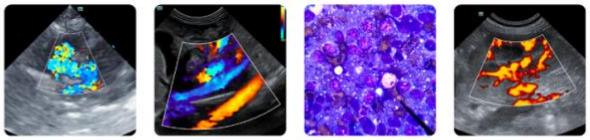

PATIENT

Tim Martin

SPECIES

Canine

BREED

Maltese

SEX

Neutered Male

AGE

6.5 Years

WEIGHT

4.8 Pounds

INTERPRETED BY

Eric Lindquist, DMV, DABVP (CFM), Cert. IVUSS

IMAGING PERFORMED BY

Haley Harasimowicz

HOSPITAL NAME

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REFERRING VET

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INVOICE

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PRESENTING CLINICAL SIGNS

History: Seen 11/4 for repeated V over 18 hrs, dog ate small amt that am but V fluid repeatedly after. Staying with daughter several weeks prior and had off and on V and did not eat as well. No garbage, FB, toxin. Regurgitated foamy yellowish fluid repeatedly during visit. PE thin, 0.8 # wt loss since 1/2024. Defecated large volume normal stool after rectal. Tachycardic, inducible tracheal collapse/hack. Abd tense. Chem mild hypernatremia, ALT 605, ALP 394. CBC mild hemoconcentration. CPLI abnormal. Hw4dx all neg, Fecal NOS/neg. Resting Cortisol 14.7. Radiographs revealed normal TH and gas/fluid distention of GI tract with marked gastric distention and moderate SI dissension, no obvious FB or obstructive pattern. Responded to several days of IV supportive care, injectable GI meds, Amp and Metro. 11/6 improved, ALT 504. Disch on ID low fat canned, Amoxi, Metro and Denamarin. Did well, recheck 11/20, eating well, gained 0.5lbs. Chem ALT 208. Recommended full 4 wks Amoxi and Metro, finished early Dec, and Denamarin ongoing, planned to recheck in 2 mos. Seen 12/20 for progressive lethargy and poor appetite over several days. PE weight stable, dehydrated and abdomen tense. Although no report of diarrhea, mucusy soft stool on rectal. Chem ALT 234. CBC WNL. CPLI normal. Submitted GI Panel and outpatient supportive care SQ fluids, Cerenia SQ, Famo SQ, Convenia SQ and Vit B12 SQ. Responded well. GI Panel Folate low 5.6, WNL otherwise. Rec starting Folate 200mcg PO SID and Abd US.

Abnormal PE/Chem/CBC/UA Results: 11/4: Na 162, ALT 605, ALP 394, HCT 53.3%, cPLI abnormal, resting cortisol 14.7 Radiographs revealed gas and fluid distension of GI tract 11/6: ALT 504 11/20: ALT 208 12/20: ALT 234 Texas A&M GI Panel: Folate 5.6

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** revealed a trace amount of sand. A small calculus was noted, measuring 2.0 mm, without acoustic shadowing.

The **kidneys** revealed normal size and structure, corticomedullary definition and ratio for this age. The cortices presented largely uniform texture with normal echogenic relationship to liver and spleen. Medullary structure differed distinctly from the cortex, and no evidence of pelvic dilation was present. The capsules were acceptably uniform without significant irregularities. The left kidney measured 3.69 cm. The right kidney measured 3.67 cm. An anechoic cyst was noted at the medial cranial cortex of the right kidney, measuring 0.42 cm. Slight pinpoint mineralizations were noted.

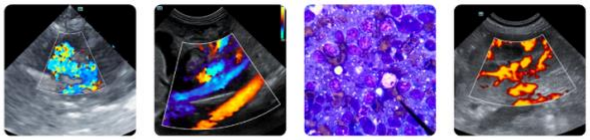
Adrenal Glands

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 0.37 cm at the cranial pole and 0.31 cm at the caudal pole. The right adrenal gland measured 0.45 cm at the cranial pole and 0.29 cm at the caudal pole.

Spleen

The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes were noted.

Liver



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The **liver** as mildly subnormal in size with coarse architecture. The gallbladder was mildly overdistended.

Gastrointestinal

Some minor shadowing **pyloric** material (up to 0.8 cm) was noted in this patient with a minor amount of retained chyme. The small intestine and colon were unremarkable with normal curvilinear patterns and content.

Pancreas

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

ULTRASONOGRAPHIC FINDINGS

- Minor gallbladder overdistention without mucocele formation
- Mild microhepatica
- Slight shadowing gastric structure, possible oral medication or foreign body
- Slight pinpoint renal mineralizations and an anechoic cyst at the medial cranial cortex of the right kidney
- Urinary bladder sand

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If vomiting persists despite medical management, then endoscopy is indicated. GI protectant protocol, ultrasound guided FNA, bile acid profile, and ursodiol therapy are all indicated. If bile acids are significantly elevated, then further imaging of the portal vein to vena cava ratio to assess for portosystemic shunting is indicated, though not overtly suspected. After 12–18-hour NPO, recheck sonogram of the pyloric outflow is warranted to assess if the 8.0 mm shadowing structure is persistently present. GI protectant protocol, such as the following may prove effective:

Helicobacter/Gastritis protocol

A clinical trial of **Zithromax (*Dogs:*** 5-10 mg/kg p.o. q24h. May increase dosing interval to q48h after 3-5 days of treatment)**, Metronidazole** (10-20 mg/kg p.o. b.i.d.), **Pepcid** (0.5-1 mg/kg s.i.d.) and **Sucralfate** (0.5-2 g/dog PO) or **Omeprazole** (1 mg/kg p.o. s.i.d.) over the next 3 weeks along with a **novel-protein or hydrolyzed diet** with slurry feeding b.i.d./t.i.d. over the next 2-4 days and then increase to canned diet bid. Dry food should be avoided over the next 4 weeks. A recheck sonogram to assess GI improvement or progression would be ideal in 4 weeks.

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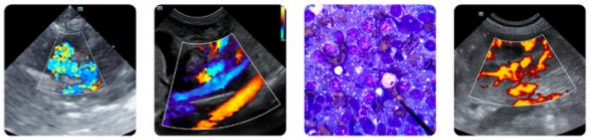

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Educational Teleconsultation Services™

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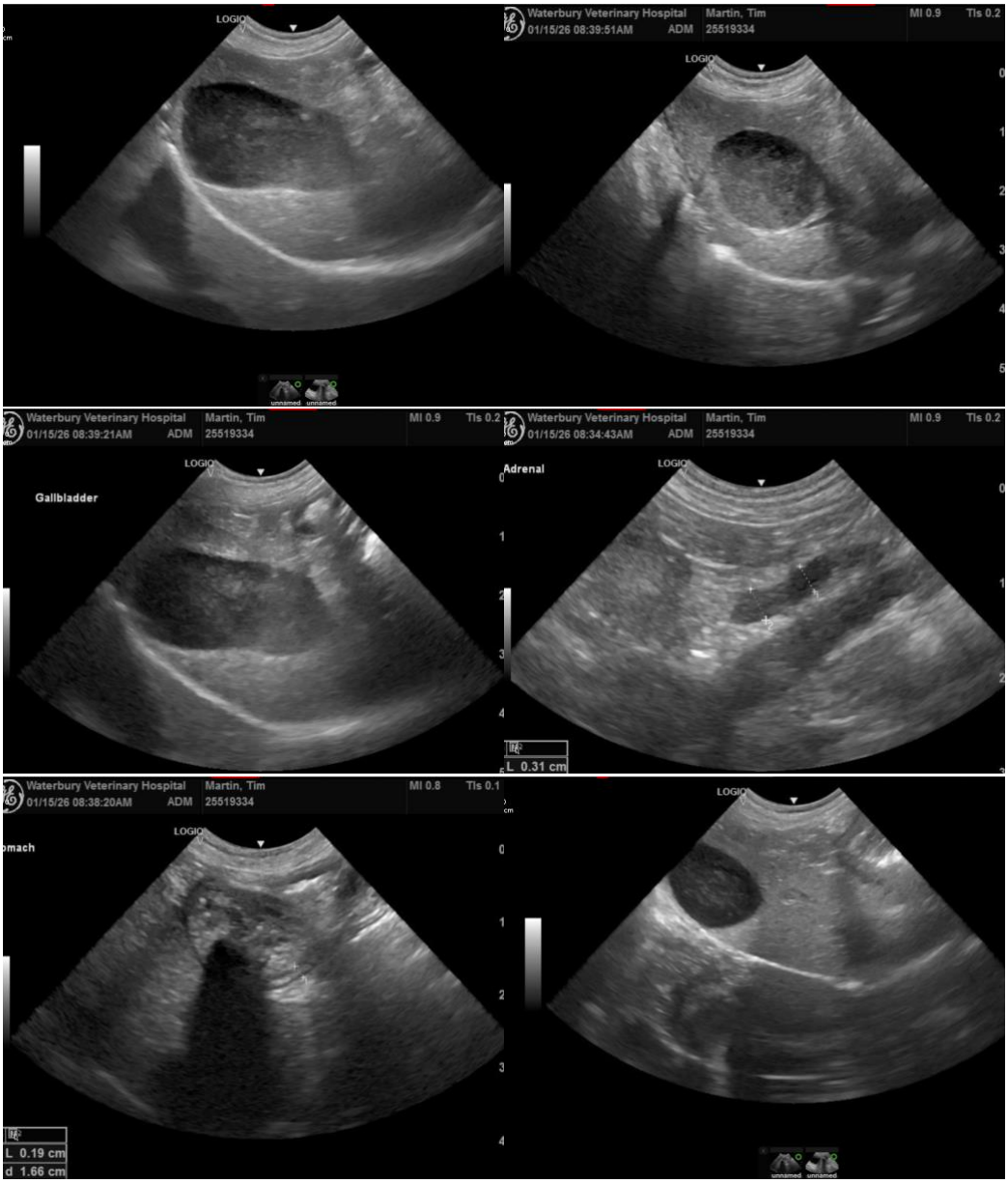

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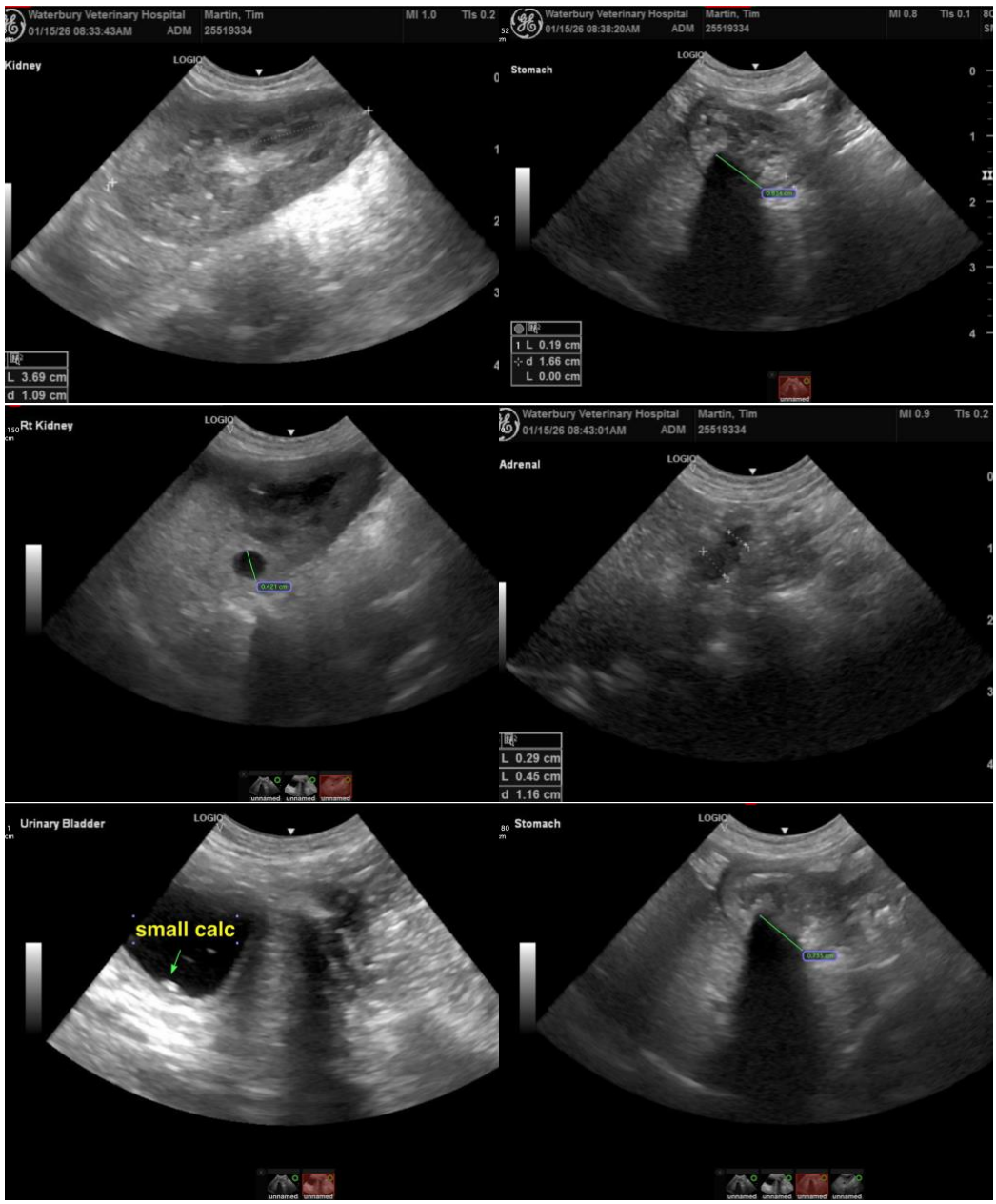

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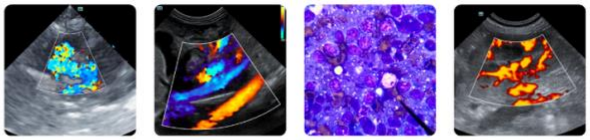

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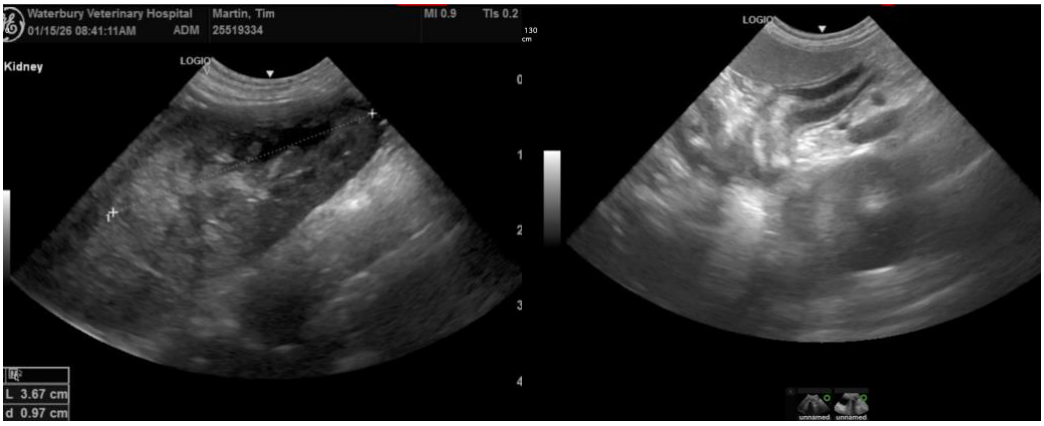

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Eric Lindquist, DMV, DABVP(CFM), Cert. IVUSS,
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