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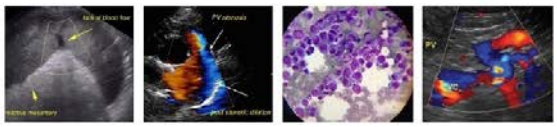


THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Maggie Shaw

SPECIES

Canine

BREED

Min Poodle

SEX

Spayed Female

AGE

14 Years

WEIGHT

6.5 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

BPH Stoney Creek

REFERRING VET

Dr. Mellish

INVOICE

47252

DATE

5/9/23

PRESENTING CLINICAL SIGNS

Chronic recurrent diarrhea with blood and potential tissue sloughed in BM. Very strange mucoid consistency to stools. Fecal testing WNL and NSF on PE. Has been on Clavaseptin, metronidazole and Fortiflora.

Abnormal PE/Chem/CBC/UA Results: Lymph low, PLT quite low 43(148-484), PCT low 0.06(0.14-0.46)ALKP M1 elevation. Urine sp. Grav – 1.029, Protein 30mg/dl, blood 250ery/ul, WBCs greater than 50/hpf, RBCs 31/hpf, Rods present.

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.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of mineral or infarcts observed. The left kidney measures 4.01 cm. The right kidney measures 4.2 cm. Pyelectasia measuring 0.20 cm in the sagittal view is noted in the right kidney.

Adrenal Glands

The right adrenal gland is normal in size (1.39 cm long x 1.21 cm at the cranial pole and 0.61 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 (1.32 cm long x 0.60 cm at the cranial pole and 0.54 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

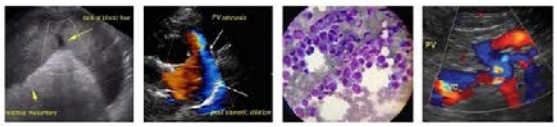
Spleen

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

Liver is subjectively enlarged (swollen contour) without disruption of architecture. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen and falciform fat. 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.



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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.

ULTRASONOGRAPHIC FINDINGS

- **Hyperechoic hepatomegaly -** This appearance is non-specific and most consistent with a benign steroid (endocrine) or vacuolar hepatopathy or reactive or idiopathic hepatopathy. Inflammatory and/or infiltrative disease (such as round cell neoplasia) are also possible, but considered less likely.
- **Age related kidney changes with mild left kidney pyelectasia –** Differentials for pyelectasia include pyelonephritis, diuresis, congenital malformation or ureteral or lower urinary tract obstruction.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

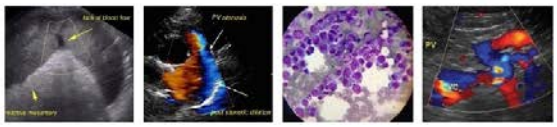
This patient's reported thrombocytopenia is not subjectively believed to be low enough to contribute to the ongoing hemorrhage reported in this patient. However, it could be contributing at least partially. Confirmation of the thrombocytopenia via a manual platelet count, recheck, etc. is recommended if not already evaluated.

Additionally, a fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact the lab for recommendations regarding how long to stop antibiotics prior to obtaining stool for submission.

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.

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

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



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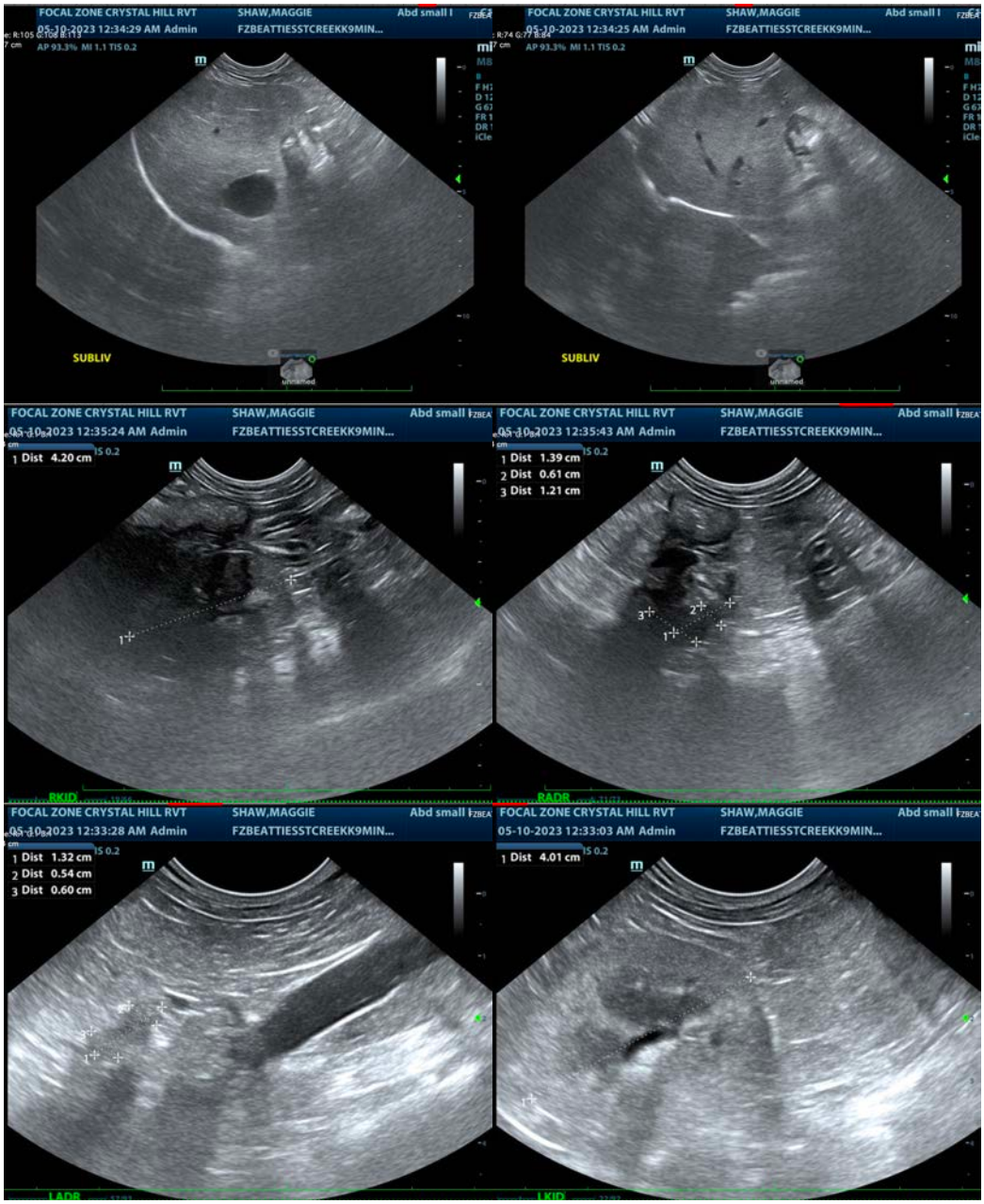
In the meantime, supportive/symptomatic medical management of clinical signs is recommended, including antiemetics (if necessary) a probiotic such as Visbiome or Proviable, empirical deworming with a 5-day course of Panacur, and, if tolerated, transition in diet, potentially beginning with a hydrolyzed protein diet, and if no effect, transitioning to a fiber responsive or colitis diet, etc.

After obtaining stool samples, transitioning from Metronidazole to Tylosin should also be considered if long-term antibiotics are going to be required.



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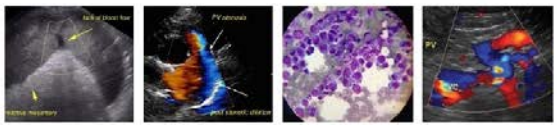

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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