

PATIENT PRESENTING CLINICAL SIGNS

Rikki Griggs

SPECIES

Canine

BREED

Miniature Fox Terrier

SEX

Neutered Male

AGE

11 Years

WEIGHT

3.2 kg

Owner reports that he has not been acting himself since around June 20th. He is no longer jumping on the couch/bed like he used to and seems to have trouble with the stairs. It seems difficult for him to get up from laying down, especially on his hind end. Owner remembers once instance of him collapsing and another instance that he tripped on his front legs and wouldn't get back up without help. He is still interested in playing with his housemate, but seems tired often. He has also been losing weight since May, but still eats and drinks the same amount. Patient also had a recent episode of hiding under the bed and seemed to be nauseous, however, this resolved on its own without treatment. Patient has a history of intermittent episodes of screaming, crying, hiding, and doing the praying position that only CBD seems to help him get through these episodes. Upon exam, patient is QAR and has moderate dental disease. BCS 5/9. No overt pain or crepitus upon manipulation of any limbs. Patellas sit appropriately within patellar grooves. No overt pain upon manipulation of neck or palpation of spine. A month ago at another clinic, patient was diagnosed with hypothyroidism (based upon TT4) and owner disagreed with diagnosis so stopped levothyroxine administration. Whole body radiographs performed yesterday were unremarkable (per radiologist review). MEDS: 25mg gabapentin PO SID; 6.25mg carprofen PO BID; CBD

Abnormal PE/Chem/CBC/UA Results: Per previous clinic blood work performed 6/26/23 - TT4 was low (0.7 with normal being 1-4), CBC was unremarkable, ALKP was elevated (250 with normal being 5-160), and hyperglobulinemia (4.2 with normal being 2.4-4) was present. Remainder of blood work was WNL. USG 1.062. BP 119mmHg

INTERPRETED BY

Beth Johnson, DVM
DACVIM

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.

Prostate is normal in size, echotexture and echogenicity for a neutered male.

IMAGING PERFORMED BY

Loetitia Saint-Jacques,
LVT

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 pyelectasia, mineral or infarcts observed. A hyperechoic band parallel to the corticomedullary border is present in both kidneys. The left kidney measures 3.66 cm. The right kidney measures 4.23 cm.

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Adrenal Glands

The right adrenal gland is normal in size (0.37 cm at the cranial pole and 0.44 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

REFERRING VET

Dr. Kristin Kee

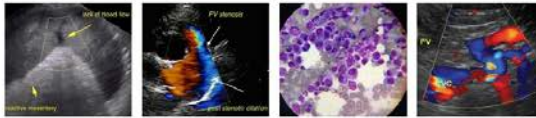
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The left adrenal gland is normal in size (0.53 cm at the cranial pole and 0.49 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

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PATIENT *Spleen*

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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.

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Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion.

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Gallbladder is moderately distended with anechoic bile as well as 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.

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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.

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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.

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The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

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LVT

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.

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The sublumbar lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

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ULTRASONOGRAPHIC FINDINGS

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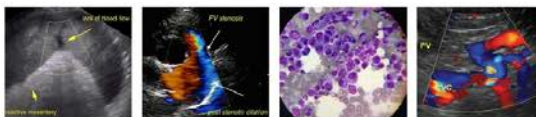
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- Age related kidney changes with bilateral medullary rim sign - This finding is of unknown clinical significance and can be a normal variant, often idiopathic. Medullary rim sign can be present with renal disease including FIP, lymphoma, hypercalcemic 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.

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- Heterogenous Liver - These changes are most consistent with benign processes such as nodular hyperplasia, steroid (vacuolar) hepatopathy, extramedullary hematopoiesis or possibly



PATIENT

chronic inflammatory disease and less commonly infiltrative round cell or metastatic neoplasia.

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- 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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- Reactive sublumbar lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the sublumbar lymphadenopathy, if not recently evaluated, a thorough rectal and perianal exam is recommended.

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Given the subtle medullary rim sign combined with the weight loss, recheck evaluation of the kidneys as well as ruling out the recent development of diabetes mellitus could be considered.

WEIGHT

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Pending results, further evaluation of digestion and absorption is recommended, beginning with a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory.

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In the meantime, recheck assessment of patient's daily caloric intake is recommended to rule out an inadvertent decrease in daily calories due to diet change, competitive eating environment, hiding food, etc.

Additionally, empirical deworming with a 5-day course of Panacur is recommended.

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If tolerated, transition in diet based on trial and error response could also be considered, beginning with a hydrolyzed protein diet.

Heart base image provided and interpretation declined.

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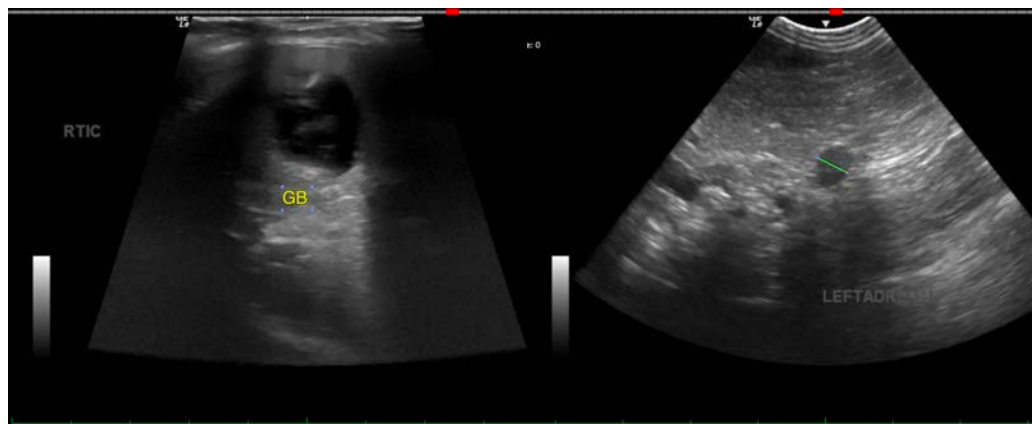
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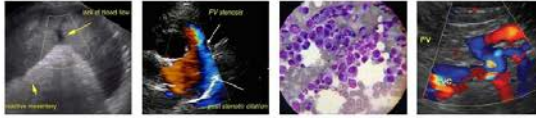
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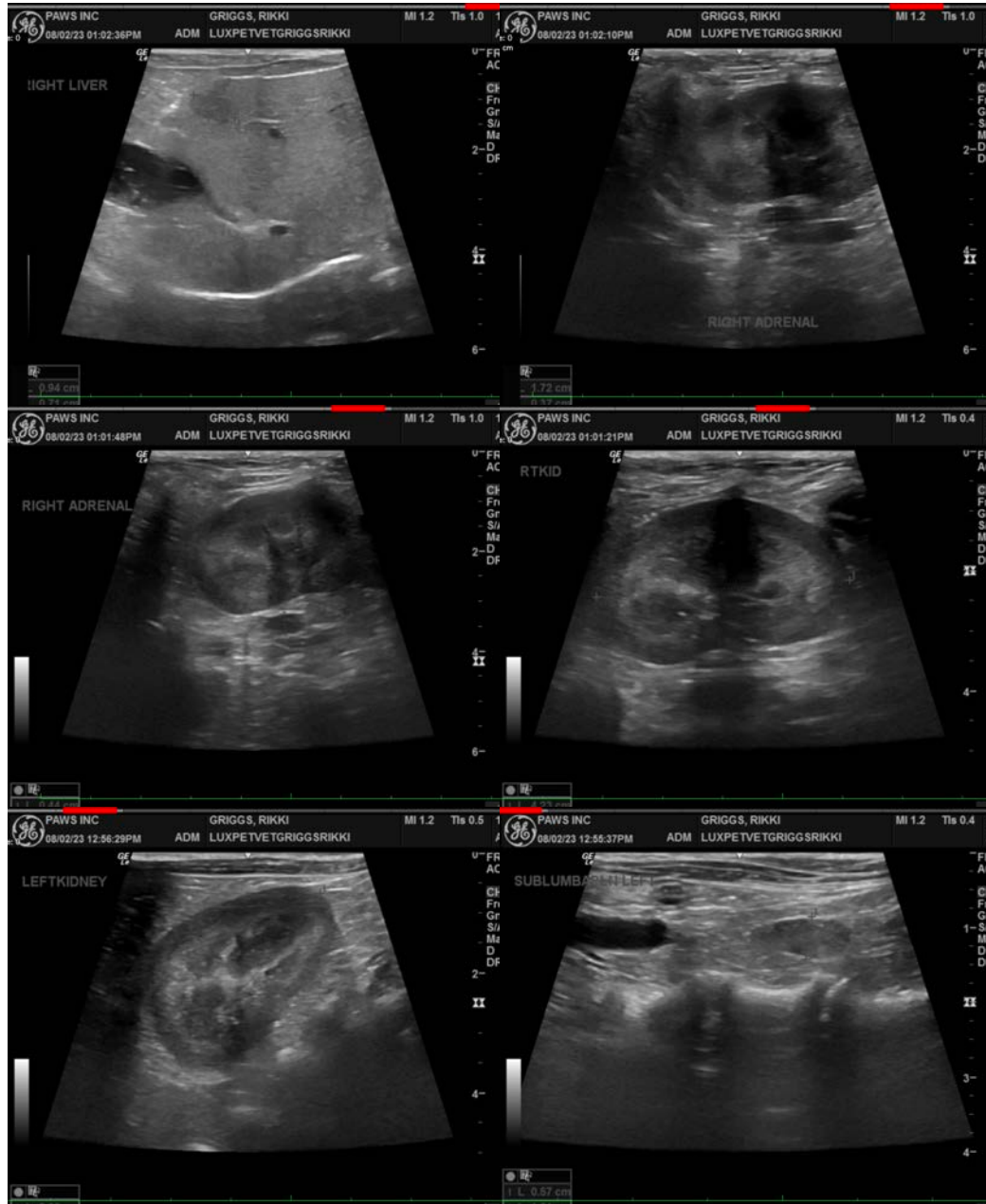
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
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