**PATIENT**

Mi-Go Ory

SPECIES

Canine

BREED

Chihuahua X

SEX

Neutered Male

AGE

12 Years

WEIGHT

7.7 kg

INTERPRETED BYEric Lindquist, DMV
DABVP, Cert. IVUSS**IMAGING
PERFORMED BY**

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VETMadison Vet
Specialists**INVOICE**

35371

DATE

2/2/22

PRESENTING CLINICAL SIGNS

48hr history of vomiting, inappetence, lethargy. Came for outpatient care 1/31. No improvement so came in 2/1 for hospitalization. Previous history: Vomiting Anorexia Lethargy Wt loss (~2.1 kg since last check at MVS) Hypertension (stable at this time) Right adrenal gland nodule Cholecystolithiasis (very small, and there is no evidence of bile duct obstruction)

Abnormal PE/Chem/CBC/UA Results: CBC: elevated WBC/Bands/Lymph/Mono, decreased NEU. CHEM: elevated SDMA/BUN/ALKP, decreased Tp/ALB/GLOB. UA: Leu 25leu/uL, Protein trace, UBG 8mg/dL, BIL 3mg/dL, BLD 10Ery/uL, WBC 2/HPF, RBC 1/HPF, EPI <1 non squam. Radiographs of abdomen and thorax done here (no results yet though).

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 were noted. Ureteral papillae were normal. The residual prostate measured 0.94 cm. Pre- and post-prostatic urethra were unremarkable.

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. The right kidney measured 4.46 cm. The left kidney measured 4.33 cm.

Adrenal Glands

The **right adrenal gland** was swollen, measuring 0.94 cm in width. The **left adrenal gland** was mildly swollen, measuring 0.69 cm at the caudal pole and 0.50 cm at the cranial pole, technically within normal limits.

Spleen

The **spleen** was mildly enlarged and folded upon itself caudally, yet parenchyma was uniform. Likely reactive state. Mild potential for emerging round cell neoplasia.

Liver

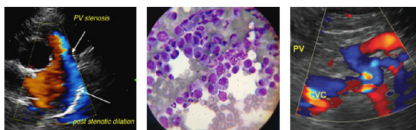
The **liver** presented minor increased portal markings. Uniform parenchyma. The gallbladder was overdilated with striating bile and was rounded, measuring 3.0 cm x 3.0 cm. The gallbladder presentation does not have any significant inflammatory response around the capsule. However, some peripheral striating bile was noted and immobile coalesced bile.

Gastrointestinal

A minor amount of chyme was noted in the **stomach**. The pylorus was free of evident pathology. Curvilinear patterns were maintained. Some areas of mucosal fogging noted in the small intestine. Protein losing enteropathy suspected. No evidence of neoplasia or foreign bodies. Reactive mesenteric lymph nodes noted up to 0.5 cm.

Pancreas

The **pancreas** was largely unremarkable. No evidence of any significant inflammation. Curvilinear patterns were maintained.

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Free Abdomen

Trace free fluid/effusion noted in the abdomen.

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ULTRASONOGRAPHIC FINDINGS

- Prominent right adrenal gland – hyperplasia, pheochromocytoma, minor potential for adenocarcinoma
- Gastroenteritis with reactive lymph nodes
- Trace free fluid – May be owing to lymphatic congestion. However, if albumin levels are <1.5, this may be spontaneous third spacing of fluid.
- Mucosal fogging/protein losing enteropathy pattern

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**SEX**

Neutered Male

Malassimilation may be the cause of weight loss in this patient. Alk Phos and bilirubin elevations should be monitored carefully. GI protectant protocol recommended. Maldigestion panel, three view chest radiographs and full CNS examination is recommended to examine for occult disease that could be responsible for the weight loss. Evaluation for competitive eating environments should also be considered.

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PLE Therapy

Part or all of this protocol may be considered based on your clinical impression of the patient:

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OBJECTIVE: keep albumin levels > 2 g/dl, avoid thromboembolism and cavitory effusions, monitor concurrent PLN (Wheaton Terrier PLE/PLN) and liver disease:

Plasma 10 mL / kilogram IV over 4 hours

Or Human albumin 2 ml/kg/h over 10 hours. Total daily volume 20.l/kg/day

And Colloids/Hetastarch

10 to 20 mL per kilogram per day and dogs

10 to 15 mL per kilogram per day cats

(Can bolus first 1/3 of dose over 15 minutes)

& maintain on LRS maintenance otherwise.

Metronidazole (10-20 mg/kg po bid)

Famotidine 1 mg/kg Iv Im po dc Sid /bid

Sucralfate 0.5-1 g po tid dogs, 0.5 g bid cats in slurry **Or Misoprostol** 1-5 ug/kg po tid

Diet: Highly digestible high quality protein, low fiber, low fat diet (< 15% of dry matter). Hydrolyzed protein or novel protein. Purina HA or Royal Canine HP or similar.

Prednisone or prednisolone 2 mg/kg bid x 3-5 days then 2 mg/kg sid. **Chlorambucil** in refractive severe IBD/alimentary lymphoma cases (monitor cbc for rare bone marrow suppression) 4 mg/m² Q 24-48 hours.

Cobalamine (B12) 250-1500 ug/dog weekly x 6 weeks.

Calcium supplementation if necessary.

Aspirin 0.5-1 mg/kg/day **or Clopidrel** (Plavix) 1-5 mg/kg/day.

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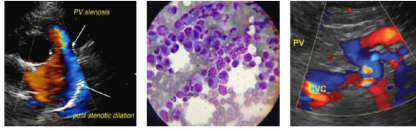
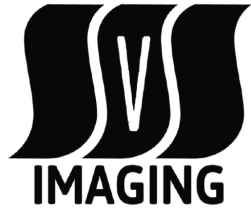
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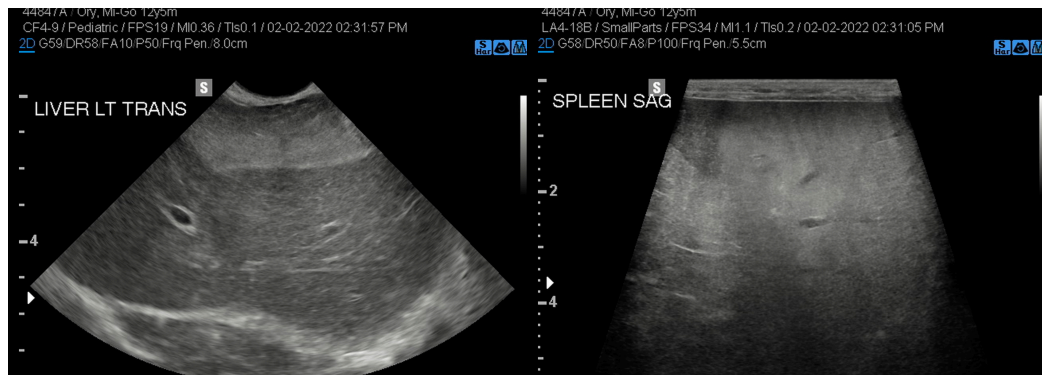
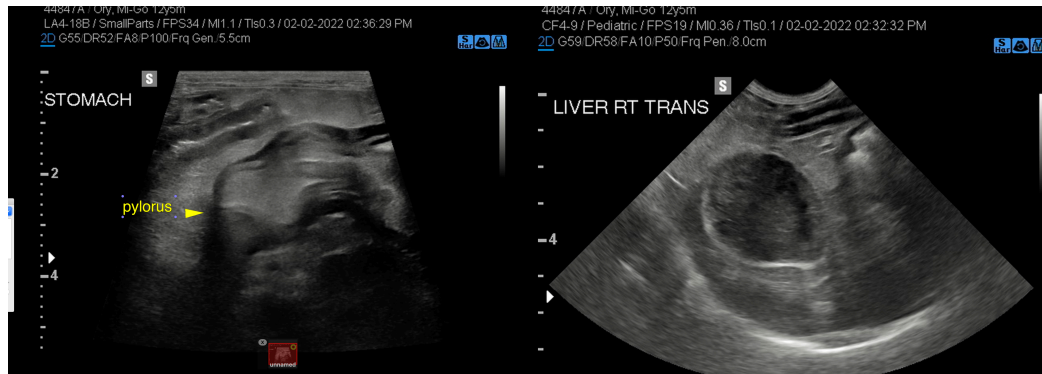
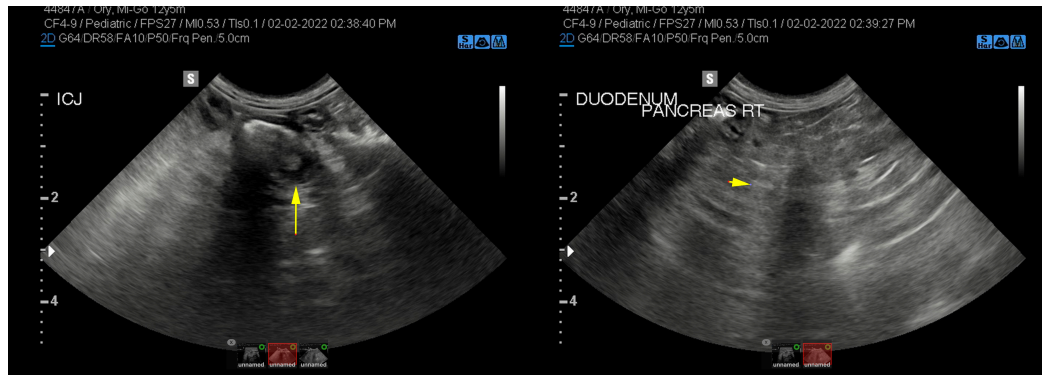
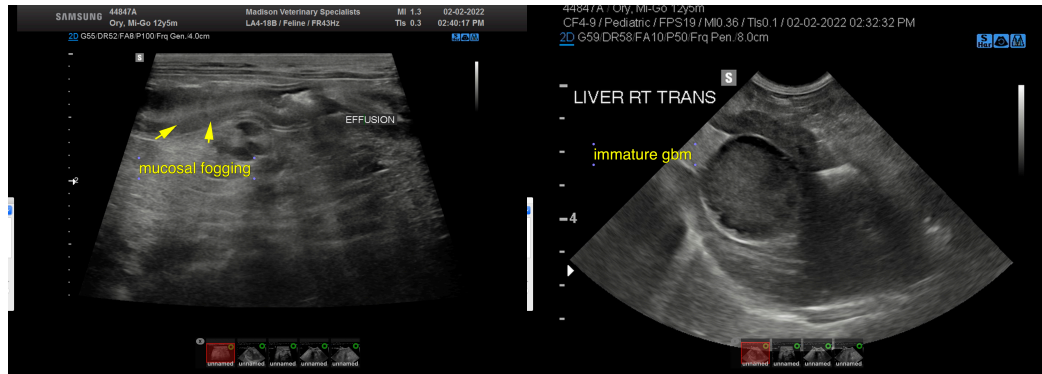
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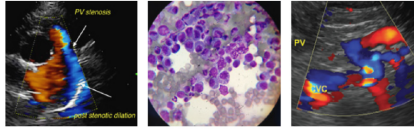
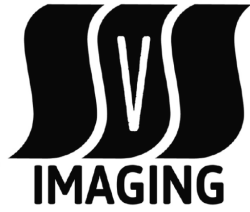
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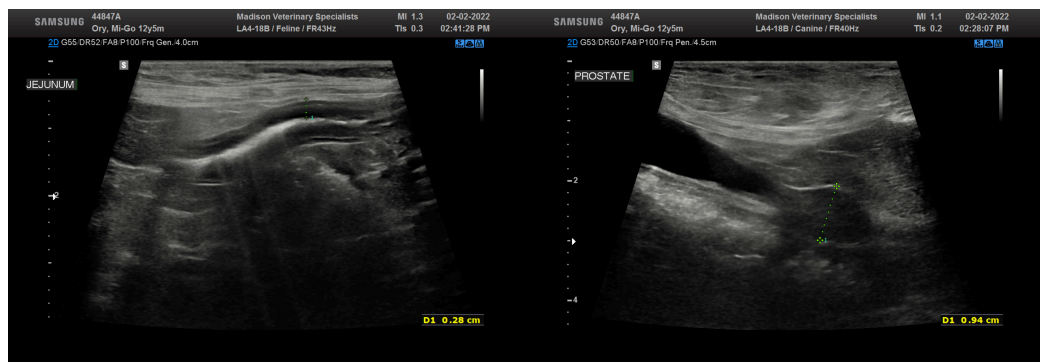
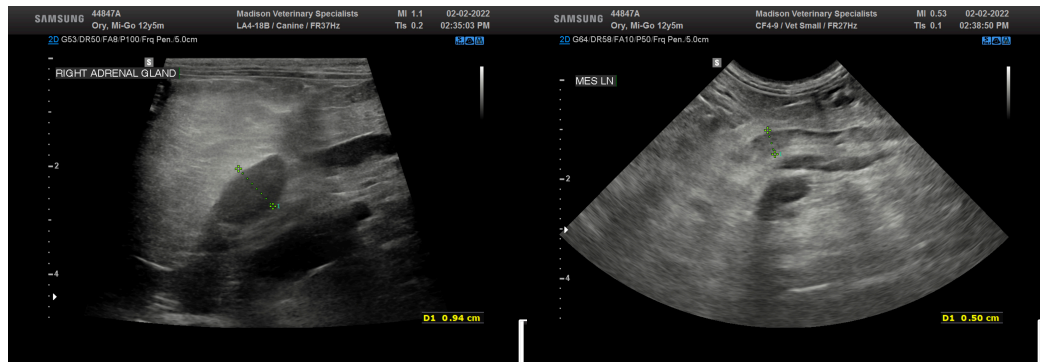
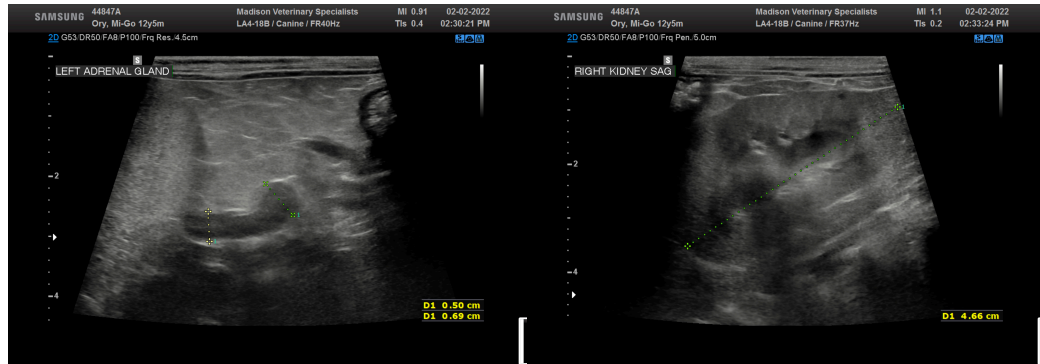
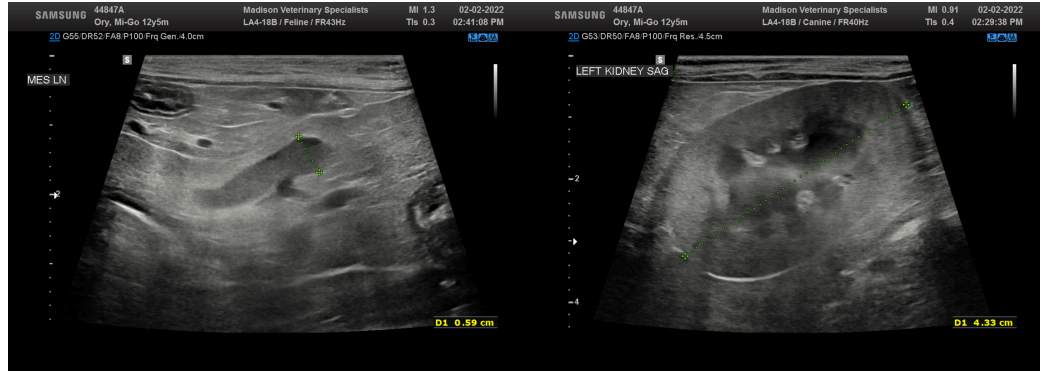
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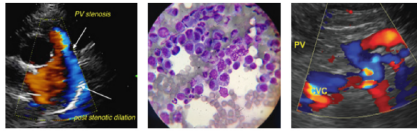
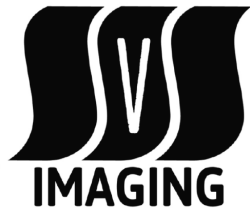
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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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