



PATIENT

Kain Gale

SPECIES

Canine

BREED

Husky

SEX

M/N

AGE

6 years

WEIGHT

69.6 lbs.

INTERPRETED BY

R. McKenzie Daniel,
DVM, DABVP
(Canine and Feline)

IMAGING PERFORMED BY

Chrissy Krell, DVM

HOSPITAL NAME

Town & Country AC

REFERRING VET

Amanda Bergin,
DVM

INVOICE

15999

DATE

1/28/23

PRESENTING CLINICAL SIGNS

Over Thanksgiving Kain was boarded and O was told he had diarrhea, they gave pumpkin and endosorb. Boarding facility informed O he was lethargic. She picked him up on Saturday(11/26) and he was covered in diarrhea. Brought him to the clinic (employee at Town & Country) and gave Kain a bath. pDVM took xrays - no evidence of obstruction. Started Diagal and Metronidazole 500mg BID. Sunday(11/27) vomited up a baby wipe and rubber thing. Brought in on Monday(11/28) gave barium to screen for obstruction, etc - no evidence found, barium passed normally. Rechecked bloodwork. Tuesday(11/29) did an exploratory on him and found nothing. Bloodwork came back with CPL number of 2000(0-200 normal). Overnight vomited 4 times black/dark red material. Went to ER on 11/30 and stayed for 4 days. O picked up Saturday (12/3) Kain was then receiving Omperazole, entyce, Cerenia, Amoxicillin(for his aspiration pneumonia) Gabapentin, Cisapride. 12/6 Was doing good, eating small amounts of boiled chicken. 12/14 came into clinic for regurgitating food/water. Diagnosed with esophagitis. Put on Sucralfate & metoclopramide. 12/20 feeding blended id stew in a syringe. 12/29 started on odansatron. 1/14 had a set back and regurgitated 20 times overnight. Currently he has continued to lose weight, down 17 lbs (was 87 lbs before Thanksgiving). He is only medication he is on is Metoclopramide. Eating i/d low fat dry(1/4-1/2 cup) multiple times a day(max of 2 cups) if gets more then will be lethargic and regurgitate a lot.

Abnormal PE/Chem/CBC/UA Results: TODAY PE: thinning body condition, vitals wnl. BW history: 11/29 CPL number of 2000(0-200 normal) 12/6 CPL was 224. 12/30 sent out bloodwork CPL 141, TLI 12.4(5-35) B-12 743(284-836) folate 8.8(4.8-19)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

The area of the aortic trifurcation was free of pathology.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. The left kidney measured 6.6 cm in length. The right kidney measured 6.6 cm in length.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.52 cm width at the caudal pole and 0.65 cm width at the cranial pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.49 cm width at the caudal pole and 0.46 cm width at the cranial pole.



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Spleen

Kain Gale

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

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Liver/ Gallbladder

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The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

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Gastrointestinal

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The stomach presented mild to moderate wall thickening secondary to mild to moderate echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. The stomach contained a mild amount of retained anechoic fluid. No evidence of mechanical pyloric outflow obstruction or obstructive pyloric mural pathology was noted. The pylorus wall width measured up to 0.94 cm.

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The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of mechanical / metabolic ileus, obstruction, or foreign material. The duodenum wall measured 0.34 cm width. The jejunum wall measured 0.32 cm width.

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Normal visible colon wall layers were present with apparent formed feces in lumen.

IMAGING PERFORMED BY

Chrissy Krell, DVM

Pancreas

The parenchyma of the left limb, body, and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease were evident.

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Free Abdomen

Focal to intermittent mesenteric nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). The lymph nodes were not consistent with inflammatory or neoplastic criteria and likely incidental. An example of a lymph node measured 2.6 cm x 0.48 cm.

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ULTRASONOGRAPHIC FINDINGS

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- Gastritis pattern with mild gastric stasis, sonographically unremarkable small bowel

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No sonographic evidence of significant visceral, specifically gastrointestinal or pancreatic pathology. Sonographically, the appearance of the stomach was suggestive of gastritis with likely minor secondary metabolic hypomotility. No evidence of a gastrointestinal obstructive pattern or foreign material was noted.



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Continued empirical therapy for gastritis with possible empirical coverage for helicobacter and esophagitis would be reasonable. If not recently or already done, three view chest radiographs to rule out occult thoracic or esophageal pathology as a contributing factor is suggested. Although considered unlikely a resting cortisol level to rule out occult Addison's Disease is recommended.

Given the thinning body condition yet normal GI panel and pending additional diagnostics, intestinal biopsies may be considered if clinical signs continue or evidence of progressive weight loss. Some or all of the following protocol may be considered.

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 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. High colony count probiotics such as Provable is suggested if antibiotic therapy is elected. A recheck sonogram to assess GI improvement or progression would be ideal in 4 weeks.

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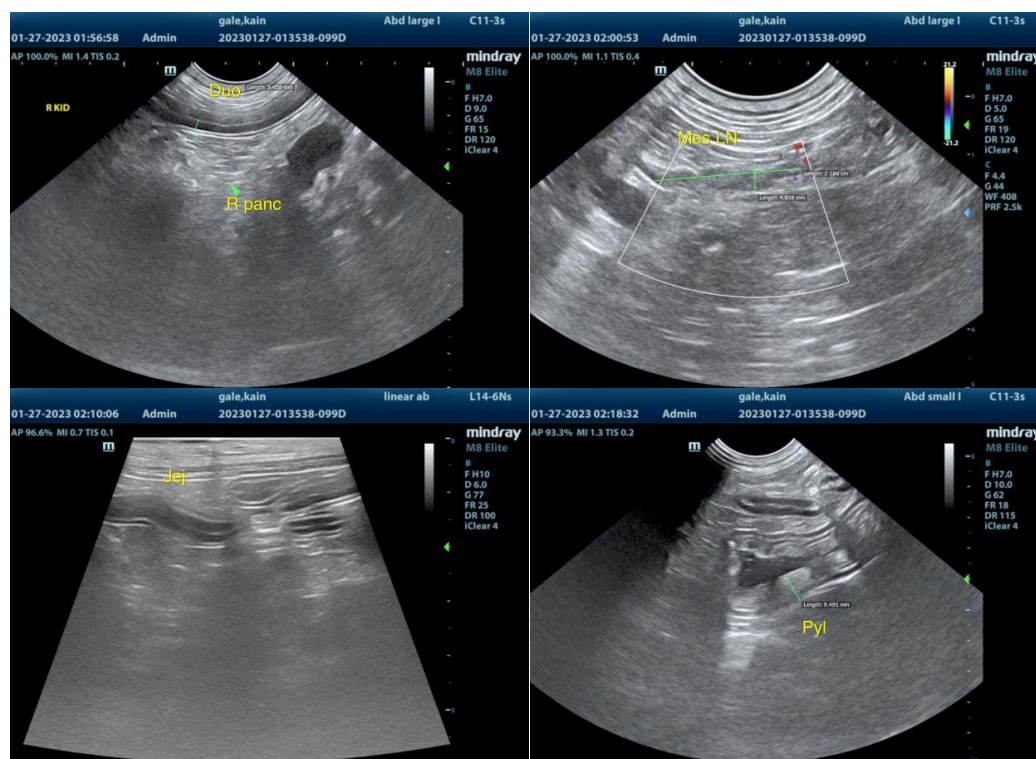
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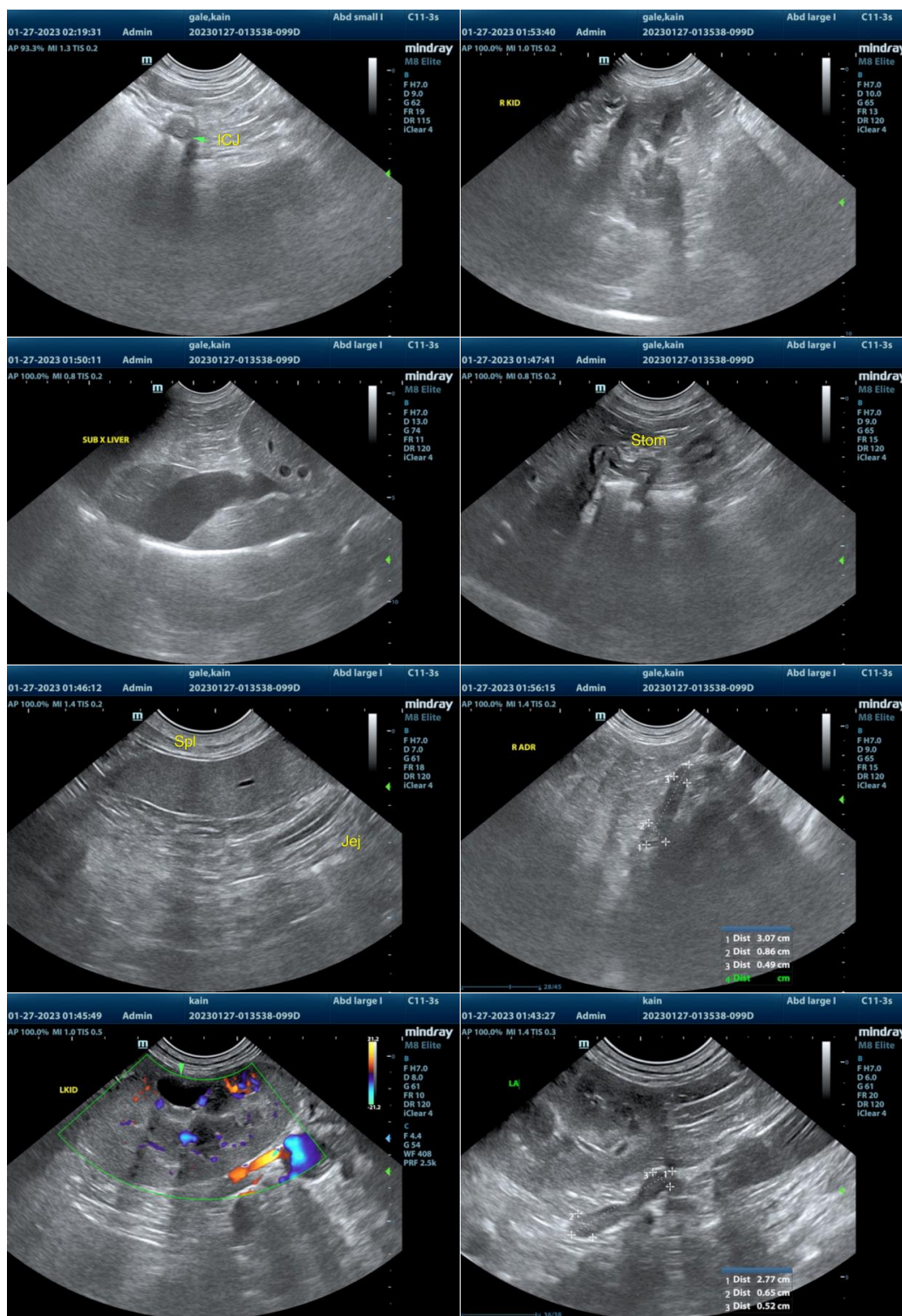
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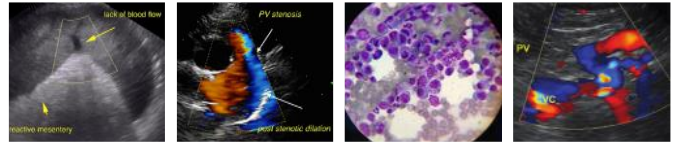
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology



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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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)
info@SonoPath.com