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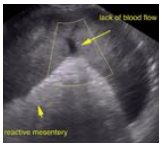
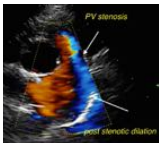
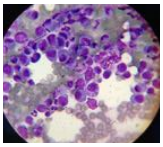
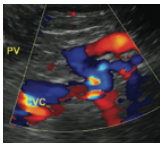

PATIENT

Jackson Herriott

SPECIES

Canine

BREED

Toy Poodle

SEX

Neutered male

AGE

11 years

WEIGHT

3.69 kg

INTERPRETED BY

Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Mergl

HOSPITAL NAME

Niagara Falls AMC

REFERRING VET

Dr. Mergl

INVOICE

31652

DATE

7/13/22

PRESENTING CLINICAL SIGNS

-Presented for diarrhea and abdominal pain of 3 days duration on July 7, 2022. -He has never had a history of gastrointestinal problems before. He is carefully watched, does not go anywhere, did not get into any thing at all, according to clients. -Originally the dog responded to a bland diet with a normal stool, but soft mucousy, frequent stools started up again within 24 hours. -Bloodwork shows only mild elevation in ALT, BUN and SDMA; urinalysis was normal. spec CPL is normal. The fecal panels were negative. - He was treated with tylosin and probiotics and sent home. His diarrhea and distress returned in 4 days, along with anorexia and lethargy. -He was admitted for 2 days of IV fluids, repeat of bloodwork, radiographs and ultrasound, and treatment with sulcrate, metronidazole and probiotics, as well as pain meds. -His radiology report came back with a non-specific gastrointestinal disease or IBD. -He was sent home July 12 with metronidazole, and probiotics, as he was alert, barking and very active in the hospital, but would not eat. He had no diarrhea while in the hospital, and was comfortable. -At home, he worsened again and has been uncomfortable and diarrhea restarted.
Abnormal PE/Chem/CBC/UA Results: -Mild elevation in ALT, BUN and SDMA;

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 was uniform and measured 1.0 cm.

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. Mild mineralization was noted in the kidneys. The left kidney measured 3.27 cm. The right kidney measured 3.32 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 0.33 cm at the cranial pole and 0.44 cm at the caudal pole. The left adrenal gland measured 0.47 cm at the cranial pole and 0.39 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 was noted.

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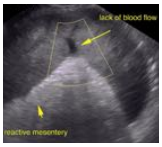

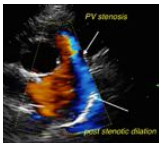

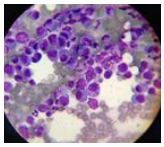
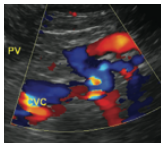

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Liver

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

Gastrointestinal

There was some residual chyme and gas was noted in the **stomach**, yet not pathological. This is consistent with end post prandial presentation. Transit of chyme into the small intestine was normal. Curvilinear patterns were maintained throughout the GI tract. No evidence of pathology. Small and large intestine demonstrated normal luminal chyme and stool consistency respectively. The colonic wall was slightly thickened with no loss of mural detail. Wall thickness measured 0.3 cm. No obstructive or overt infiltrative disease was noted. No associated abnormal lymphatic activity was noted.

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

Minor colonic thickening.

Age related renal changes with mineralization.

Benign hepatopathy.

Minor excessive gallbladder debris.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There was no structural evidence of significant GI disease, food intolerance, dietary indiscretion and occult parasitism. Broad spectrum anti-parasitic protocol, fecal test and hydrolyzed geriatric diet may be appropriate in this patient.

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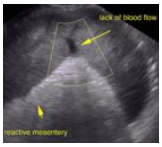
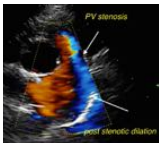
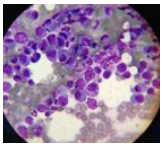
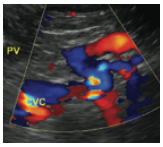

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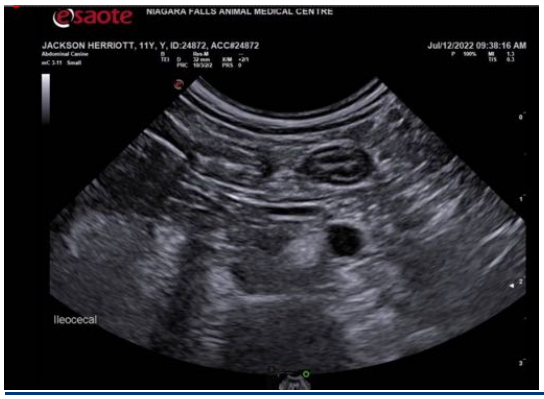

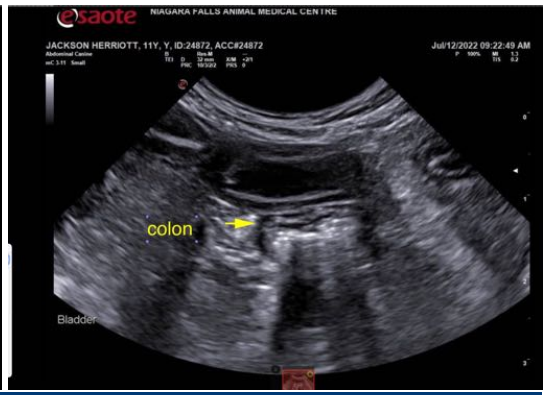

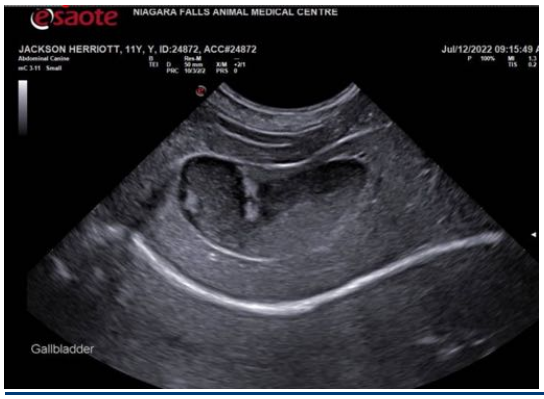

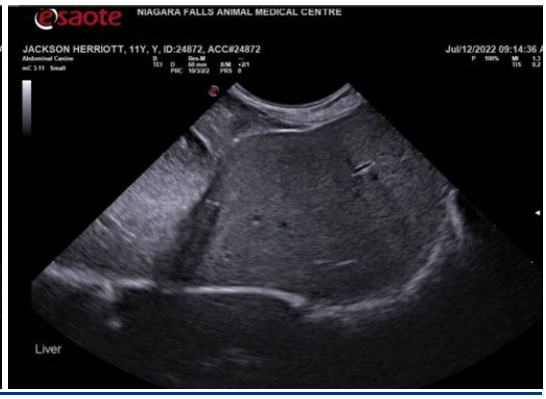

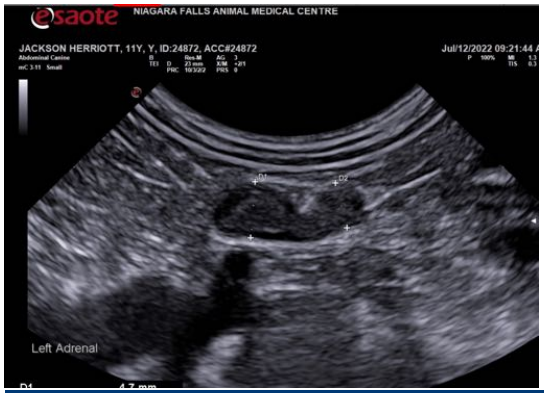

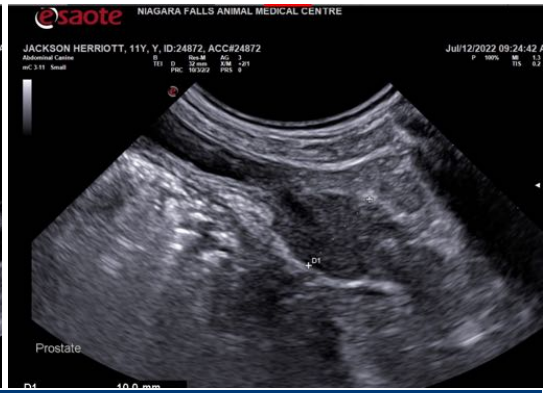

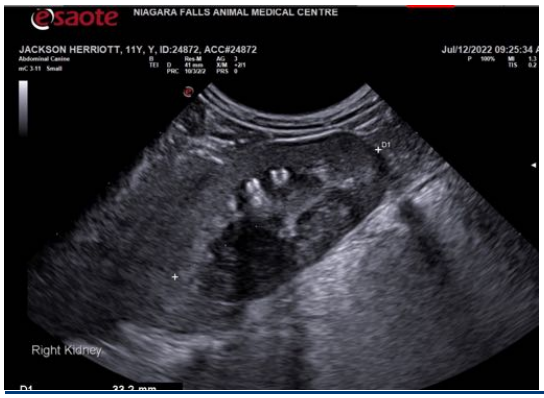

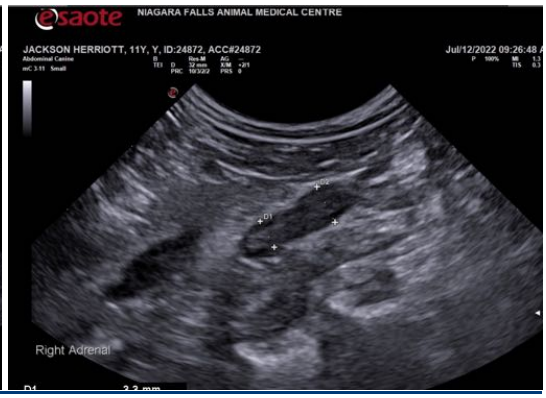

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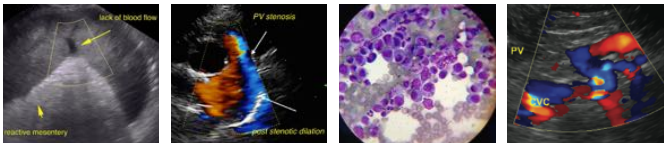

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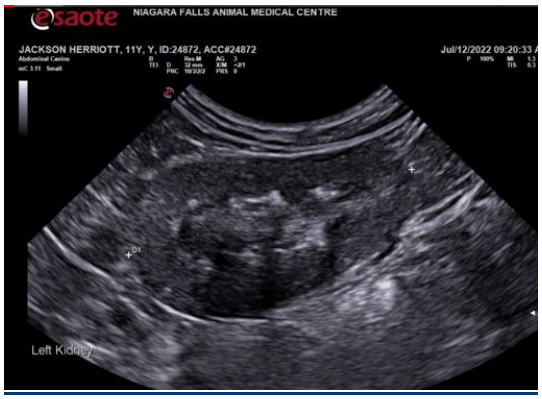

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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