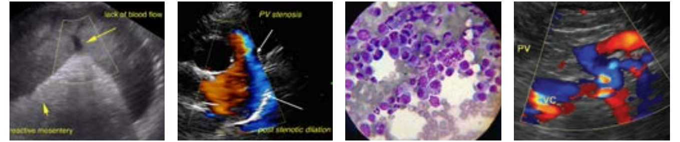

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1-800-838-4268 info@sonopath.com

PATIENT
Rylee Jacquette

SPECIES
Canine

BREED
Maltipoo

SEX
Spayed Female

AGE
7.5 Years

WEIGHT
14.8 Pounds

INTERPRETED BY
Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY
Dr. Tam Mengine

HOSPITAL NAME
Stoney Creek VH

REFERRING VET
Dr. Tam Mengine

INVOICE
38682

DATE
6/14/22

PRESENTING CLINICAL SIGNS

Patient had an acute IMHA episode in 3/22, attributed to recent convenia injection. Patient was in ICU, multiple transfusions, but has been stable on pred /mycophenolate since late March, also omeprazole & clopidogrel. Pred is being tapered, currently at 2.5mg once daily. Shortly after most recent taper, patient became inappetant - cerenia and mirtazapine did not help. Patient is now anorexic and vomited several times yesterday. On bloodwork yesterday, Hct stable at 37%, all else normal except an abnormal Snap CPL. Chest rads pending.

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 right kidney is normal in size (4.94 cm) 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 echogenicity and mild loss of corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal in size (4.83 cm) 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 echogenicity and mild loss of corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

The right adrenal gland is normal in size (0.36 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 (0.38 cm at the cranial pole and 0.29 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

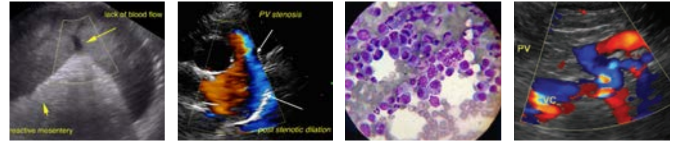
Spleen

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. Margins are smooth but round. 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. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

GB is moderately distended with anechoic bile and gravity dependent echogenic sediment. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.



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Gastrointestinal

Gastric fundic mucosal hypertrophy with hyperechoic mucosa and some mucosal remodeling is noted. There is no loss of mural detail. Layering is normal. There is mild luminal fluid accumulation. No evidence of masses/nodules or foreign material present. There is possibly some mild delayed gastric emptying, given the presence of chyme and ingesta in a reportedly fasted patient.

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 peritoneal effusion. There is no apparent lymphadenopathy.

PRIMARY FINDINGS

- Gastritis with mild delayed gastric emptying – Microulceration cannot be ruled out. No evidence of obstructive material or foreign body.

SECONDARY FINDINGS

- Hyperechoic hepatomegaly – most consistent with benign steroid (endocrine) hepatopathy or reactive or idiopathic hepatopathy. Infiltrative neoplasia such as round cell neoplasia is also possible, but considered less likely.

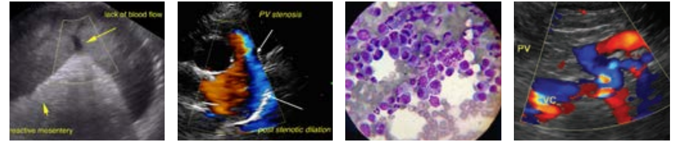
- Gallbladder debris - Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in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

- Mildly age related kidney change – This finding is expected/consistent with age-related mild degenerative disease and should be interpreted clinically in combination with laboratory changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Mild pancreatitis can be present with minimal to no ultrasound changes initially. Therefore, combined with the suspected gastritis, recommendations include medical management of possible mild pancreatitis/gastritis with antiemetics, gastroprotectants (which are reportedly already in place, but Sucralfate could be added to the treatment plan), a different appetite stimulant if the first one has not been effective, +/- promotility agent + Metoclopramide could be considered.

Mycophenolate can cause pretty severe gastrointestinal upset. However, given the timeline of mycophenolate administration versus clinical signs, that seems unlikely in this patient, but could still be



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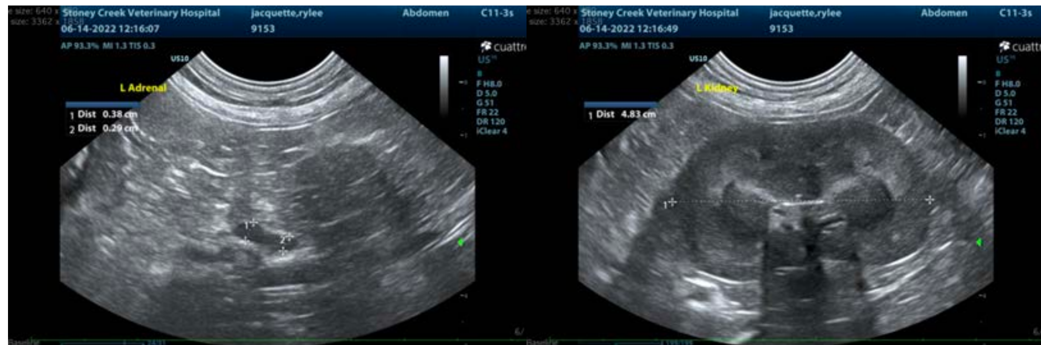
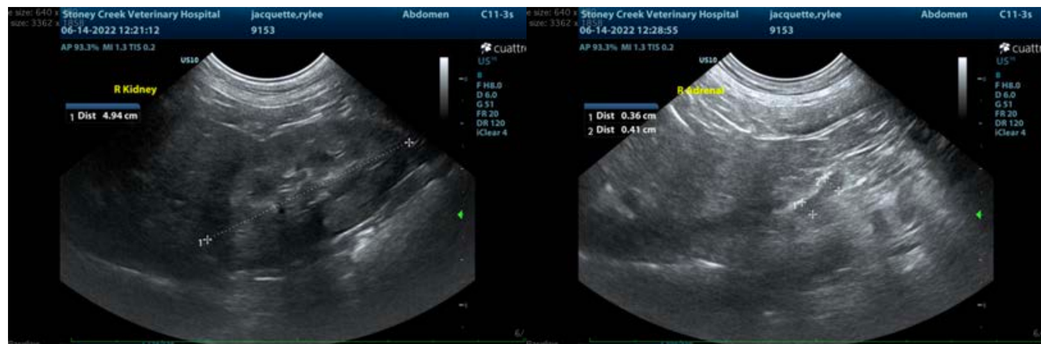
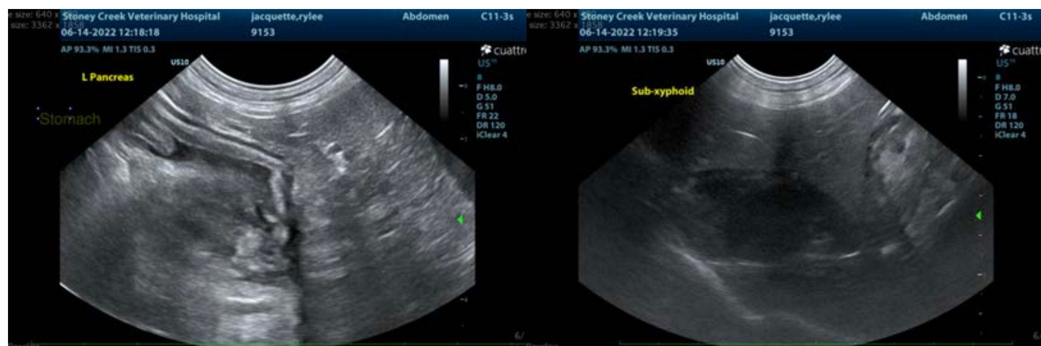
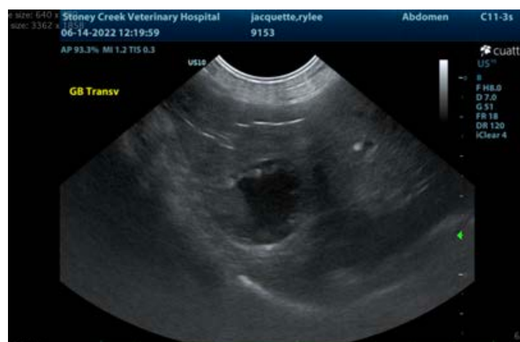
considered a potential cause.

Empirical deworming with a 5 day course of Panacur could be considered if not recently done. If clinical signs persist, next diagnostic steps to be considered include gastroscopy for further evaluation of the gastric mucosa and biopsies.









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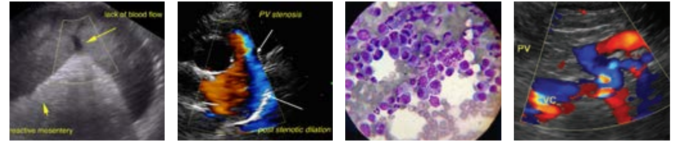

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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