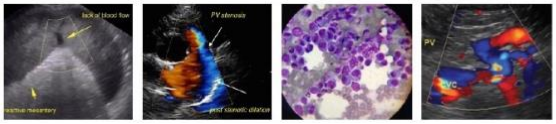


PATIENT

Odie Lanille

SPECIES

Canine

BREED

Maltese

SEX

Intact Male

AGE

8 Years

WEIGHT

3.9 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

Beattie PH Burlington

REFERRING VET

Wittenrich

INVOICE

21014

DATE

2/6/23

PRESENTING CLINICAL SIGNS

History: Chronic vomit of undigested food even 4 hours after eating, foul smelling liquid diarrhea. Only eats real foods not dog foods. Mild diffuse abdominal discomfort progressing to mod pain caudal. Fluid and gas-filled loops Musculoskeletal: Generalized wasting Current Medications forti flora , sucralfate , metronidazole, cerenia inj., GI food , SC Fluids

Abnormal PE/Chem/CBC/UA Results: low protein, anemia, high normal WBC's neutrophils, monocytes.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately 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 visible prostate appears normal for an intact dog.

Left kidney is normal is size (4.46 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.

Right kidney is normal is size (4.52 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

Left adrenal gland is normal in size (1.63 cm long x 0.4 cm at cranial pole and 0.49 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (1.96 cm long x 1.23 cm at cranial pole and 0.58 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

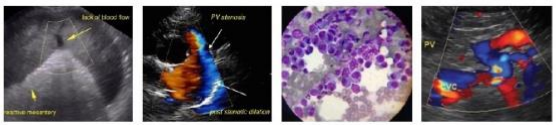
Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

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 non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal



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The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines is diffusely thick, measuring between 0.6 cm and 0.7 cm thick with diffuse marked hyperechoic mucosal fogging or speckling noted, almost to the degree of resulting in some loss of normal layering. Small intestinal hyperperistalsis is noted. The lumen is empty with no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is moderately distended with liquid stool.

Pancreas

The observed pancreas appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is a small amount of anechoic free fluid, as well as diffusely enhanced hyperechoic mesenteric fat throughout the abdomen. There is no apparent lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

- Marked Mucosal speckling – Mucosal speckling is often present with inflammatory bowel disease (IBD). It is not specific for type or severity of disease. Mild speckling change can occur as a normal patient variant in the post-prandial state. The diffuse thickness supports an infiltrative process, as is seen with inflammatory bowel disease and likely secondary protein losing enteropathy given this patients reported hypoalbuminemia.
- The free fluid is likely secondary to hypoalbuminemia

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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.

Ideally, biopsies of the GI tract are recommended to definitively diagnose and therefore manage the infiltrative bowel process.

If biopsies cannot be obtained safely due to low albumin or patient stability, etc., empirical therapies could include diet change to an ultra-low fat diet, empirical deworming with a 5 day course of Panacur, cobalamin supplementation (unless cobalamin level is evaluated and supplementation is not warranted) a probiotic and prednisolone (if not contraindicated based on patient contraindications, co-morbidities, etc.). Calcium monitoring, and supplementation if necessary, is also recommended.

If not recently evaluated, to rule out concurrent proteinuria as a cause of the hypoalbuminemia, urinalysis and, if indicated based on urinalysis results, urine culture are recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

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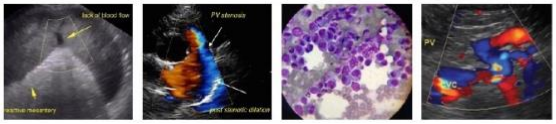

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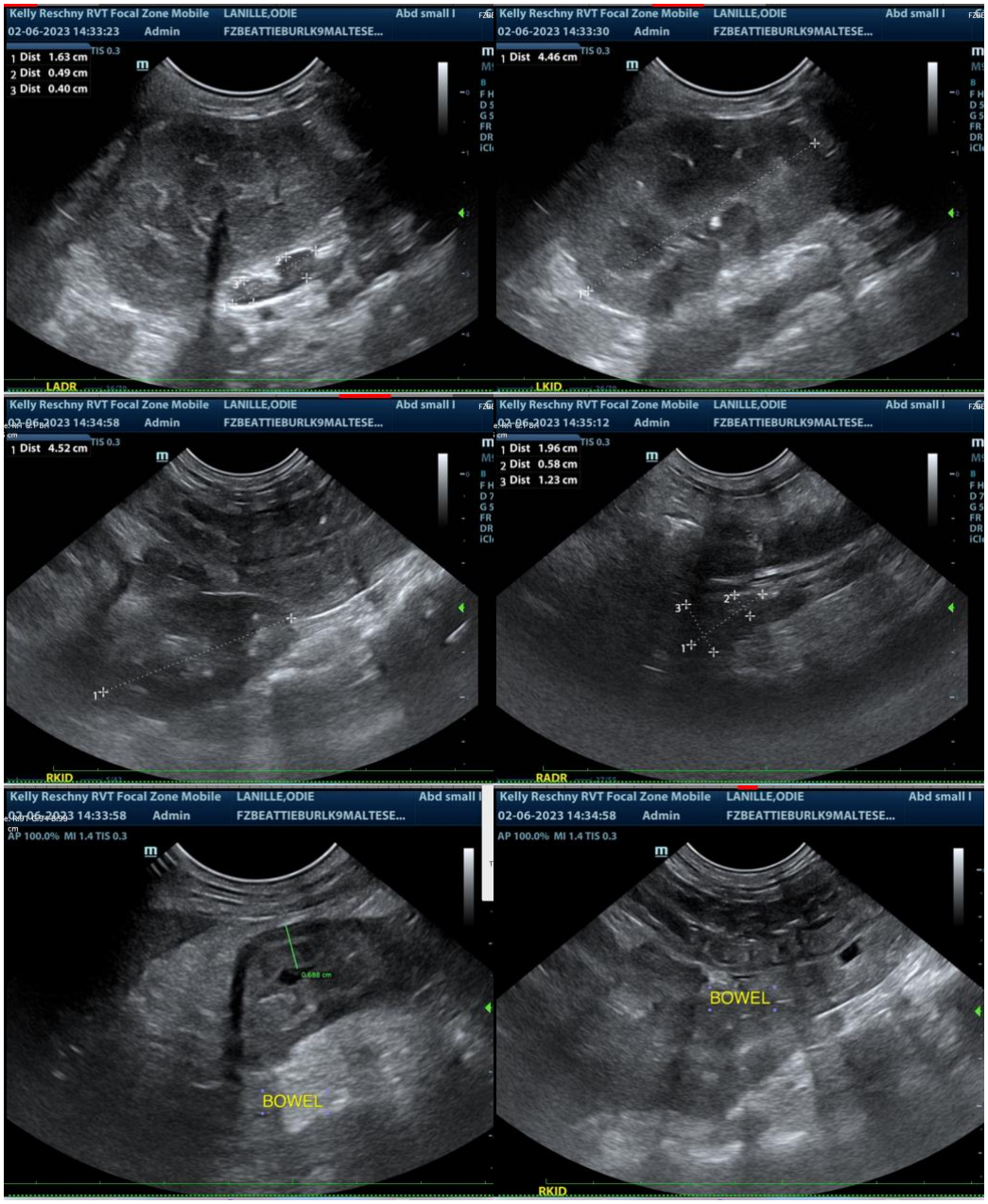

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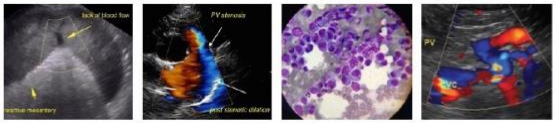

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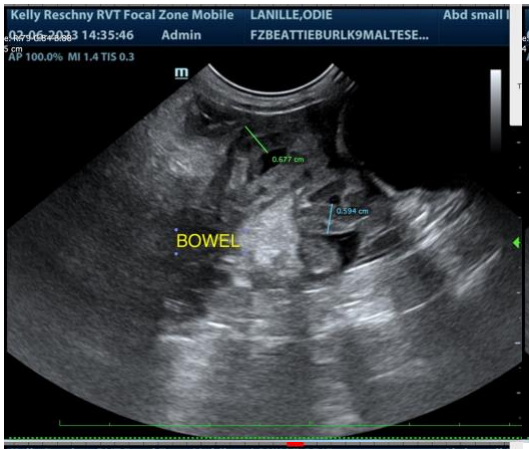

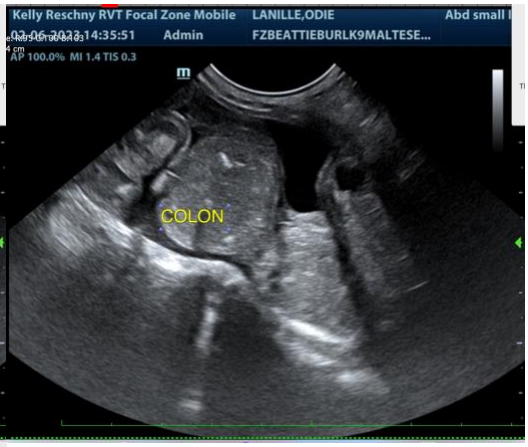

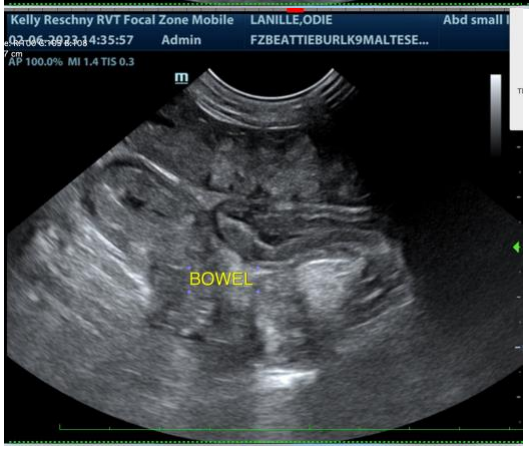

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM DACVIM

Beth.Johnson@SonoPath.com