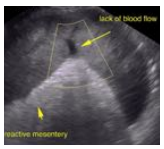

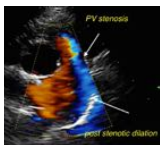

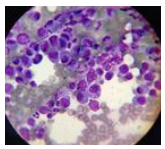
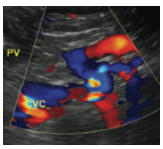

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PATIENT

Millie Downs

SPECIES

Canine

BREED

Miniature Dachshund

SEX

Spayed female

AGE

14 years

WEIGHT

7.8 lbs

INTERPRETED BY

Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Beachy

HOSPITAL NAME

Willamette VH

REFERRING VET

Dr. Beachy

INVOICE

42597

DATE

2/7/23

PRESENTING CLINICAL SIGNS

History: Presented 2/5 for 3d anorexia, 2 day vomiting, contained some wisteria leaves (GI toxin). Bloody stool prior to presentation. 1d hunched stance and shaking. O gave pepto prior to presentation. Possible muzzle swelling the day before presentation. ASPCA case #230027719 Wisteria may cause vomiting, diarrhea, and blood within the stool. It does not typically cause organ dysfunction, ulcerative injuries, or shedding of intestinal lining. Patients may develop acute hemorrhagic diarrhea syndrome. Facial edema is not a typical sign and is more consistent with allergic reactions. Recommendations: GI supportive therapies, fluids, anti-nausea medications, and bland diet. If organ involvement then look for additional signs. Abdominal Radiographs (3): mineral opaque material suspected at the level of the gallbladder (suspect pepto in gastric lumen). Mild gas distension of the colon. Gas and soft tissue opaque small intestines. Kidneys and urinary bladder in normal size and locations. Adequate serosal detail. No obvious obstruction. 2/5/23 night updates Multiple episodes of regurgitation. 2/6/23 daytime updates Placed NG tube; 2 episodes of regurg through day 1, 8, 10ml residuals FNA and cytology submitted (no evident MCT); p was admin diphenhydramine before FNA cleaned out both ears which were very dirty Have GP service or other docs prepare dental and mass removal estimate for O. 2/6/23 night updates: P doing OK o/n. Still having D. Regurgitation noted once at 8pm. P not eating on her own yet and is receiving 1/4 RER via NG tube Residuals- 1 mL at 12 am, 3 mL at 1 am and 2 mL at 4am.
Abnormal PE/Chem/CBC/UA Results: 02/05- CBC: HCT 53.9, Eosinophils 0.05, MCV 60.8, Plt 0.47 Chem 17: Ca 7.7, TP 11.2, Albumin 4.9, Glob 6.3, ALP 21, t-bili 5.7, Cholesterol 101, Amylase 487 ALT dilution: <30, wnl EPOC: Bicarbonate 28.7, Ca 1.11, Chloride 104, TCO2 27.8 cPL: 75.1, wnl aFAST: no free fluid, gastric distention, no obvious masses. 02/06 - tbili normalized HCT 50%/ 5.8 EPOC- HCT 48%, Bicarb 30.3, NSF

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 **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 4.0 cm. The right kidney measured 4.0 cm with slight pinpoint mineralization.

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 0.5 cm.

Spleen

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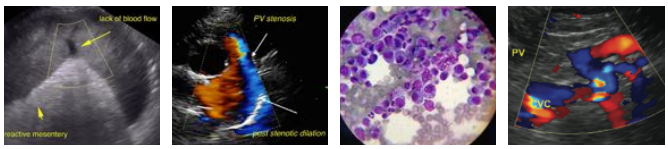

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The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated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

Liver

The **liver** images from right and left intercostal as well as subcostal views revealed subjectively normal liver contour and structure. The liver was mildly subnormal in size. Some age-related parenchymal remodeling was noted but likely not clinically significant at this time. Vascular and biliary tracts were of normal volume and no evidence of congestion was noted. The gallbladder presented some dependent debris with essentially normal contour. The cystic and common bile ducts were normal. No overt evidence of active inflammatory, infiltrative or regenerative pathology was noted but should be paired with current or past LE elevations regarding any clinical significance to this presentation. The hepatic lymph nodes were unremarkable.

Gastrointestinal

The **stomach** revealed a fluid filled lumen. Gastric over distension was noted. The small intestine and colon were unremarkable with mildly increased submucosal echogenicity and spastic bowel, yet no evidence of obstruction.

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

Gastritis pattern.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Supportive care should prove effective with 24 hour n.p.o. There was no evidence of foreign body or obstruction. I recommend reassessing the bilirubin. If the bilirubin value is persistent and not artifactual then FNA should be considered.

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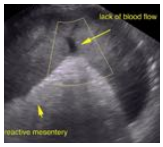

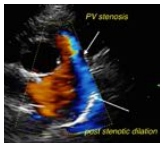

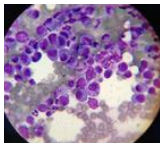
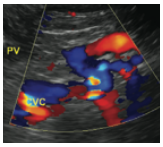

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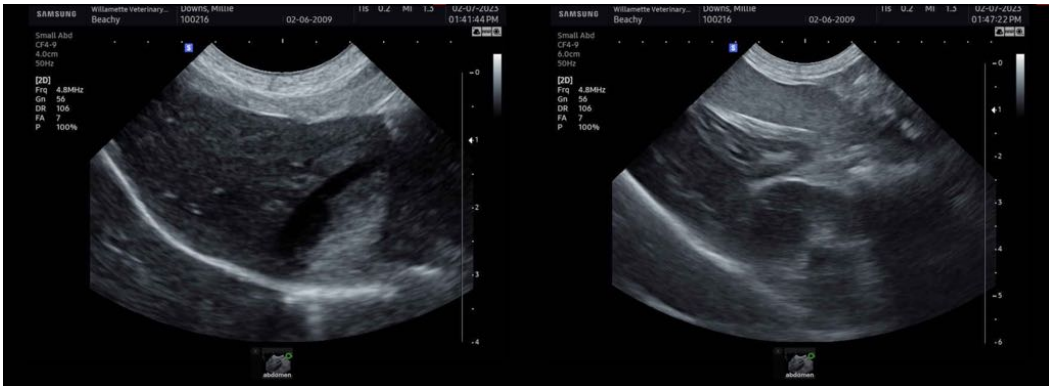

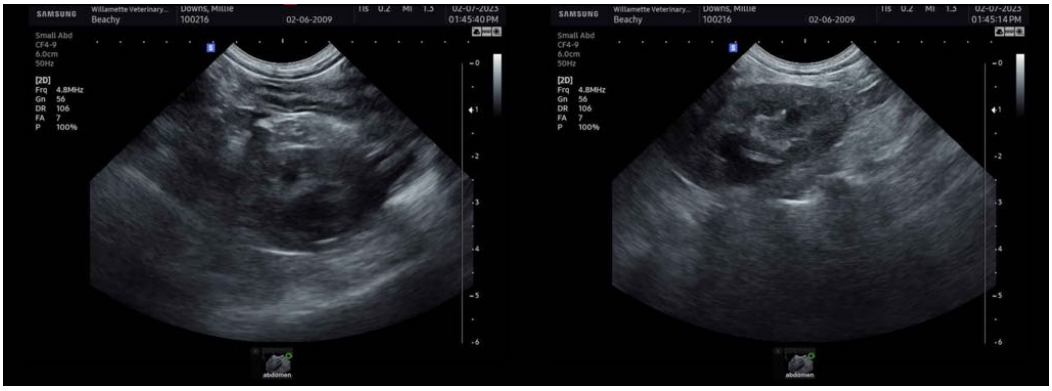

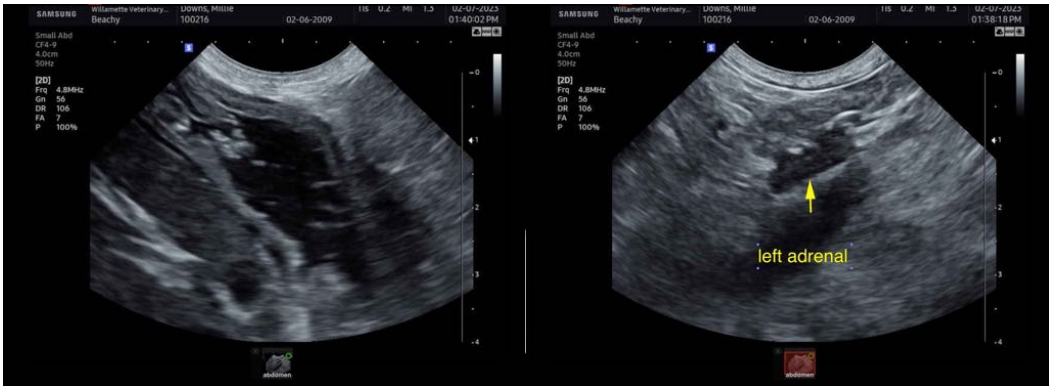

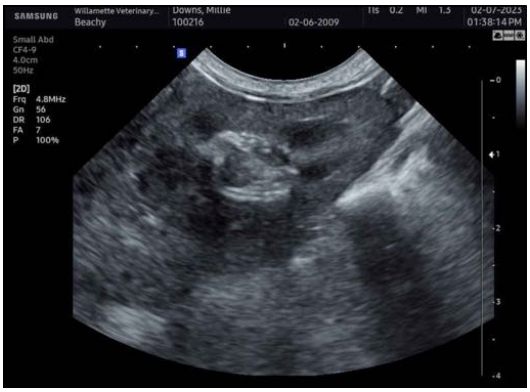

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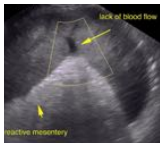

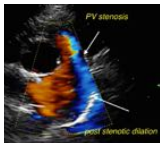

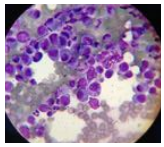
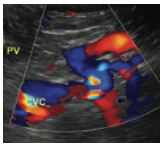

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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