



**PATIENT**

Theo Lynn

**SPECIES**

Canine

**BREED**

French Bulldog

**SEX**

Neutered Male

**AGE**

1 Year 10 Months

**WEIGHT**

31.5 Pounds

**INTERPRETED BY**

Eric Lindquist, DMV  
DABVP, Cert. IVUSS

**IMAGING  
PERFORMED BY**

Dr. Wymard

**HOSPITAL NAME**

Brookwood AC, LLC

**REFERRING VET**

Dr. Wymard

**INVOICE**

15841

**DATE**

6/1/22

**PRESENTING CLINICAL SIGNS**

History: P presented to ER clinic 7 days ago for vomiting. Abdominal rads at that time were WNL. Only abnormality on BW was SDMA (16). P was treated supportively and sent home. P has not fully recovered. Very lethargic and not eating much. O started feed chicken/rice and P has been eating that but not much. P has been on cerenia up until today (6-1). No vomiting has occurred. Stool was soft yesterday - fecal ran was negative. P had several accidents in the house which is very unlike him - U/A yesterday was negative.

Abnormal PE/Chem/CBC/UA Results: 5-25: SDMA (16) 5-31: trace proteinuria; USG 1.025

**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 pelvic urethra was imaged 1.0 cm beyond the cystourethral junction. The residual prostate measured 1.0 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 left kidney measured 5.0 cm. The right kidney measured 5.0 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 left adrenal gland measured 0.5 cm. The right adrenal gland measured 0.8 cm at the cranial pole and 0.5 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*

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.

*Gastrointestinal*

The gastrointestinal tract presented considerable gastric artifact due to the presence of ingesta. This did not permit thorough evaluation of portions of the gastric and upper intestinal structure. No overt



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abnormality was seen in the visualized tissue, however. This is consistent with a post-prandial presentation within a few hours of mealtime. If the prandial temporal interval does not fit the case history, and the patient presents a history of post-prandial vomiting, this could indicate a delayed upper gastrointestinal outflow due to primary or secondary pyloric hypertrophy, upper GI infiltrative disease, motor deficits, or a non-visualized foreign body. A prudent approach would be to rescan this patient at 24-hour NPO status to further review the non-visible regions if stomach primarily as well as assess any delayed outflow issue.

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## 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.

## SEX

Neutered Male

## ULTRASONOGRAPHIC FINDINGS

- Structurally unremarkable abdomen
- Minor retention of ingesta

## AGE

1 Year 10 Months

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Dietary indiscretion, food intolerance, structurally insignificant inflammatory bowel or occult parasitism and occult Addison's are all potentials. Screening for Addisons warranted. Baseline cortisol, if not already performed, even though the adrenals appear structurally normal.

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A clinical trial of the following could be considered.

## Helicobacter/Gastritis protocol

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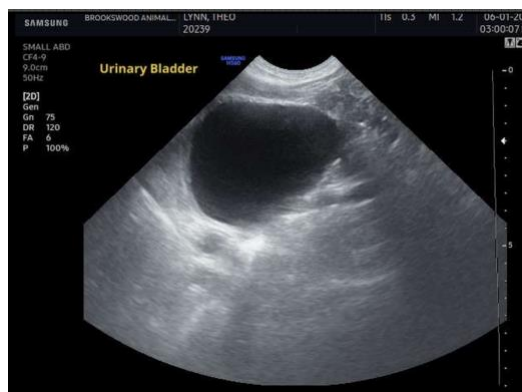
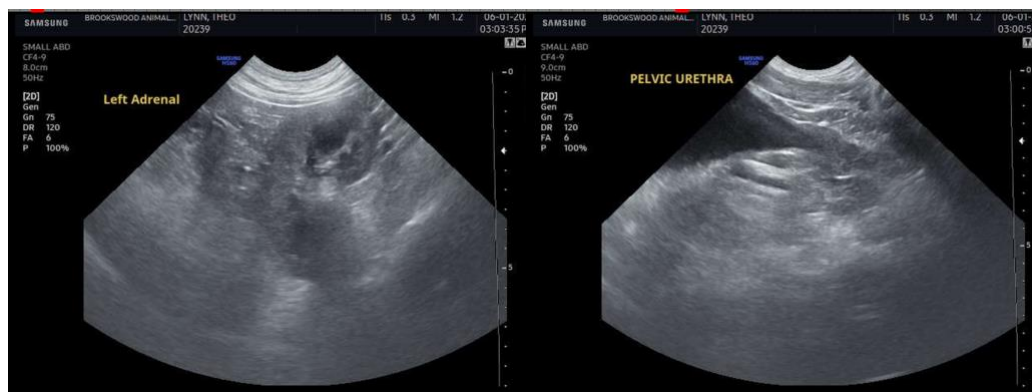
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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  
info@SonoPath.com