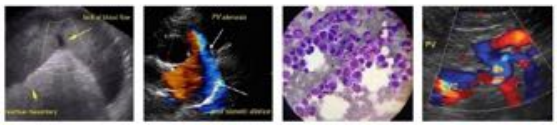


PATIENT

Sir Alex Viveiros

SPECIES

Canine

BREED

Old English Bulldog

SEX

Neutered male

AGE

10 years

WEIGHT

21 kg

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Kelly Reshny, RVT

HOSPITAL NAME

Upper Canada AH

REFERRING VET

Dr. Dickie

INVOICE

42757

DATE

2/14/23

PRESENTING CLINICAL SIGNS

History: Sir alex is a 9yo MN Old English Bulldog, who presented to Upper Canada for a second opinion on chronic diarrhea and severe weight loss since Dec 2022. Sir Alex first presented to previous DVM for vomiting and weight loss. The owner had just switched foods as he was struggling to get Sir Alex to eat/keep down food so an injection of Duplocillin was given. Sir Alex returned Jan 20, 2023 as there had been o improvement and further weight loss. Sir Alex would eat a new novel food for 2-3 days then stop eating entirely. DVM recommended diarrhea panel, bloodwork and xray, and owner declined at this time. Sir Alex returned for diagnostic on Jan 23, 2023 and bloodwork performed included a CBC, Chem and Lytes which revealed an unremarkable CBC, mildly low cholesterol and an otherwise unremarkable chemistry and lytes. On Jan 30,2023 Sir Alex had a lumpectomy performed as owner was concerned infected mass on his ventrum may be contributing to clinical signs. At this time his weight was 24.6kg. O then transferred to Upper Canada, and was seen Feb 11, 2023. He weighed-in at 21.10 kg, was lethargic, anorexic as per owner but would eat bunny bullies in clinic ravenously, had liquid diarrhea, refuses to eat any type of food offered by the owner, has not vomited in ~2 weeks as he has not been eating, and physical was unremarkable expect for BCS of 3/9. The owner had been prescribed Mirtazapine 7mg q 72 hrs by previous rdvm, and has noted no improvement. Last meal was 2-3 days ago. A GI panel is pending at the laboratory and owner will drop-off a fecal sample Monday.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and visible pelvic urethra were of normal thickness. The ureters were not visible which is normal. There was normal wall layering with no masses, uroliths or abnormal thickening visualized. Urine was anechoic. No evidence of inflammatory or neoplastic changes were noted.

The kidneys have a smooth capsule and with hazing of corticomedullary definition to the point of inability to determine cortical/medullary ratio. No evidence of pelvic dilation was present. The left kidney measured 6.8 cm and the right kidney measured 6.66 cm.

Adrenal Glands

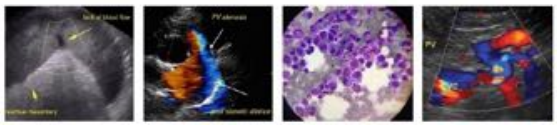
Both adrenal glands were visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The left adrenal gland measured 2.79 cm in length, 0.66 cm at the caudal pole and 0.58 cm at the cranial pole. The right adrenal gland measured 1.7 cm in length and 0.57 cm at the caudal pole and 1.78 cm at the cranial pole.

Spleen

The spleen was normal with a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma and smooth capsule, with normal splenic vasculature with no signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarct changes were noted.

Liver

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative



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pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed. Gallbladder is moderately distended with normal wall thickness and anechoic contents. Common bile duct is non-distended and tapers normally

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with focal loops with fluid/ingesta distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness.

Sections of colon are visualized with liquid fecal material and gas shadowing. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The base and limbs of the pancreas were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour and parenchyma were normal. No overt evidence of active inflammatory or neoplastic disease was noted.

Lymph Nodes

Enlarged, rounded and hypoechoic ileocolic lymph nodes with largest measuring 1.85x1.88cm with surrounding hyperechoic mesentery

Free Abdomen

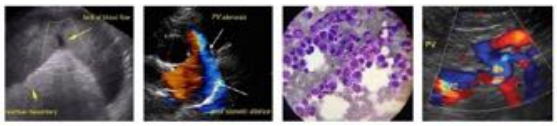
No masses or free fluid were noted.

ULTRASONOGRAPHIC FINDINGS

1. Ileocolic lymphadenopathy with surrounding inflammation
2. Degenerative renal changes
3. Normal small GI thickness and wall layering

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Lymphadenopathy with parenchymal changes and loss of normal length to width ratio is most concerning for infiltrative disease (lymphoma, MCT, other) and lymph node aspirate and cytology is



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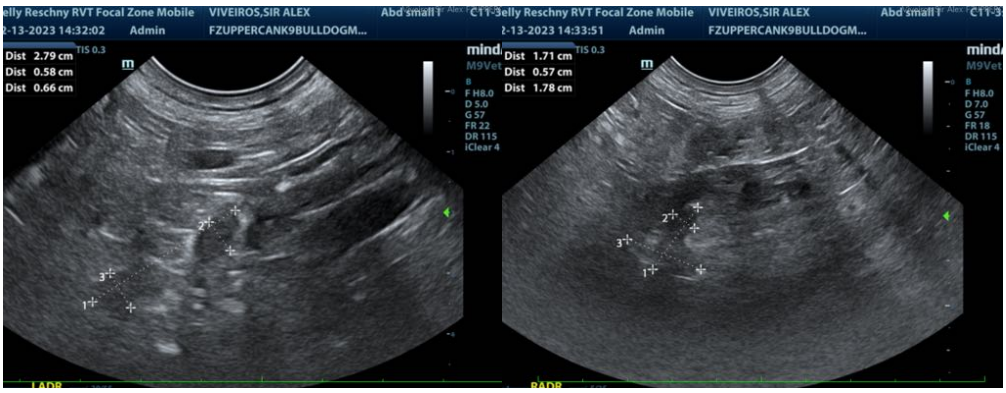
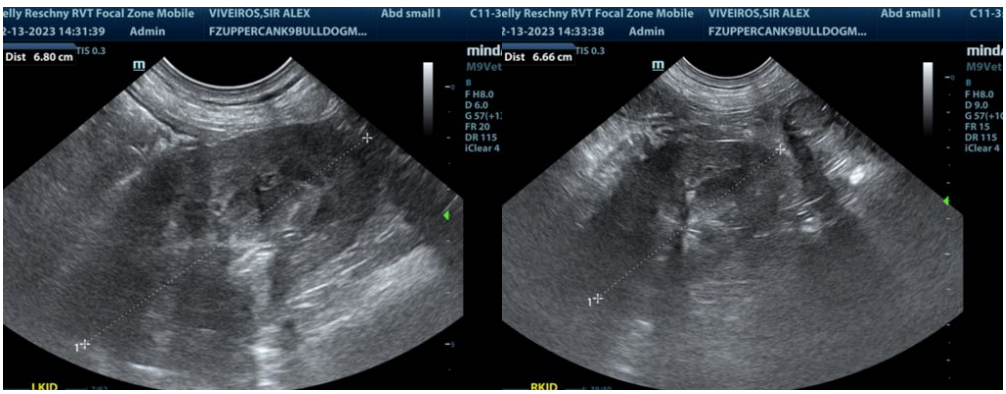
recommended. Less likely but possible causes include infectious lymphadenitis (bacterial, viral, protozoal or less likely fungal infection) or reactive lymphadenitis (parasitism, migrating foreign body). Lymph node culture could be considered.

While GI tract appears grossly normal ultrasonographically hypocholesterolemia, severe weight loss, liquid diarrhea and lymphadenopathy are all concerning for GI disease. If lymph node aspirate is non-diagnostic, additional diagnostics to be considered include GI panel (TLI/PLI/cobalamin/folate), baseline cortisol +/- ACTH stimulation test, fecal pathogen panel, thyroid testing, bile acid profile, and thoracic radiographs to rule out occult neoplasia, cardiac disease and esophageal disease as potential causes for GI signs. Ultimately GI biopsy (upper and lower endoscopy or surgical biopsy) may be required for more definitive diagnosis if the patient is not responsive to medical treatment.

Empiric treatment for GI signs including anti-nausea, appetite stimulant (mirtazapine can be increased to up to every 24 hours, entyce is an alternative appetite stimulant) and fluid support as clinically indicated is warranted. A diet trial with hydrolyzed protein or select protein diet could be considered if food sensitivity is suspected clinically.

Renal changes are likely age related degeneration. Correlate clinical significance with blood work/urinalysis findings and clinical signs.





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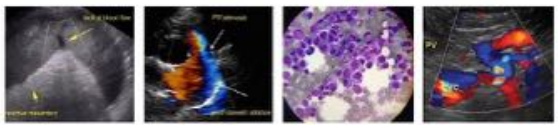

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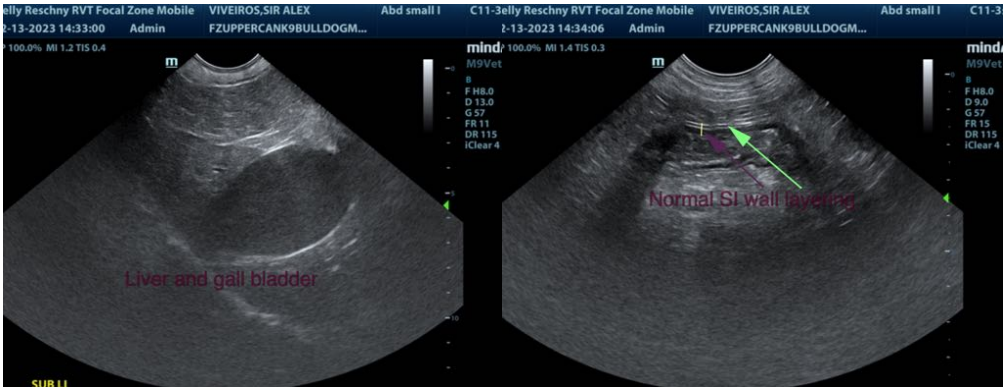

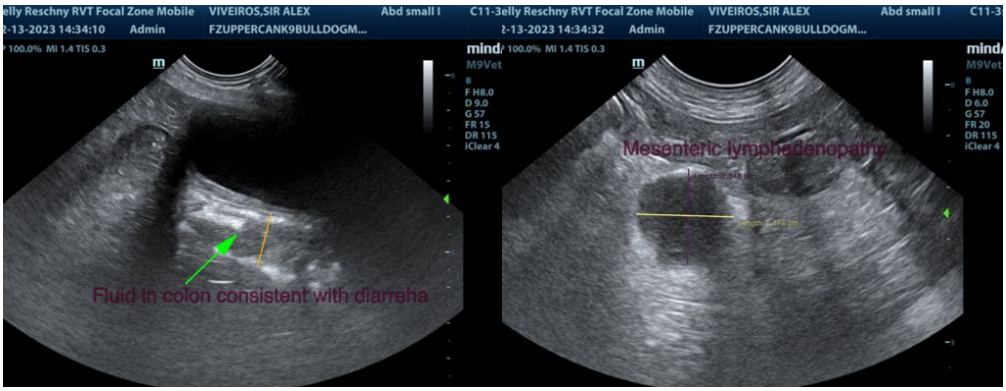

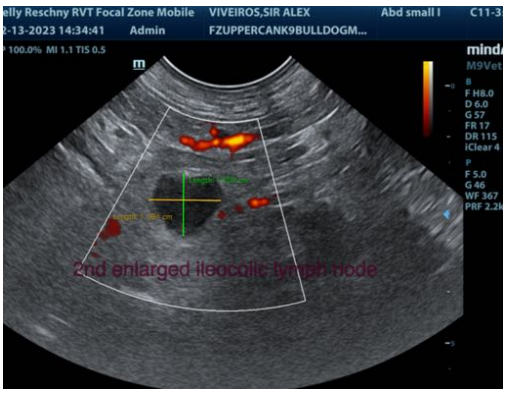

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Dr Brittany Sinclair, BVSc(hons), DACVECC
info@SonoPath.com