



PATIENT PRESENTING CLINICAL SIGNS

Max Slote History: inappetence, weight loss, vomiting meds: clavaseptin for UTI, Cerenia, mirtazapine

SPECIES Abnormal PE/Chem/CBC/UA Results: low BUN otherwise chem and elect WNL CBC low MCV, MCH, mild lymphopenia

Canine

BREED

Dogo Argentino

SEX

Neutered Male

AGE

10 years

WEIGHT

35 kg

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

New Hamburg VC

REFERRING VET

Findlater

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14001

DATE

8.9.23

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended with primarily anechoic contents and occasional echogenic non-shadowing debris. Apical urinary bladder wall is diffusely thick (0.90 cm). Mucosa is hyperechoic and irregular with multiple pedunculated masses extending into the lumen of the bladder. No cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface.

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

Left kidney is normal in size (7.12 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 in size (6.26 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 (0.64 cm at cranial pole / 0.76 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (2.00 cm at cranial pole / 1.00 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

The stomach is diffusely thick (measuring 0.90 cm thick) with intact normal 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. 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 and layering. Contents are consistent with normal formed feces and gas.

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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.

SEX

Neutered Male

Free Abdomen

There is no evidence of peritoneal effusion. There is no apparent lymphadenopathy with no enhanced hypoechoic mesenteric fat adjacent to the stomach.

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ULTRASONOGRAPHIC FINDINGS

WEIGHT

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Findings

- Polypoid Cystitis – Urinary bladder wall changes are most consistent with polypoid cystitis. Infiltrative neoplasia cannot be ruled out but is considered less likely given the appearance of the polyps.
- A diffusely thick gastric wall trends in appearance toward benign, as is seen with an inflammatory change secondary to other metabolic disease, or potentially parasitic infectious diet-related insult, with less likely, infiltrative neoplasia being considered.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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- Given this patient's history of a recently-diagnosed urinary tract infection and current antibiotic therapy, the reported gastrointestinal signs and lethargy could be secondary to that, and supportive/symptomatic medical management of potentially antibiotic-exacerbated nausea can be considered in the form of antiemetics, gastric protectants, etc., while managing the urinary tract infection.
- Given the mild gastric wall thickening however, if clinical signs do not resolve with management of the urinary tract infection and/or discontinuation of antibiotics (and/or they progress) further evaluation of the thickening can be considered in the form of tissue sampling, to include either fine-needle aspirate of the gastric wall (if coagulation status of the patient is appropriate) or potentially, upper GI gastroscopy/endoscopy for further visualization and biopsies of the stomach and small bowel.

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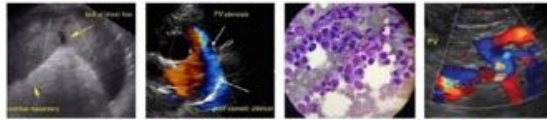
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- Additionally, in the meantime, gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.
- Empirical deworming with a 5-day course of Panacur is recommended.



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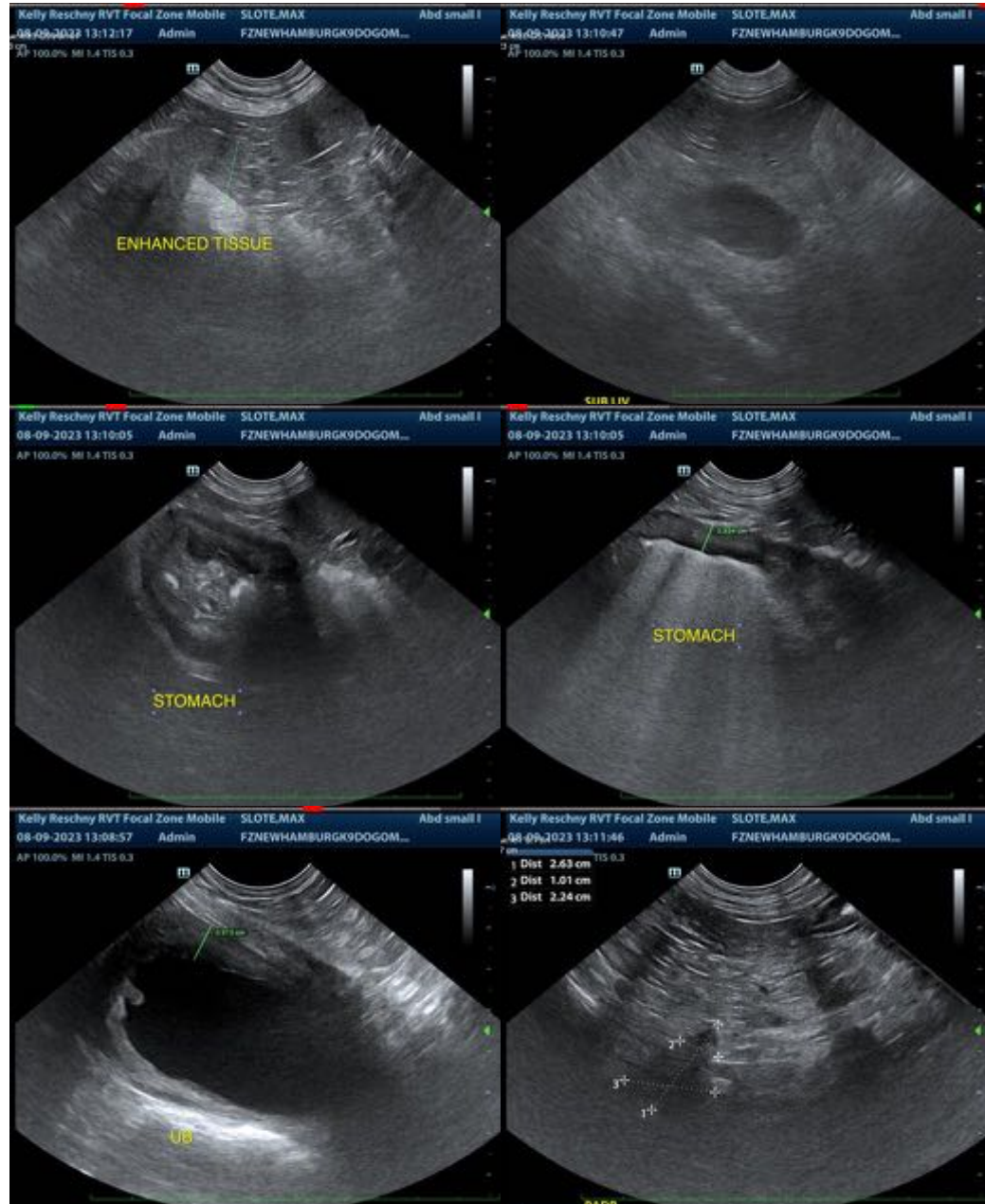
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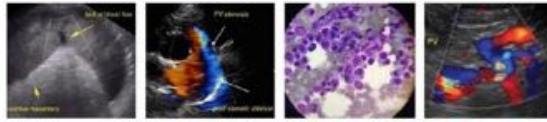
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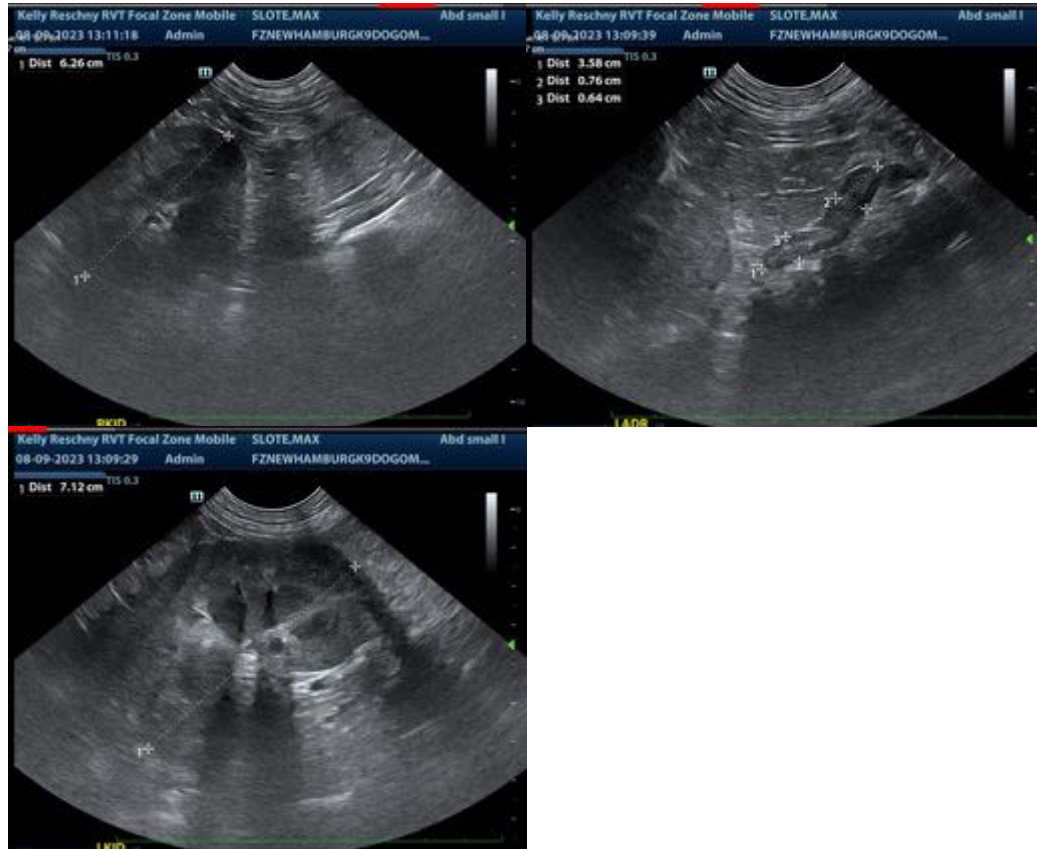
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
info@SonoPath.com