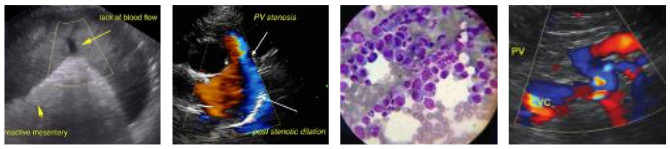
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Cielo Sawyer

SPECIES

Canine

BREED

Italian Greyhound

SEX

FS

AGE

11yr

WEIGHT

12lb

INTERPRETED BY

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

IMAGING PERFORMED BY

Hess

HOSPITAL NAME

Petmedic Urgent Care Vet Clinic

REFERRING VET

Amy Hess

INVOICE

12624ag

DATE

01/08/2023

PRESENTING CLINICAL SIGNS

vomiting after H2O2 administration 2 weeks ago- suspect gastritis, treated with famotidine and pepcid. Improved until 2 days ago, stopped pepcid and started vomiting again, vomiting after eating and drinking any food/water vomited a small stick 2 days ago

Abnormal PE/Chem/CBC/UA Results: radiographs- fluid and gas in stomach, stool in colon, no FB

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder was normal in overall size and tone. Focally thickened to mildly non-homogenous dorsal trigone wall area of the ureteral papilla measuring 0.7 cm x 0.3 cm was present. The thickening exhibited mild non-homogenous mural echogenicity with potential for pinpoint discrete hyperechoic mural foci. 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.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 4.0 cm in length. The right kidney measured 4.0 cm in length

The area of the aortic trifurcation was free of pathology.

The area of the iliac trifurcation was free of pathology including no evidence of medial, iliac or sublumbar lymphadenopathy.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.45 cm width at the caudal pole and 0.40 cm width at the cranial pole. The right adrenal gland was not visualized.

Spleen

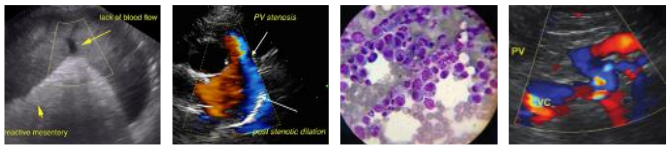
The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute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

Liver/Gallbladder

The liver presented enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented mild to moderate wall thickening secondary to echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. Mild gastric distension with mild to moderate retained



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primarily anechoic fluid and hyperechoic chyme was present. No evidence of overt gastric foreign material, pyloric outflow obstruction or obstructive mural pathology. The ventral gastric wall measured 0.49 cm in width.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. Minor segmental jejunal ileus with non-specific mild segmental hyperechoic mucosal speckling was present. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material.

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

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 was evident.

Free Abdomen

No omental masses, overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Focally thickened dorsal trigone wall in the subjective area of the ureteral papilla-patient variant or benign prominent ureteral papilla, focal cystitis, potential for emerging mass i.e. transitional cell carcinoma cannot be excluded
- Hypomotile gastritis pattern with possible concurrent enteritis
- Sonographically unremarkable pancreas
- Mild chronic renal changes
- Minor hepatic parenchymal remodeling-benign

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A screening BRAF assay is suggested along with sonographic monitoring of the focally thickened dorsal trigone wall for evidence of progression, ideally with initial recheck in 3-4 weeks. Possible persistent to resolving hemorrhagic gastritis could be considered given history of H2O2 administration. No evidence of GI foreign material or mechanical obstructive pattern was present. Continued therapy for gastritis/gastroenteritis +/- coverage for helicobacter would be reasonable. Although considered less likely considering normal adrenal presentation, a resting cortisol level to rule out occult Addison's disease is recommended. Some or all of the follow protocol or similar may be considered with assessment of clinical response.

A clinical trial of **Zithromax (*Dogs:*** 5-10 mg/kg PO q24h. May increase dosing interval to q48h after 3-5 days of treatment)**, Metronidazole** (10 mg/kg PO BID), **Pepcid** (0.5-1 mg/kg PO SID.) and **Sucralfate** (0.5-2 g/dog PO) or **Omeprazole** (1 mg/kg PO SID.) over the next 3 weeks along with a **novel-protein or hydrolyzed diet** with slurry feeding BID/TID. 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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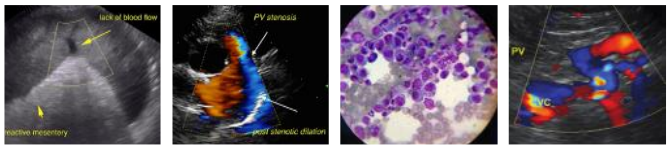

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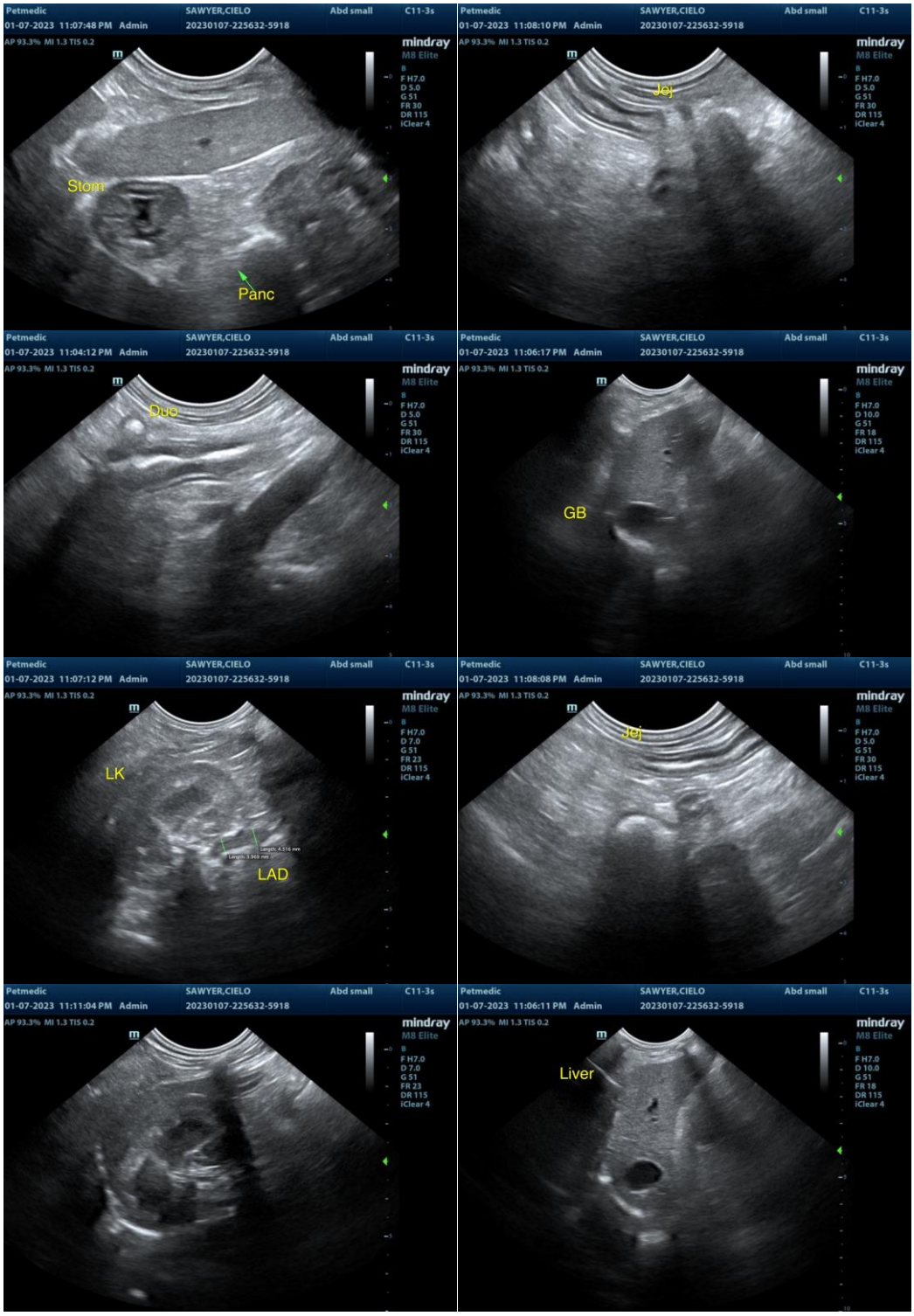

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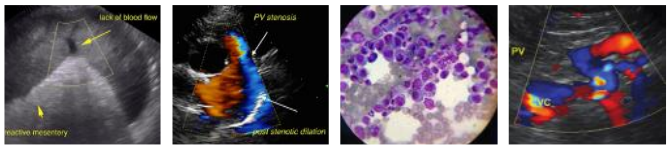

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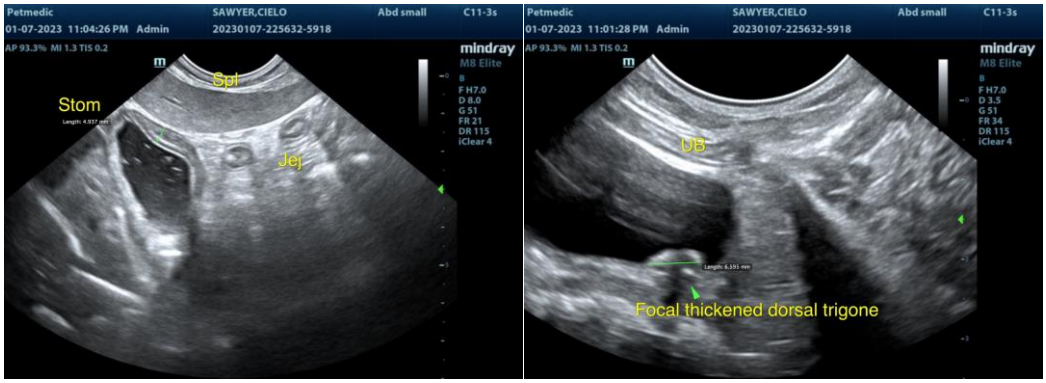

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine/Feline Practice)
mac.daniel@sonopath.com