



PATIENT

Max Davison

SPECIES

Canine

BREED

Yorkie Mix

SEX

Neutered male

AGE

11 years

WEIGHT

23 lbs

INTERPRETED BY

Eric Lindquist, DMV
DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Melissa DaSilva

HOSPITAL NAME

Rockaway AH

REFERRING VET

Dr. Coyle

INVOICE

42886

DATE

11/30/22

PRESENTING CLINICAL SIGNS

History: Decreased appetite and frequent panting. On/off diarrhea, lethargy, vomiting 3-4x a week-sometimes containing blood. Patient is BAR & anxious.

Abnormal PE/Chem/CBC/UA Results: G 1-2 left-sided heart murmur, collapsing trachea

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. No uroliths or sediment were visualized and anechoic urine was present. No evidence of inflammatory or neoplastic changes was noted. Ureteral papillae were normal.

The residual prostate measured 0.5 cm.

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 right kidney measured 6.0 cm. The left kidney measured 5.2 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 right adrenal gland measured 2.31 x 0.63 cm at the caudal pole and 0.41 cm at the cranial pole. The left adrenal gland measured 1.9 x 0.47 cm at the caudal pole and 0.6 cm at the cranial 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 was noted.

Liver

Exam of the cranial abdomen demonstrated excessive **liver** size, swollen contour, with conserved uniform architecture. Parenchymal echogenicity was diffusely isoechoic to the spleen and falciform fat. Minor excessive GB debris was noted with the presence gall bladder dilation and precipitate without the overt formation of mucocele but this may be an issue in the future. This type of liver presentation typically is associated with slow and gradual SAP elevations with low-grade ALT rise. USG-FNA sampling is encouraged if more aggressive LE profiles are present such as ALT > 200 or rapid rise in SAP. These presentations are usually reactive hepatopathies owing to other disease processes either



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endocrine (Diabetes, Hypothyroidism, Cushing's disease), "antigen surveillance" from the gut/pancreas, or idiopathic breed predisposed progressions.

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Gastrointestinal

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Examination of the **gastrointestinal tract** revealed a stomach and intestine free of stasis, of normal wall thickness, acceptable curvilinear mural detail, and peristaltic activity. Small and large intestine demonstrated normal luminal chyme and stool consistency respectively. No obstructive or overt infiltrative disease was noted. No associated abnormal lymphatic activity was noted.

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Pancreas

Neutered male

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.

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ULTRASONOGRAPHIC FINDINGS

Unremarkable abdomen.

WEIGHT

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Benign hepatopathy.

INTERPRETED BY

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Eric Lindquist, DMV
DABVP, Cert. IVUSS

There is no evidence of significant disease. Other cause of poor appetite such as orthopedic disease should also be considered despite the vomiting. Dietary intolerance, occult parasitism and Helicobacter are all possible. The following empirical treatment may prove effective along with fecal exam and anti-parasitic protocol.

IMAGING PERFORMED BY

Helicobacter/Gastritis protocol

Melissa DaSilva

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.

REFERRING VET

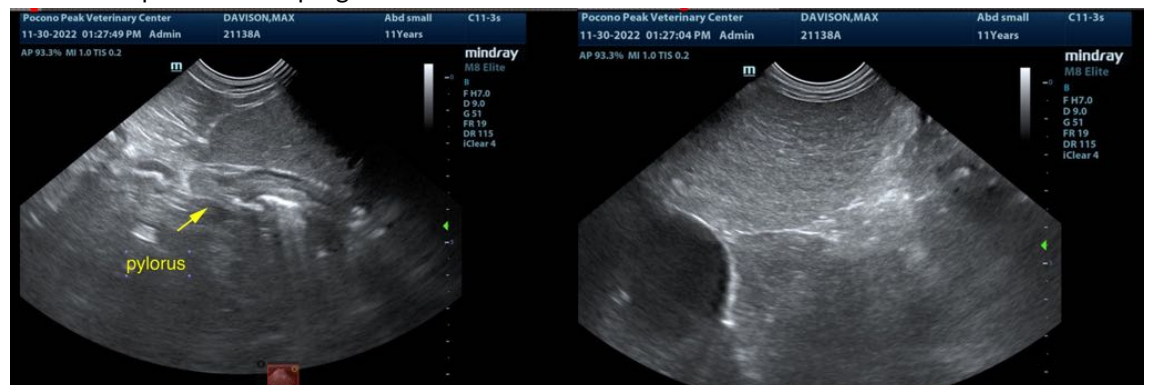
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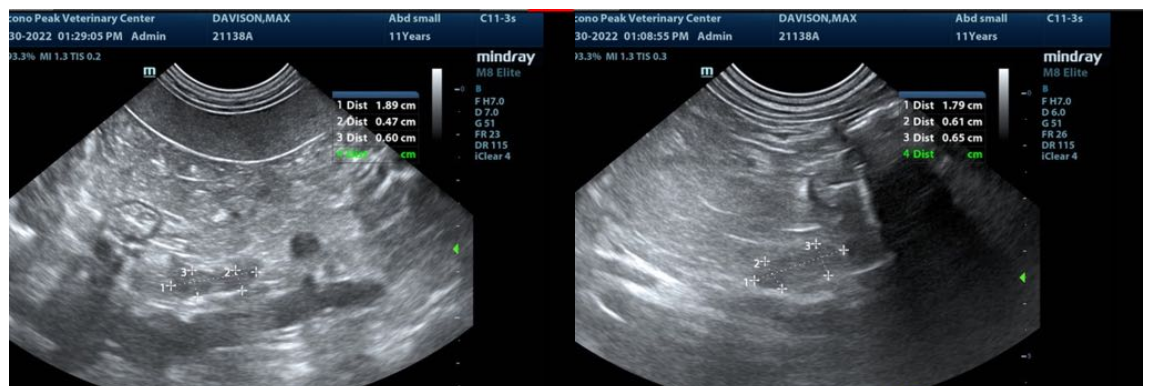
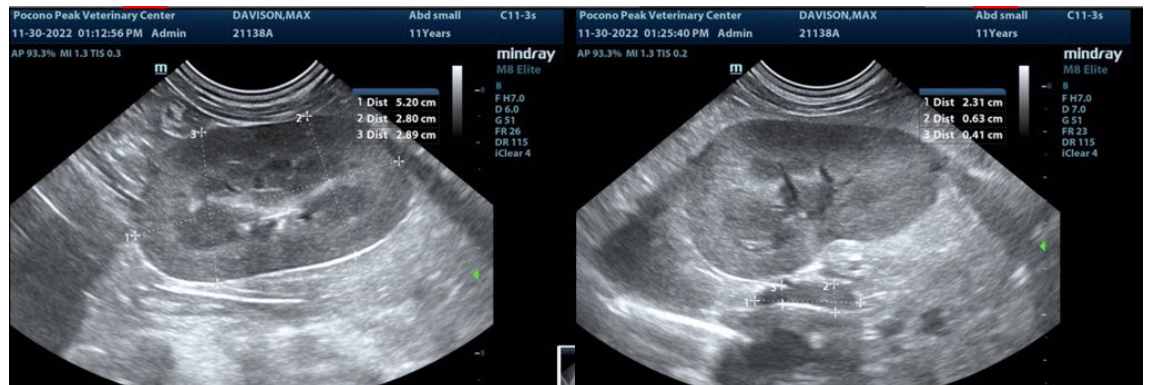
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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, Cert. IVUSS, CEO of SonoPath.com
info@SonoPath.com