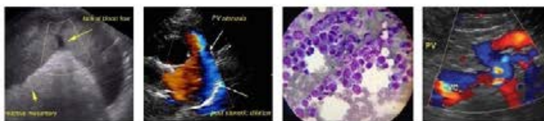


PATIENT
Buddy Desouza

SPECIES
Canine

BREED
Coton de Tulear

SEX
Neutered Male

AGE
10 Years

WEIGHT
5.74 kg

INTERPRETED BY
Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY
Kelly Reschny

HOSPITAL NAME
Graham AH

REFERRING VET
Dr. Lukacs

INVOICE
46648

DATE
4/13/23

PRESENTING CLINICAL SIGNS

Recurrent episodes of vomiting, (hemorrhagic) diarrhea, hyporexia since dog was a young adult; episodes occurring more frequently in last 6-12 months. Responds to symptomatic management (fluids, cerenia, metronidazole or tylosin). Due to patient's picky appetite, compliance with a strict food trial has been difficult. Owner has given home cooked mostly. Switched to Hills i/d in last 3-4 weeks. Episodes usually start as small/frequent diarrhea, with tenesmus, and may progress to hemorrhagic diarrhea (blood and mucous), vomiting and hyporexia. Most recent episode March 3/23, presented for 3 day history of diarrhea, progressing to vomiting multiple times in 24 hours, blood tinge to last vomit, and hematochezia. PE: M2 dehydration, vitals WNL, mild abdominal pain on palpation. BCS 4/9, rest of PE NSF. Treatment: SQF q12h x 1d, cerenia 16 mg PO q24h x 4d, tylosin 100 mg PO q12h x 14d; sucralfate 3 mL PO q12h x 10d; Fortiflora probiotic; switch to Hills i/d food Improvement noted within 24 hours. Recurrent, milder episode March 28/23, intermittent diarrhea, no blood in stool, signs of nausea, hyporexia - Treatment: Proviable DC probiotic daily; cerenia 16 mg PO q24h x 8d Patient has continued on Hills i/d food and Proviable probiotic. Patient may get some cooked turkey and rice as well to tempt to eat. Current Medications Proviable DC probiotic daily

Abnormal PE/Chem/CBC/UA Results: Most recent diagnostics 3/5/23: -aFAST: no abdominal free fluid – CBC: HCT 60% - Biochemistry: Amylase elevated 1968 U/L; CREA low 38 µmol/L – PT/PTT WNL

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 pathology.

The right kidney is normal in size (4.2 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. A hyperechoic band parallel to the corticomedullary border is present.

The left kidney is normal in size (4.35 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. A hyperechoic band parallel to the corticomedullary border is present.

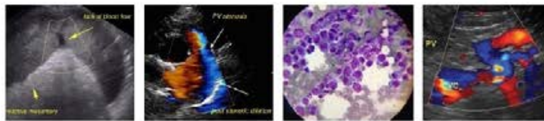
Adrenal Glands

The right adrenal gland is normal in size (1.58 cm long x 1.13 cm at the cranial pole and 0.25 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 (1.36 cm long x 0.45 cm at the cranial pole and 0.51 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). A 1.0 cm x 0.80 cm hypo- to anechoic nodule is noted at the tail of the spleen, resulting in a mild capsular bulge. Splenic vasculature appears normal.



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

The 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

The stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) 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 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.

There is no evidence of heart base or pericardial pathology noted in these images at this time. If cardiac function evaluation is desired a full echocardiogram is recommended.

ULTRASONOGRAPHIC FINDINGS

- **Subtle bilateral medullary rim sign –** This finding is of unknown clinical significance and can be a normal variant, often idiopathic. Medullary rim sign can be present with renal disease including FIP, lymphoma, hypercalcemic nephropathy, Leptospirosis, tubular disease, other and should be interpreted in combination with other more specific indications of kidney disease such as isosthenuria, proteinuria, azotemia, etc. This is a common incidental finding in patients with diabetes mellitus.

- **Splenic nodule –** Likely represents a benign lesion such as a cyst, hematoma, nodular hyperplasia, extramedullary hematopoiesis, etc. However, infiltrative neoplasia can mimic benign lesions and cannot be ruled out.

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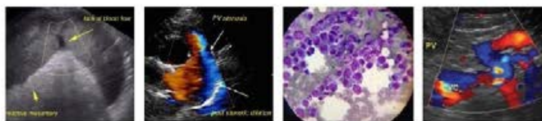

THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

A fecal exam is recommended if not recently evaluated.

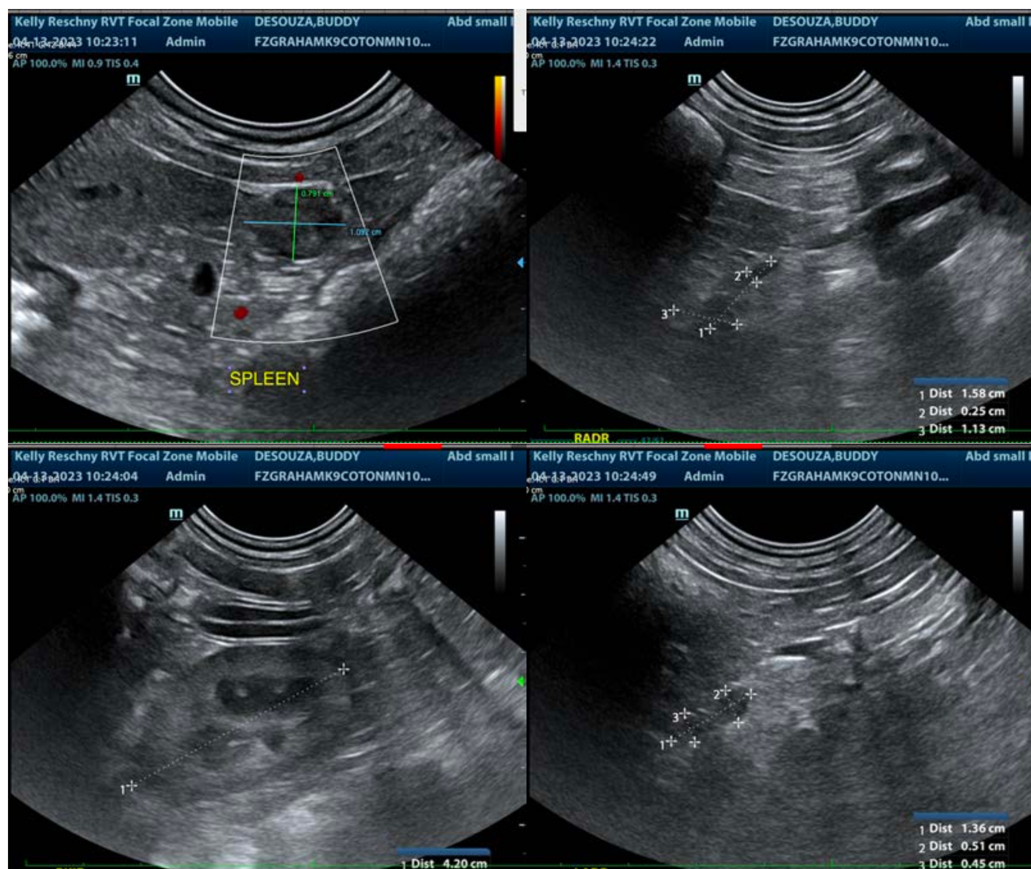
A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease.

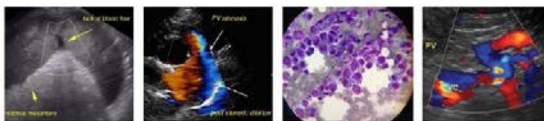
A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

Additionally, a fine needle aspirate of the spleen could be considered if patient's coagulation status is appropriate.

In the meantime, supportive/symptomatic medical management of clinical signs is recommended in the form antiemetics, gastroprotectants including sucralfate, a probiotic such as Visbiome or Proviable, empirical deworming with a 5-day course of Panacur +/- Tylosin, and if tolerated, a short-term course of a bland, easy to digest or potentially fiber responsive diet. An appetite stimulant may be necessary to help stimulate tolerance of the new diet.

Ultimately, however, if clinical signs persist and a diagnosis is not reached, further evaluation of the GI tract via upper and lower endoscopy/colonoscopy for both visualization and biopsies may be warranted.





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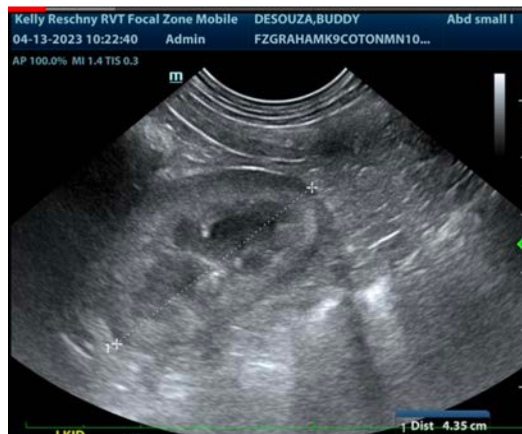

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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