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Clinical Sonography & Telecytology
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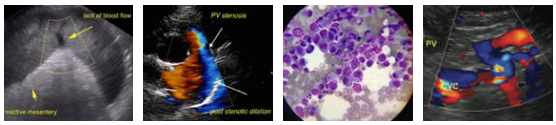


ANIMAL SOUNDS NW
MOBILE VETERINARY ULTRASOUND
IMAGING PERFORMED BY
AnimalSoundsNW.com 541-357-9423

PATIENT
Wallace Fawver

SPECIES
Canine

BREED
Labrador

SEX
Neutered male

AGE
11 years

WEIGHT
58.5 lbs

INTERPRETED BY
Eric Lindquist, DMV, DABVP, Cert. IVUSS

IMAGING PERFORMED BY
Jenna Walsh, CVT

HOSPITAL NAME
Albany AH

REFERRING VET
Dr. Fletcher

DATE
11/16/21

Invoice
93150

PRESENTING CLINICAL SIGNS

History: Pt seen 10/20/21 for Exam - vomiting blood. - vomited blood 10/18/21. - has a hx of vomiting blood & was seen at an emergency clinic. - appetite decreased. - eating grass. - lethargic when he's going to vomit. Current Medications Galliprant 60 mg - 1 Tab PO SID, Adequan Inj 10/20/21, Cosequin & CBD
Abnormal PE/Chem/CBC/UA Results: 10/20/21 CBC - all WNL except EOS High (3.26 K/mcL), CHEM 10 & Lytes WNL.

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 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 this age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. The left kidney measured 6.03 cm. The right kidney measured 6.28 cm.

Adrenal Glands

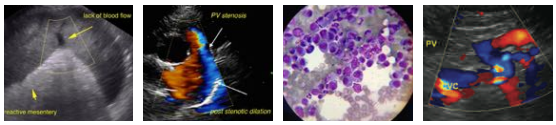
Both **adrenal glands** were flattened and isoechoic. This may be normal for this patient or potentially owing to occult Addison's disease or adrenal burnout from chronic disease. Baseline cortisol or ACTH stim is recommended to rule out typical, atypical, occult or active Addison's disease. The right adrenal gland measured 3.08 x 1.51 cm at the cranial pole and 0.77 cm at the caudal pole. The left adrenal gland measured 3.03 x 0.97 cm at the cranial pole and 0.73 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.

Liver

The **liver** images from right and left intercostal as well as subcostal views revealed subjectively normal liver size, contour, and structure. 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



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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 **gastrointestinal** presentation revealed mild uniform prominence of the gastric mucosa as well as areas of "ropey" small intestinal wall. Diffuse muscularis thickening was noted without loss of definition. Excessive gastrointestinal gas was present.

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

Diffuse gastrointestinal thickening with minor fluid filled lumen. This is most consistent with inflammatory bowel.

Bilateral adrenal hypertrophy.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

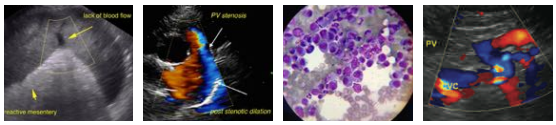
Dietary indiscretion, food intolerance/indiscretion, structurally insignificant inflammatory bowel or occult parasitism and occult Addison's are all potentials. There was no evidence of neoplasia or foreign bodies. Full thickness GI biopsies would be ideal in this patient for further definition.

If the patient appears Cushingoid and urine specific gravity is less than 1.020 then work-up for PDH is indicated. Gastrointestinal protectant protocol and hydrolyzed diet is recommended. Endoscopy could also be considered. A clinical trial of the following may prove effective. Hydrolyzed diet may be in this patient's best interest. Broad spectrum anti-parasitic protocol is warranted.

Triaditis/Pancreatitis protocol

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

Recommend pain management when anorexic with **Buprenorphine** (0.01-0.02 mg/kg IM or SC), clinical trial of **Zithromax** (50 mg sid/cat x 10 days, 3 weeks if bartonella +), **Prednisolone** (0.5-2 mg/kg tapering over 1 week to minimal effective dose), and **B12 injections** if weight loss (Cyanobalamine 250 mcg sub-q once-weekly x six weeks, then every other week for six weeks and then once-monthly, long-term if necessary), **novel-protein or hydrolyzed diet (***Hydrolyzed diets have been shown to be more effective in dietary intolerance case management compared to hypoallergenic diets***)** or the **magical Purina DM** (changing protein source is crucial and may need rotation every 6 months if clinical signs recur) Diet trials is a



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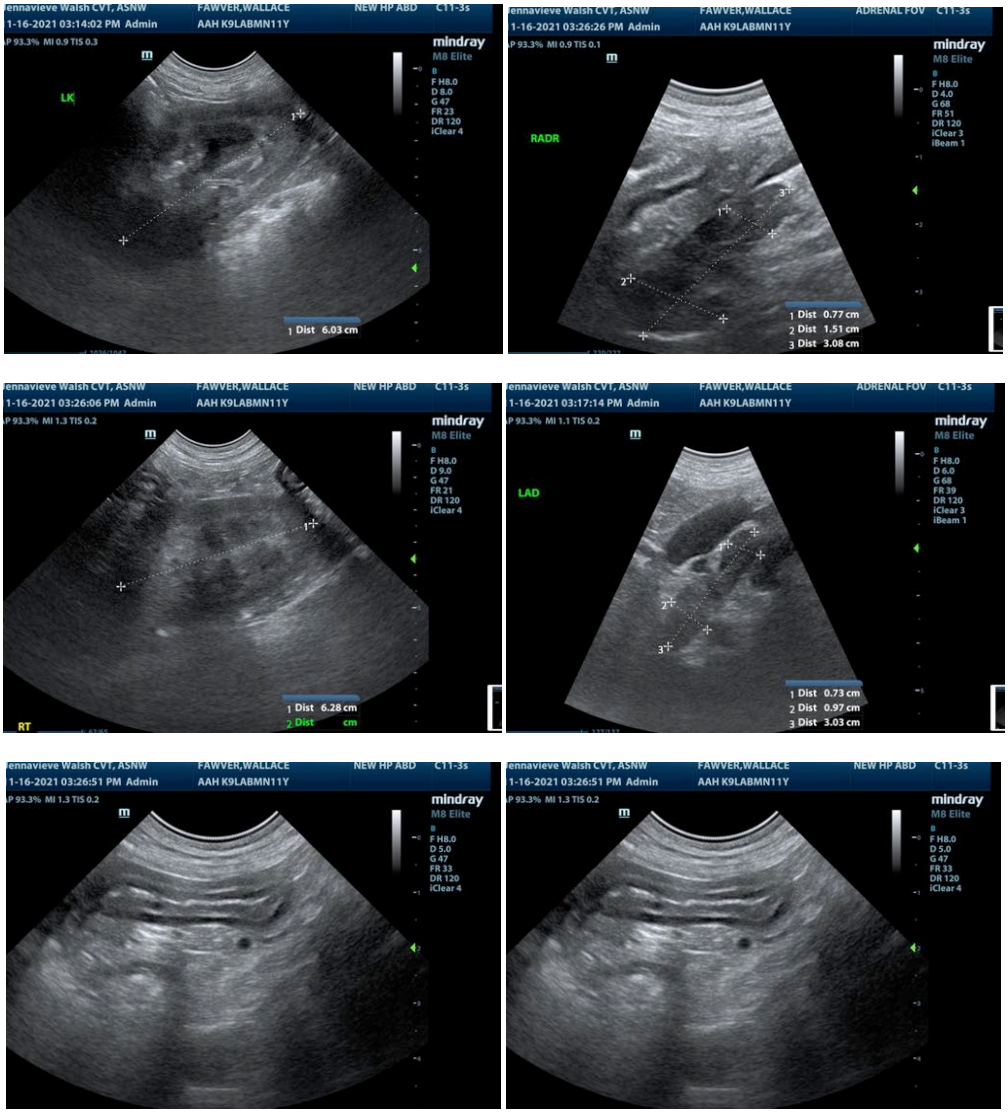
whatever works phenomenon. If vomiting becomes a persistent issue then endoscopy would be warranted and/or recheck sonogram to assess more emerging disease. One diet does not work for all patients so different trials may be necessary or protein source rotation every 6 months as new sensitivities develop.



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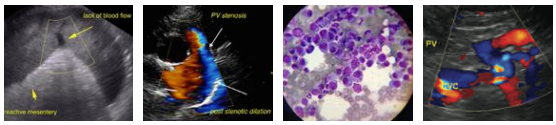

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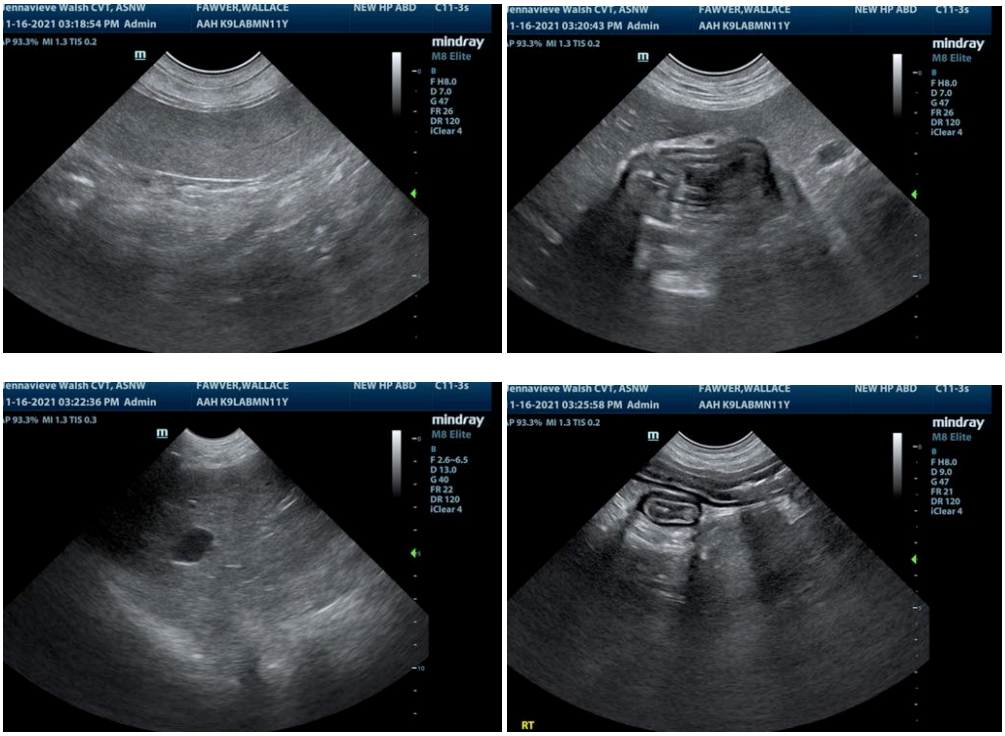

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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