



PATIENT

Gemma Miller

SPECIES

Canine

BREED

Miniature Dachshund

SEX

Spayed Female

AGE

11 Years

WEIGHT

5.35 Pounds

INTERPRETED BY

Eric Lindquist, DMV
DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Alastair Westcott

HOSPITAL NAME

Dr. Alastair Westcott,
DVM

REFERRING VET

Dr. Alastair Westcott

INVOICE

13482

DATE

10/4/21

PRESENTING CLINICAL SIGNS

History: Has been vomiting profusely yesterday and today subsequent to an exploratory laparotomy performed three days ago when some intestinal biopsies were taken. The clients have been attempting to feed with syringe feeding only as she has had no appetite since the surgery date. She has been drinking a lot of water and vomits fairly soon after consuming this water. For a little over a month she has had an intermittent appetite which was gradually becoming more pronounced. Her blood work was unremarkable and radiographs along with barium studies were normal. It was this increasing inappetence with no vomiting that prompted an exploratory laparotomy. Nothing unusual was noted during the laparotomy and intestinal biopsies came back as mild inflammatory bowel disease. She declined quite dramatically since surgery. She had had an apparent seizure about an hour before the presentation. However, according to client description there did not appear to be a tonic-clonic or grand mal variety seizure.

Abnormal PE/Chem/CBC/UA Results: Non ambulatory and lying on her side. She seems very listless but with normal vital signs. She is aware of her surroundings. Heart examination: Severe dental disease, somewhat muddy mucous membranes and ptialism. Peripheral lymph nodes unremarkable. Thoracic and cardiac auscultation NSF. Somewhat swollen abdomen that is a little tense on palpation, pulses fair and palpable, perianal examination unremarkable. Metabolic alkalosis with a lack of respiratory compensation. Mild hypochloremia Acute consumptive and potentially suppurative inflammation with some chronicity Mild hyperglycemia Marked azotemia (SDMA, BUN) - likely pre-renal/dehydration Mild hyperphosphatemia Elevated ALP Marked elevation in AMYLASE/LIPASE Urinalysis: Adequate concentration Mild glucosuria Elevated strip proteinuria Mild bilirubinuria Hyaline casts noted

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The ureters were not visible which is normal. Trace amount of luminal dilation noted in the bladder. No evidence of inflammatory or neoplastic changes were noted. Ureteral papillae were normal.

The **kidneys** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some age-related loss of curvilinear patterns regarding the capsule and C/M junction. The cortices presented largely uniform texture with some increased echogenicity expected for his age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. Slight mineralization was present in the kidneys. The right kidney measured 4.73 cm. The left kidney measured 4.66 cm.

Adrenal Glands

The **right adrenal gland** was 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 right adrenal gland measured 2.45 cm x 0.65 cm at the cranial pole and 0.49 cm at the caudal pole.

The **left adrenal gland** was slightly swollen yet technically within normal limits. The left adrenal gland measured 1.95 cm x 0.62 cm at the cranial pole and 0.62 cm at the caudal pole.

Spleen



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The **spleen** in this patient was uniform, yet volume contracted. Hydration status should be assessed.

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Liver

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The **liver** images submitted revealed subjectively normal liver size, contour, and structure. Parenchymal echogenicity was naturally coarse and hypoechoic to the spleen. Vascular and biliary tracts were of normal volume with no evidence of congestion. The gallbladder presented acceptably thin walls with primarily anechoic content. The cystic and common bile ducts were normal. No pathological hepatic lymphadenopathy was evident. No overt structural evidence of inflammatory, infiltrative or regenerative pathology was evident.

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Gastrointestinal

Variable upper **gastrointestinal** spasming noted with corrugated bowel. The stomach was significantly overdistended. Free fluid noted. Gas accumulation adjacent to the pylorus with enhanced surrounding mesentery was noted. Significant fundic stasis noted. The pylorus was thickened and corrugated yet no overt obstruction noted. Delayed outflow is evident. Colon was fluid filled. The duodenum was significantly spasmed. No overt foreign body noted, however, thin linear foreign body cannot be entirely ruled out.

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Pancreas

The **pancreas** revealed mixed hypoechoic irregular changes throughout the pancreatic parenchyma with enhanced surrounding mesentery and localized areas of free fluid.

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Free Abdomen

Ascites was echogenic. Regional adhesions noted consistent with peritonitis.

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ULTRASONOGRAPHIC FINDINGS

- Upper gastrointestinal spasming with gas penetration in the extra-pyloric area/portal hilus- Acute on chronic upper gastrointestinal disease without evidence of neoplastic criteria. Bowel perforation suspected. Possible small foreign body
- Age-related renal changes with slight mineralization
- Volume contracted spleen
- Pancreas, mixed hypoechoic irregular changes with enhanced surrounding mesentery and localized areas of free fluid
- Left adrenal gland slightly swollen
- Echogenic ascites
- Regional adhesions consistent with peritonitis

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

I recommend exploratory surgery in this patient with expectations toward abdominal lavage and GI biopsies. J2 placement at surgery may be appropriate given the extensive inflammation. Prognosis is extremely guarded.

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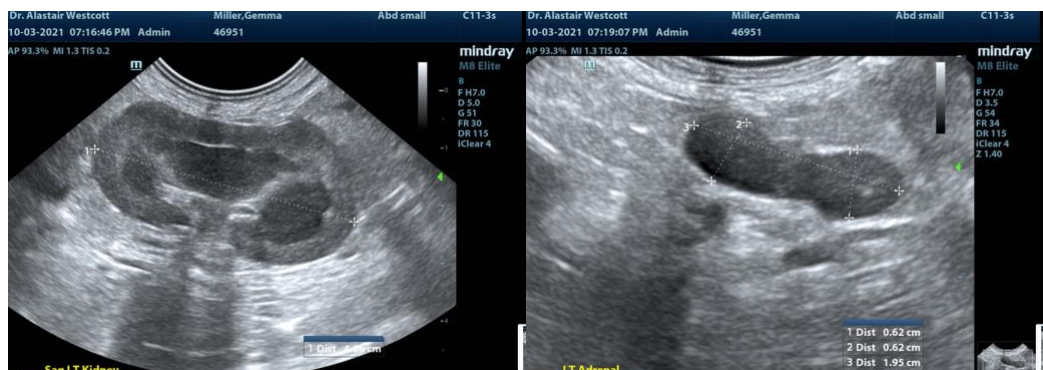
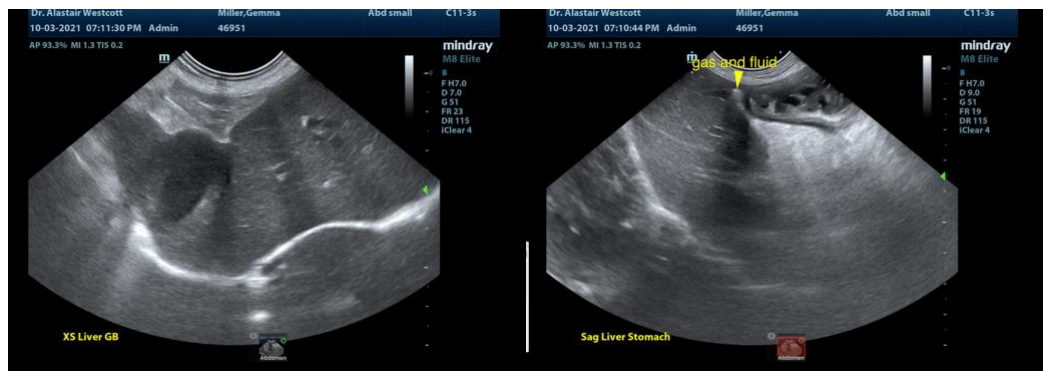
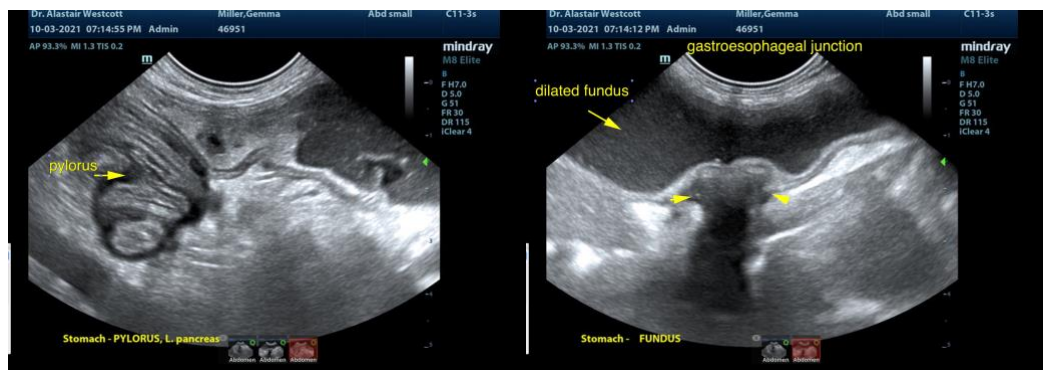
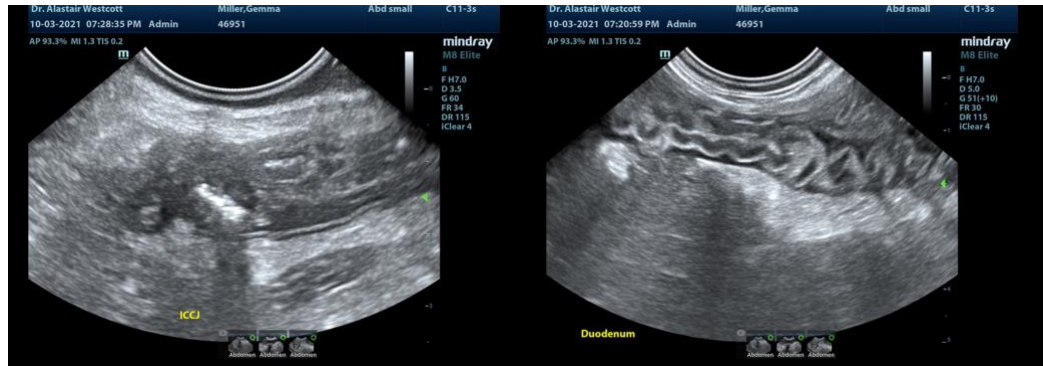
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Eric Lindquist, DMV, DABVP, Cert. IVUSS, CEO of SonoPath.com
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