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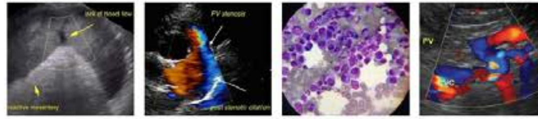


IMAGING PERFORMED BY

pawsonography@gmail.com 530-786-8340

PATIENT

Roscoe Rhodes

SPECIES

Canine

BREED

English Bulldog

SEX

Neutered Male

AGE

5 Years 6 Months

WEIGHT

48 Pounds

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT

HOSPITAL NAME

MountRose AH

REFERRING VET

Dr. Lori Burnham

INVOICE

24991

DATE

8/26/21

PRESENTING CLINICAL SIGNS

not sedated- anxious and increased RR effort ULTRASOUND FORM: Abdominal Ultrasound (routine) DATE: 08/26/2021 VETERINARIAN: Lori Burnham, DVM PATIENT/OWNER: Jordan and Andrea Rhodes Canine/Feline: Canine Age: 5 years 6 months Breed: English Bulldog Female/Male: Male neutered HISTORY: Chronic diarrhea since May 31, 2021 Patient presented on 06/01/2021 for diarrhea:Owner reports that patient has a appetite and will E and is D normal. Patient has no excessive TU and is not CSV but does have bloody diarrhea. Owner says around 3 a.m. Monday morning patient woke her up to go outside and patient had a loose stool all day that progressed into bloody diarrhea. Patient did go camping over the weekend so he did have a exciting weekend. Patient did spit up water today but that may have been from drinking too much too fast. Owner feeds a chicken, rice, veggie combo since patient has allergies. Patient is currently on Itraconazole, Clindamycin, Gabapentin, Probiotic and Prednisone 5 mg once a day. This patient has been under the care of a veterinary neurologist for congenital vertebral bodies and osteomyelitis. He has been on several antibiotics throughout the years (Doxycycline, Ciprofloxacin and Metronidazole to name a few). He has progressive pelvic limb paresis. O reports he also had a history of food allergies/sensitivities. Fecal test on July 6, 2021 was negative for parasites and on antigen tests. In house CBC/Chem 10 performed on June 1, 2021 demonstrated a high WBC count at 22.91; reticulocytes high at 168; ALT 222 and ALP 1861. The diarrhea goes away with Metronidazole but returns a few days after medications are discontinued. PHYSICAL EXAM: Weight: 47.8 lbs on 06/01. LABORATORY FINDINGS: -See lab abnormalities listed under the history portion RADIOGRAPHIC FINDINGS (email radiographs if available): No radiographs taken of the abdomen. REASON FOR ULTRASOUND: To try to identify any GI causes for chronic diarrhea, such as IBD GI LSA, other

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

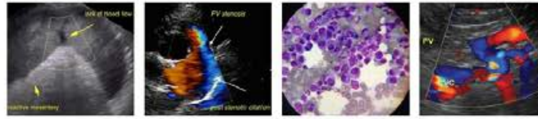
The prostate is normal in size (1.6 cm) and shape for this neutered male dog. The parenchyma is homogenous and the external margins are smooth. The prostatic urethra appears normal with no evidence of irregularity, invasion, mass effect or calculi.

The left kidney has a normal shape and size (4.7 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (5.9 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.44 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.



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The right adrenal gland is normal in size measuring 0.67 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size and the echotexture is homogenous. The splenic capsule is smooth with no visible irregularities. Rare discrete focal hyperechoic, perivascular parenchymal abnormalities are present. The appearance of these lesions is most consistent with benign splenic myelolipomas. The blood flow through the hilus and splenic parenchyma appears normal.

Liver

The liver is large in size, with normal echogenicity and smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are primarily anechoic. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.7cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal fluid distension. Wall appears subjectively, mildly increased. Bowel loops follow a typical curvilinear path with distinct wall layering. Duodenum wall measured 0.41 cm. Jejunum wall measures 0.39 cm. Visualized peristalsis appears appropriate. There is an image of the duodenum, which appears particularly thickened at 0.71 cm with intact layering. There is no evidence of a focal mass effect.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The pancreas is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is a mild lymphadenomegaly present. A mesenteric lymph node is visualized measuring 0.41 cm. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is generally of normal echogenicity.

PRIMARY FINDINGS

- Large, heterogeneous liver – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy. The significance of this is unclear, as this patient is

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on steroids, which can create a vacuolar hepatopathy.

- Thickened small intestine with intact layering – The bowel wall thickening could be consistent with inflammation, edema, or infiltrative neoplasia.

SECONDARY FINDINGS

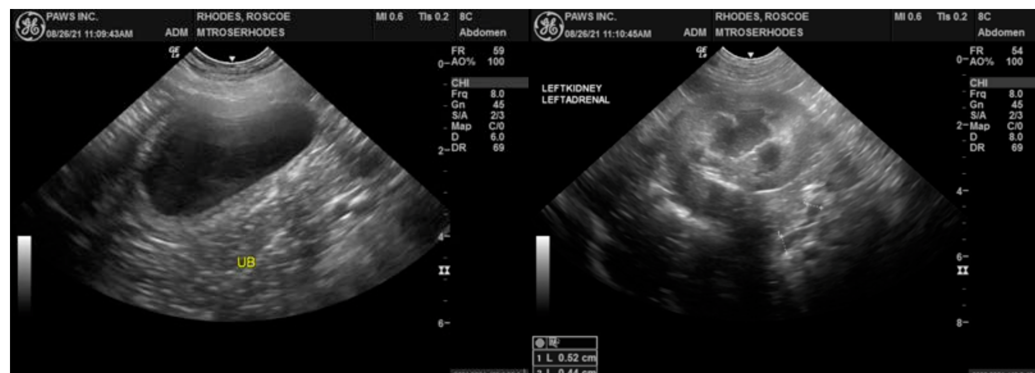
- Mild mesenteric lymphadenopathy – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The liver is large and very heterogeneous. This patient is on a lot of medications, some of which can increase liver enzymes, etc. You could consider a liver function test and fine needle aspirate of the liver if concerned.

The bowel does appear thickened, but layering intact. Large and small intestinal biopsies would be necessary to further evaluate for IBD, etc. Based on the history of a response to Metronidazole and many previous antibiotics, dysbiosis would be a concern. Consider a GI panel to Texas A&M for a PLI, B12 and folate level to better evaluate for possible bacterial overgrowth. Recommend probiotic. You could consider a fecal transplant if dysbiosis is strongly suspected, but ideally endoscopy or biopsies would precede this.

If at all possible, trying to transition off some oral medications to topicals for the skin might be helpful in addition to tapering off of the Prednisone and consultation with a veterinary nutritionist to formulate a truly hypoallergenic homemade diet, which could help to reduce need for additional medications and abe beneficial to both the skin and GI tract (I've used University of Tennessee's nutrition service and have been happy with it).



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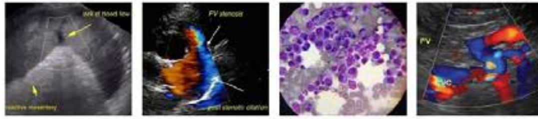

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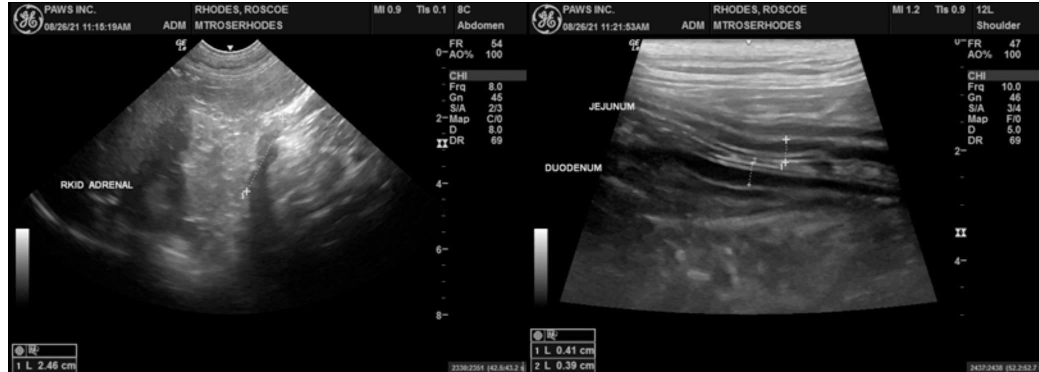

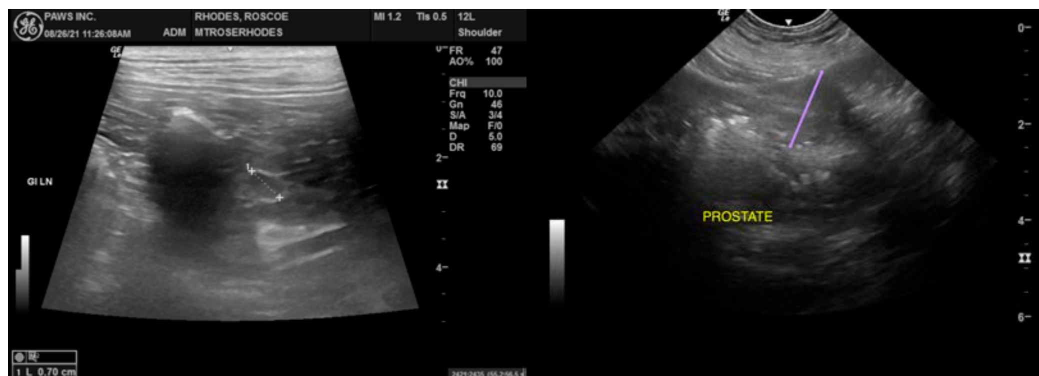

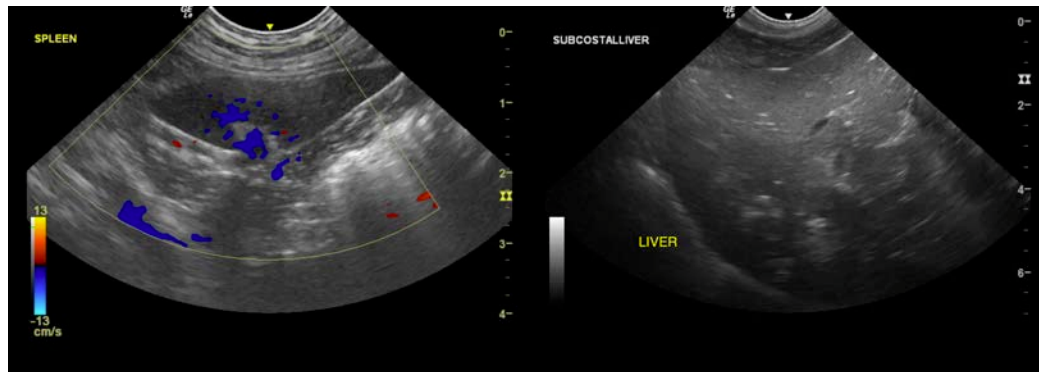

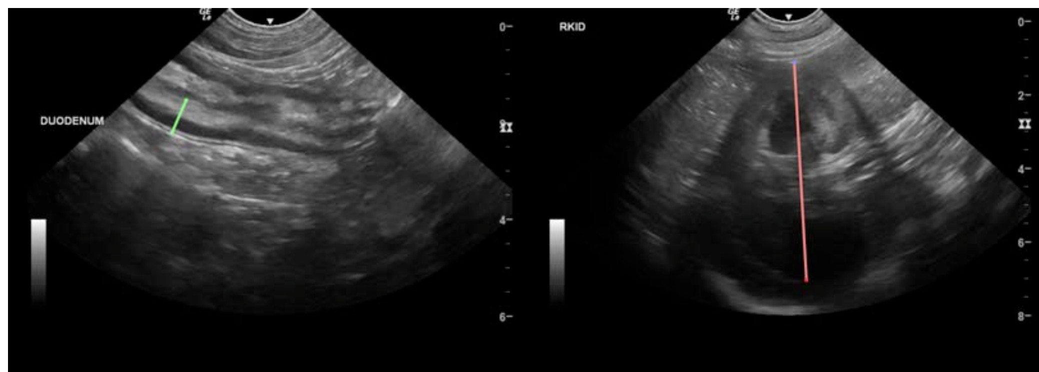

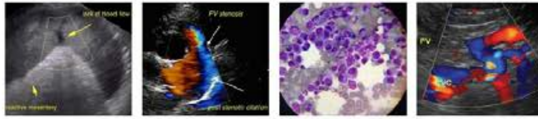

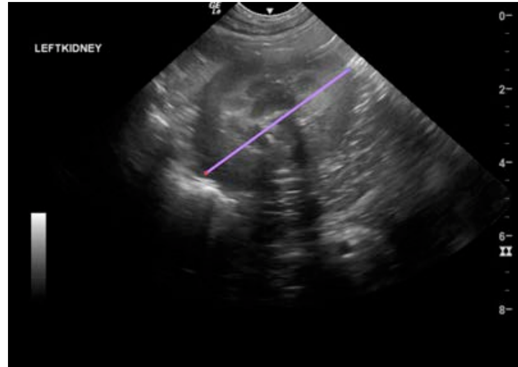

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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