


PATIENT

Freya Praus

SPECIES

Canine

BREED

Newfoundland

SEX

FS

AGE

4 yrs 4 mos

WEIGHT

94.6 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Jessie Evoniuk

HOSPITAL NAME

State Avenue VC

REFERRING VET

Dr. Jessie Evoniuk

INVOICE

15479

DATE

11/16/22

PRESENTING CLINICAL SIGNS

History: Since Friday night P has been V+ 1-2x per day Last few months has been "belching" a lot and they seem painful E/D-normal V+ is usually food and P will heave a lot with the V+ Last night was the first night she kept food down Keeps water down Was pretty lethargic until this morning, seems a bit brighter today Not usually one to chew on random things and not missing any toys Usually will go outside when she needs to V+ but the other day had a large regurg episode Meds- started a probiotic the other day to try and help Stools have been normal O wanting to update vx if possible Previous R&A due to intussusception May 2019 Previous TPLO surgeries. Doing well. Weight loss since last visit Physical Exam: General Appearance: Bright, alert and responsive Hydration: Hydration appears normal Eyes: Corneas clear, pupils normal size, symmetrical, sclera white, no ocular discharge Ears: No exudate observed, no redness present Oral Cavity: Tartar mild Nasal Cavity: No obvious abnormalities observed Cardiovascular: Regular rhythm; no murmur detected Respiratory: Lungs auscultate clear bilaterally; trachea clear Abdomen: Abnormal: Tense, guarding with abdominal palpation while not sedate. Sedated exam, no overt hard masses, cranial abdomen elicited similar guarded response but improved Rectal: Normal rectal exam, repeat temp while sedate 102.3 Musculoskeletal: Normal ambulation reported, previous TPLO surgeries Integument: Normal amount of shedding; skin looks normal; hair coat in good condition Lymph Nodes: Lymph nodes are all normal in size Assessments: Vomiting/lethargy- RO FB, other vs pancreatitis, gastritis, other Plan: Plan for bloodwork and US of abdomen. Start IV fluids and Cerenia pending Was fractious for restraint so gave Butorphanol but still fractious (not aggressive but wiggly). Gave low dose Dexmed for further handling. JME

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN
Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 5.0 cm 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.

No evidence of pathology was noted in the area of the uterine remnant.

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 6.5 cm in length. The right kidney measured 7.2 cm in length.

Adrenal Glands

The left adrenal gland exhibited potential for borderline to mild subnormal size given the patient breed and body weight. Normal position and parenchyma echogenicity was noted. The left adrenal gland measured 0.41 cm width at the caudal pole and 0.43 cm width at the cranial pole. The right adrenal gland was not definitively visualized.



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Spleen

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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 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.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained moderate, variably echogenic ingesta exhibiting variable progressive distal acoustic shadowing. No overt evidence of mechanical pyloric outflow obstruction or obstructive pyloric mural pathology was noted.

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The small intestine presented intact wall layering and primarily maintained a 1:3 muscularis/mucosa ratio with segmental propensity for subtly prominent to hypoechoic jejunal mucosa, along with minor jejunal ileus. Segmental nonshadowing ingesta / chyme and subjective increased segmental intestinal gas pattern were present. No overt evidence of obstructive mural pathology, i.e., structure, intussusception, or mass.

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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 were evident.

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Free Abdomen

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Intermittent variably prominent to nonhomogeneous mid to ventral abdominal mesenteric lymph nodes were present. These lymph nodes were homogenous, mildly hypoechoic and smoothly margined. A normal lymph node width: length ratio was maintained (<0.5). Evidence of perilymphatic inflammation was evident. An example of lymph node size was 5.0 cm x 1.4 cm. No evidence of peritoneal free fluid was noted.

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ULTRASONOGRAPHIC FINDINGS

- Moderately distended stomach with variably echogenic ingesta
- Intact small bowel walls exhibiting minor subjective nonobstructive intestinal ileus, Increased gas pattern, and nonshadowing ingesta / chyme



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- Intermittent variably prominent to nonhomogeneous mid to ventral abdominal mesenteric lymphadenopathy - subjective benign / reactive, potential mild to variable reactive lymphadenitis secondary to inflammatory bowel

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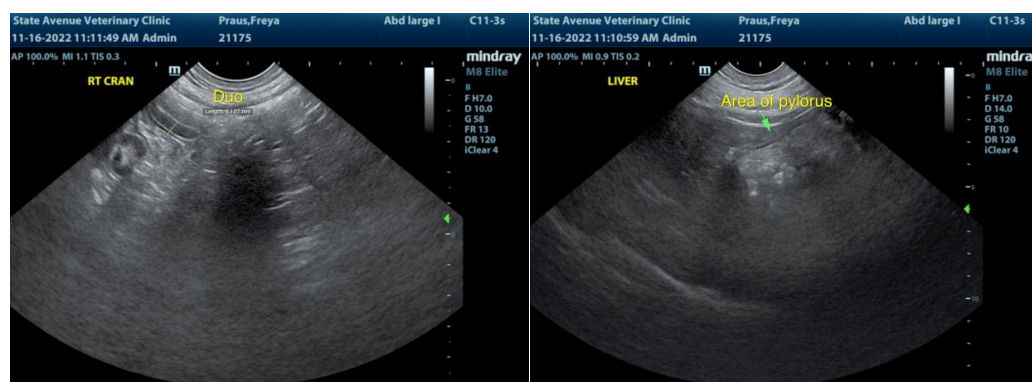
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Assuming documented NPO, the presence of moderate variably echogenic gastric ingesta may suggest some degree of metabolic vs. potential nonobvious mechanical gastric stasis. No overt evidence of a gastrointestinal mechanical obstructive pattern or obstructive pathology. Dietary intolerance / food allergy, inflammatory bowel disease, occult parasitism, occult Addison's Disease, low-grade to chronic pancreatitis which may present as sonographically normal, and less likely infiltrative neoplasia or other enteropathy are all potentials. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended.

If documented NPO, hospitalization with 24/hr. IV fluid and GI support with monitoring of gastric emptying would be ideal. A resting cortisol level to rule out occult Addison's Disease is warranted. Technically, the possibility of a small amount of gastric or intestinal nonobstructive to passing foreign material cannot be definitively excluded, although thought unlikely. Some or all of the following protocol may be considered empirically, assuming evidence of gastric emptying going forward.

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 (10-20 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. A recheck sonogram to assess GI improvement or progression would be ideal in 4 weeks.





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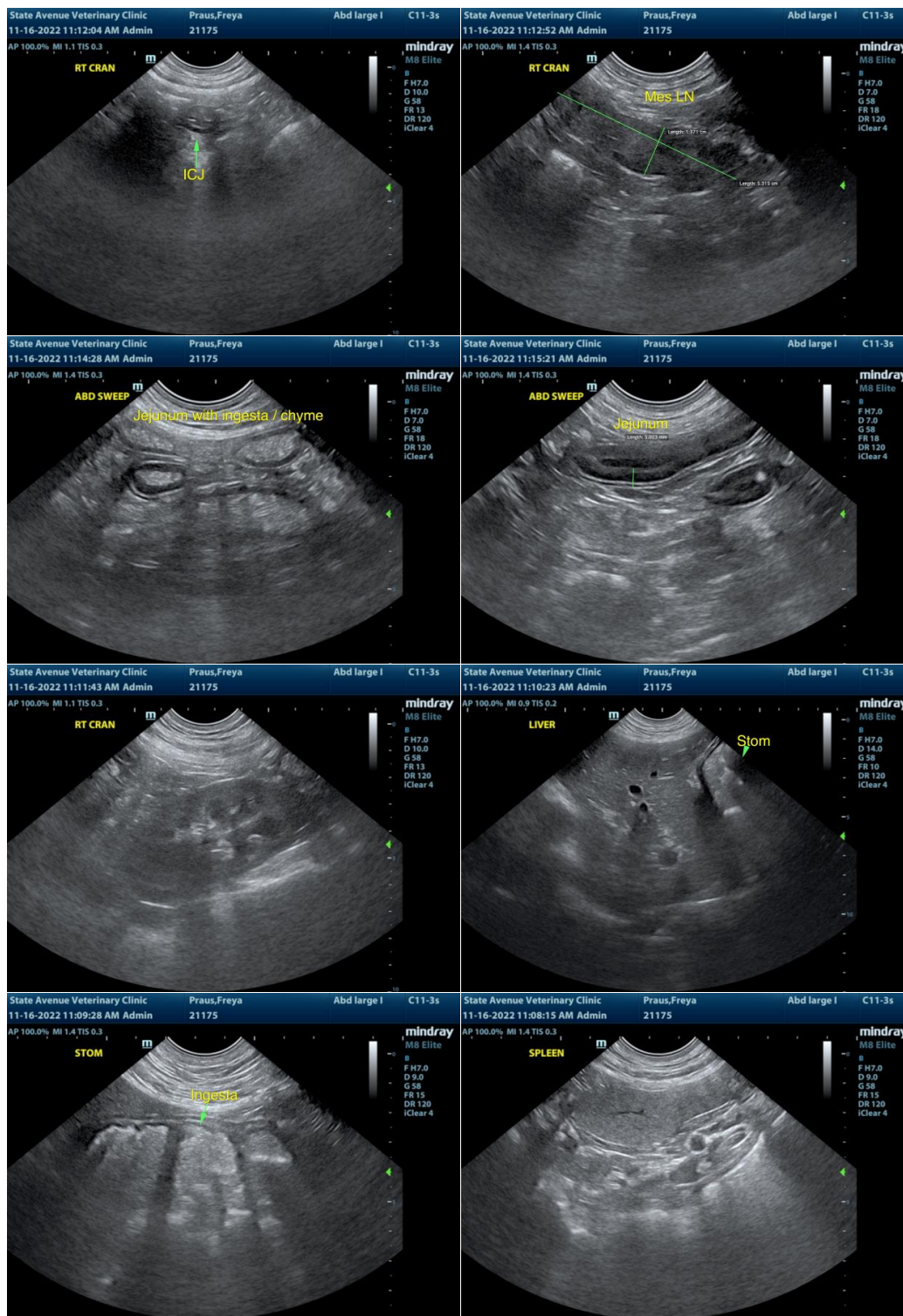
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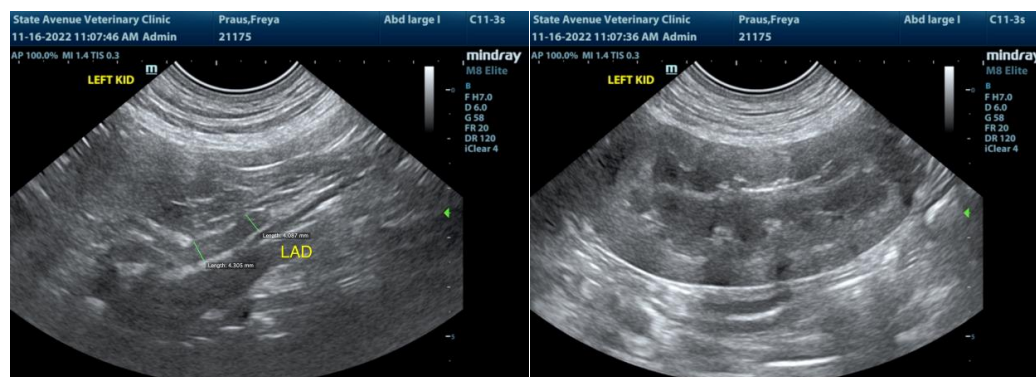
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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