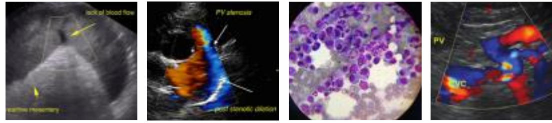


PATIENT

Tanner Baker

SPECIES

Canine

BREED

Chihuahua

SEX

Neutered Male

AGE

14 Years

WEIGHT

8.6 Pounds

INTERPRETED BY

Eric Lindquist, DMV, DABVP, Cert. IVUSS

HOSPITAL NAME

Q Street AH

REFERRING VET

Dr. Bretschneider

INVOICE NUMBER

23318

DATE

7/12/23

PRESENTING CLINICAL SIGNS

History: intermittent lethargy, loose stool, loss of appetite for 6 months. Had a low PCV at one point and put on Prednisone. PCV stabilized. Had an ultrasound in March via Animal Sounds. Main finding was thickened tissue of the stomach. Usually gets lethargic, has diarrhea and loss of appetite but improves and rebounds. Recently not rebounding. Dehydrated and lethargic. Vague - reluctance to open mouth even though no visible lesions or significant tooth disease. CBC/ full Chemistry 7/11/23 normal with exception of mild increase in BUN and Crea - possibly secondary to dehydration Current Medications Prednisone and metronidazole Radiographic Findings none taken Primary Question/Differential to Be Answered in This Exam cause of loose stool, loss of appetite, lethargy

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 0.7 cm.

The **kidneys** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some moderate 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 4.4 cm. The left kidney measured 4.5 cm.

Adrenal Glands

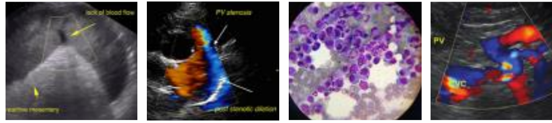
Both **adrenal glands** were visualized and recognized as having largely normal shape, size, position and acceptable echogenicity for this age group and breed. Some heterogeneity was noted within the adrenal parenchyma without concerning capsular distortion. These changes are likely age related but should be monitored by sonogram should the patient be suspected of having adrenal disease. The right adrenal gland measured 1.56 cm x 1.13 cm at the cranial pole and 0.48 cm at the caudal pole. The left adrenal gland measured 1.74 cm x 0.32 cm at the cranial pole and 0.41 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 from right and left intercostal as well as subcostal views revealed subjectively normal liver size, contour, and structure. Some minor age-related parenchymal remodeling was noted but likely not clinically significant at this time. Vascular and biliary



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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 **gastric** wall was mildly thickened. Some echogenic remodeling was noted. Wall thickness measured up to 0.9 cm. The gastric lumen was empty. The gastric thickening continued into the gastroesophageal inlet and pyloric outflow yet no neoplastic criteria was evident. The small intestine and colon were unremarkable.

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

- Geriatric abdomen with gastric wall thickening, most consistent with chronic gastritis or history of gastritis with secondary hypertrophy.

- Unremarkable abdomen otherwise.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Diet change to hydrolyzed geriatric diet may be appropriate. A clinical trial of the following may be prove effective. Endoscopy would be warranted otherwise. Other causes of anorexia should be considered as well, such as oral or esophageal disease or pain related disease, such as orthopedic pain, as the abdomen appears fairly unremarkable other than the minor gastric wall thickening.

Helicobacter/Gastritis protocol

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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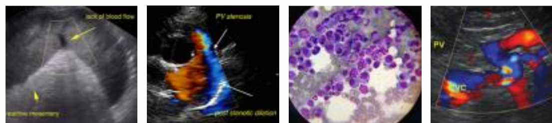

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
Eric.Lindquist@SonoPath.com