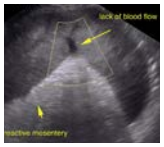
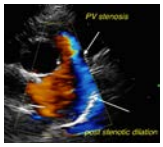
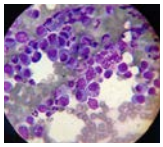
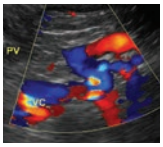

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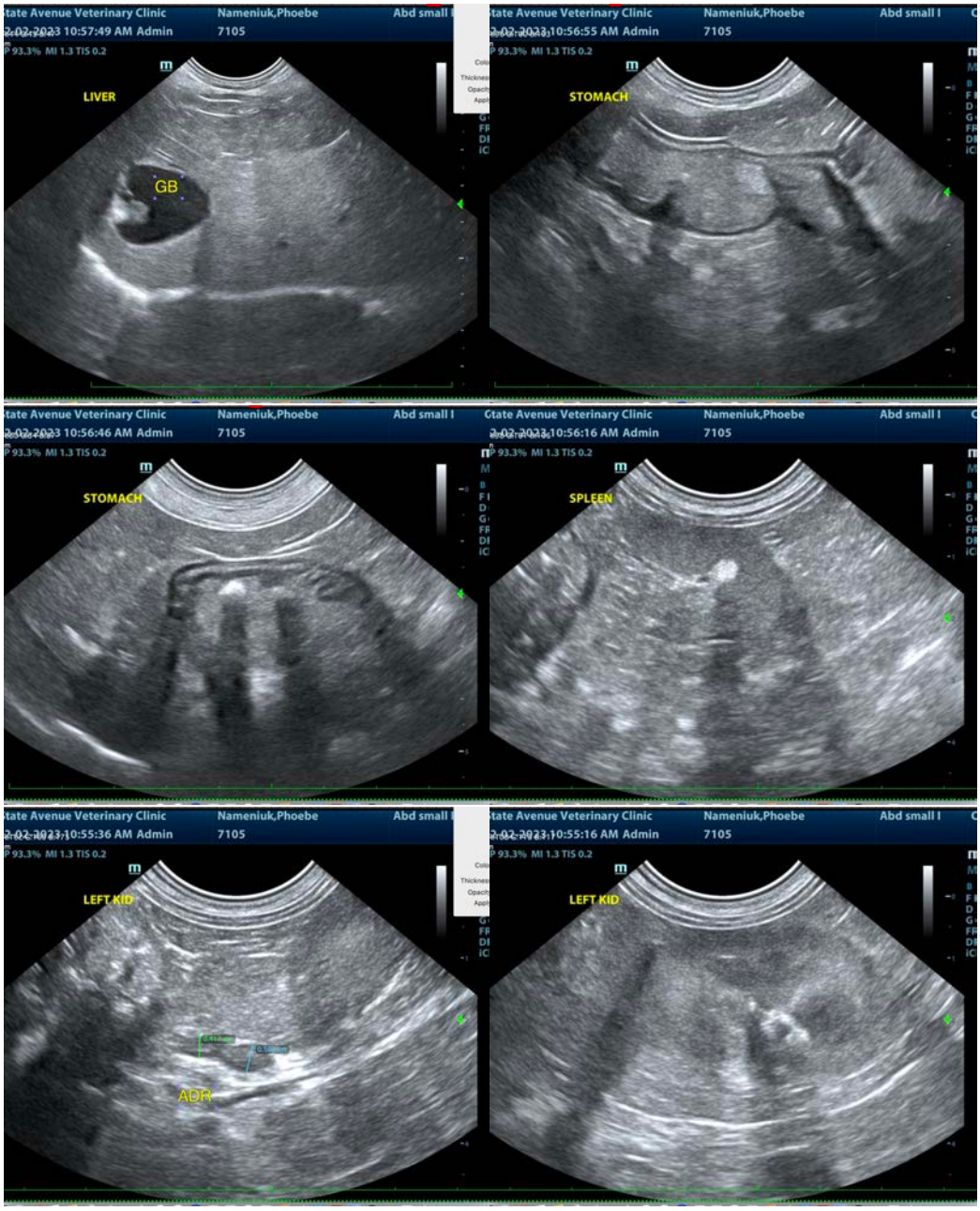

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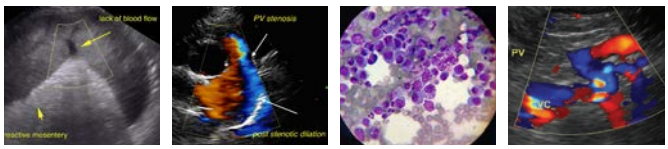

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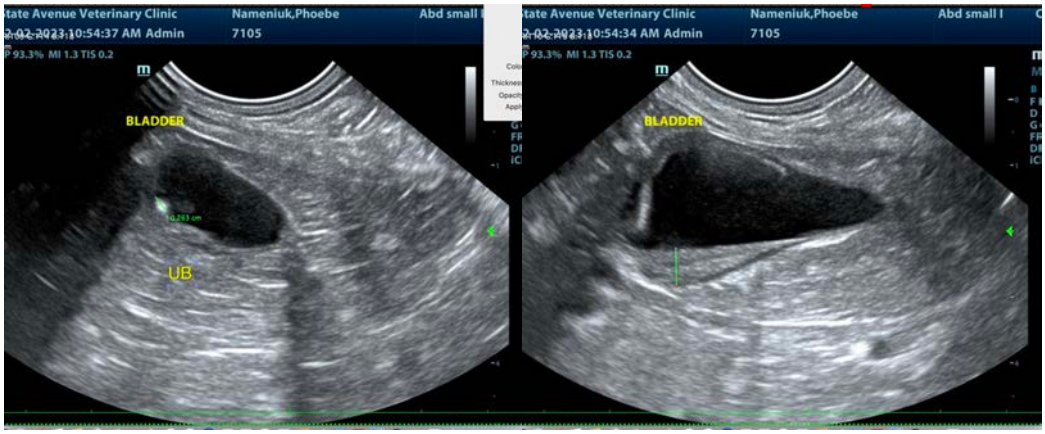

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
Beth.Johnson@sonopath.com