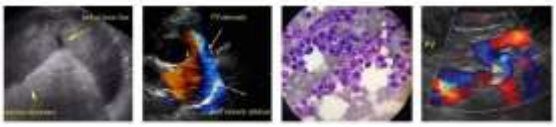


PATIENT

Nixon Gill

SPECIES

Canine

BREED

Pug X

SEX

MN

AGE

6 Years

WEIGHT

24.7 kg

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Beatties PH Stoney Creek

REFERRING VET

Baskin

INVOICE

48591

DATE

11-26-21

PRESENTING CLINICAL SIGNS

Presented with history of vomiting November 15th, was at a cottage with potential to have gotten into something abnormal. Drinking lots, not eating much. Had BW done, mostly WNL aside from liver paramater elevations. Patient seen again a week later still not eating much, no further vomiting, small BM normal consistency. Energy levels around normal. A few days later owner contacted us again as patient has been more lethargic and still not eating despite anti-nausea medication (cerenia + Famotidine injections given when seen in clinic) that seemed to help slightly before, and vomiting bile again. -PE have been NSF other than mild dental disease and patient being BCS 8/9. No meds. Abnormal PE/Chem/CBC/UA Results: ALT 414, ALKP 331, ALB 42, USG 1.010, urine pH 8 FINDINGS: A small amount of gas is within the stomach. The small intestines contain tubular gas and soft tissue, and are within normal limits for size. The largest intestine contains gas and fecal material. The liver is mildly enlarged with rounded caudoventral margins. The abdominal serosal margin detail is within normal limits. The spleen, kidneys and urinary bladder are unremarkable. CONCLUSIONS: 1. Unremarkable gastrointestinal tract; a cause for the patient's anorexia/hyporexia is not seen. 2. Mild hepatomegaly; consider endocrine/steroid hepatopathy, hepatitis or neoplasia. RECOMMENDATIONS: To evaluate the internal architecture of the abdominal organs, an abdominal ultrasound would be recommended.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal thickness and tone. Probable minor dependent sediment to sand was present. Anechoic urine was present in the lumen. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

No evidence of pathology associated with the residual prostate.

No evidence of pathology in the area of the aortic trifurcation.

Normal size and margination was 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 4.3 cm in length. The right kidney measured 5.0 cm in length.

Adrenal Glands

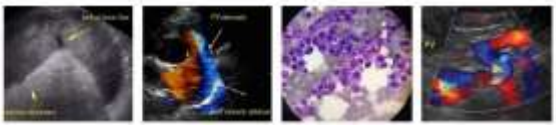
The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.50 cm width at the caudal pole and 0.57 cm width at the cranial pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.56 cm width at the caudal pole and 0.63 cm width at the cranial pole.

Spleen

The spleen exhibited normal size and contour with primarily maintained finely textured and homogenous parenchyma. Intermittent nonexpansive hypoechoic parenchymal nodules were present. An example of a nodule measured 0.92 cm diameter. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis.

Liver

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



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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 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 was empty. No evidence of gastrointestinal mechanical/metabolic ileus, or overt foreign material. The gastric body wall measured 0.36 cm width.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty. The duodenum wall measured 0.45 cm width. The jejunum wall measured 0.33 cm width.

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

Pancreas

The left pancreatic limb exhibited focal mildly hypoechoic parenchyma. The pancreas base and right pancreatic limb exhibited potential for concurrent focally hypoechoic to nodular parenchyma with potential for pancreaticoduodenal lymphadenopathy in the area of the pancreas base and right pancreatic limb with associated mild regional inflammation. The visible pancreatic duct was normal.

Free Abdomen

No overt peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Minor urinary bladder sediment/sand.
- Nonspecific yet nonexpansive splenic nodules - focal areas of lymphoid hyperplasia, hematopoiesis, splenitis infarct possible with less likely potential for infection or neoplasia.
- Hepatomegaly - subjectively benign, metabolic, reactive, vacuolar, or inflammatory hepatopathy possible. No overt neoplastic criteria which is considered unlikely.
- Focally hypoechoic to possibly nodular pancreas, potential for pancreaticoduodenal lymphadenopathy with regional inflammation.
- Sonographically unremarkable gastrointestinal tract.

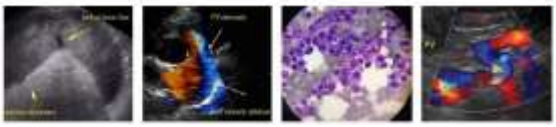
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Urine culture and sensitivity on a sterile urine sample is recommended.

Sonographic monitoring of the splenic nodules for evidence of progression is recommended.

Potential for low grade to possibly resolving pancreatitis with potential for concurrent pancreaticoduodenal reactive hyperplasia or lymphadenitis may be present and would be suggested if evidence of cranial abdominal or subxiphoid discomfort on palpation. Correlation with spec cpl may be considered. Structurally insignificant inflammatory bowel cannot be definitively excluded.

Empirically, medical therapy for low grade to possibly resolving pancreatitis and as needed gastrointestinal support would be appropriate. Reassessment of the pancreas in addition to recommended sonographic monitoring of the splenic nodules is recommended, if persistent



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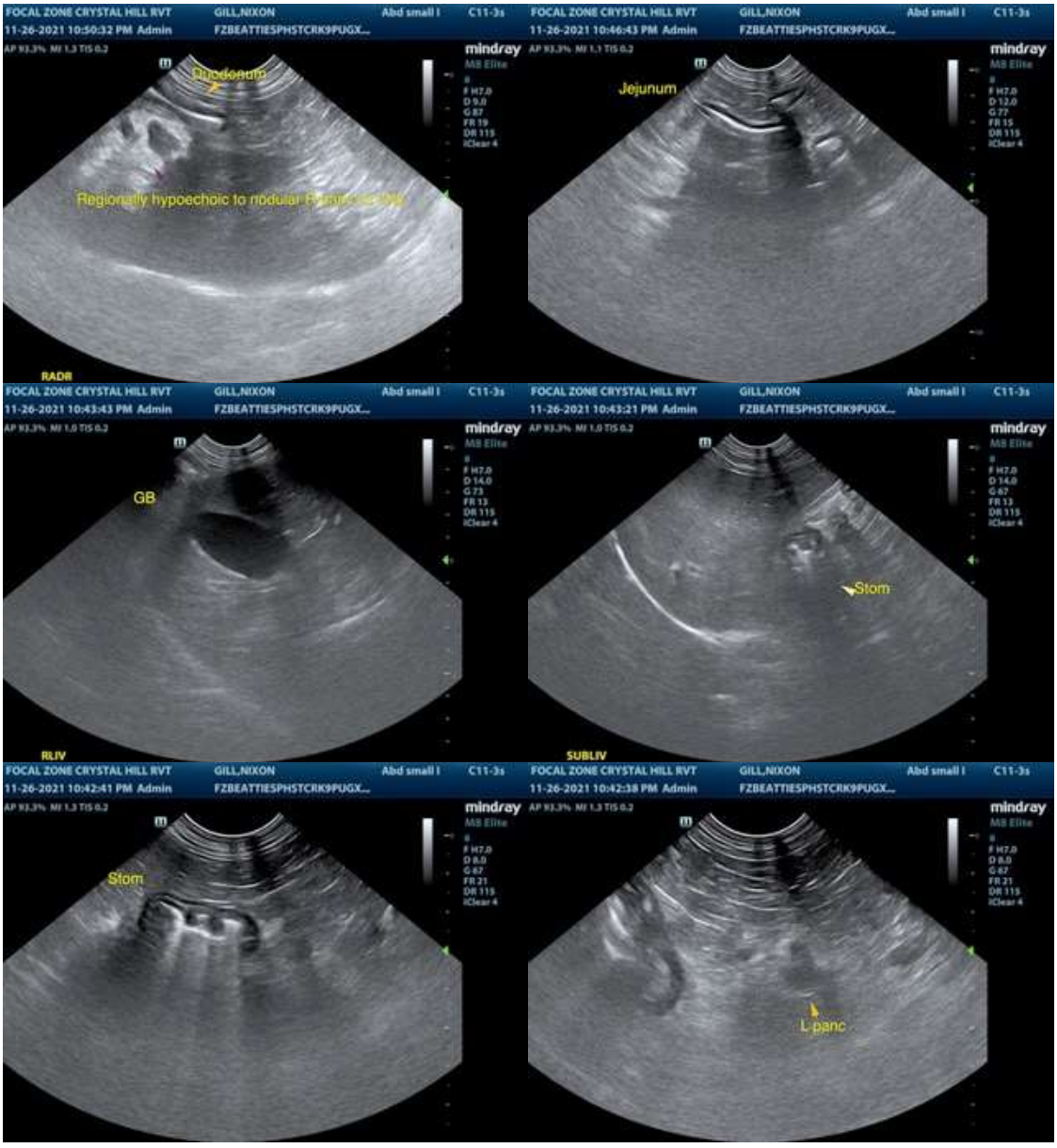
gastrointestinal signs, or nonresponsive to conservative therapy, are noted.



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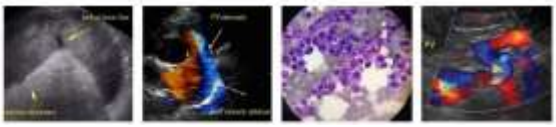

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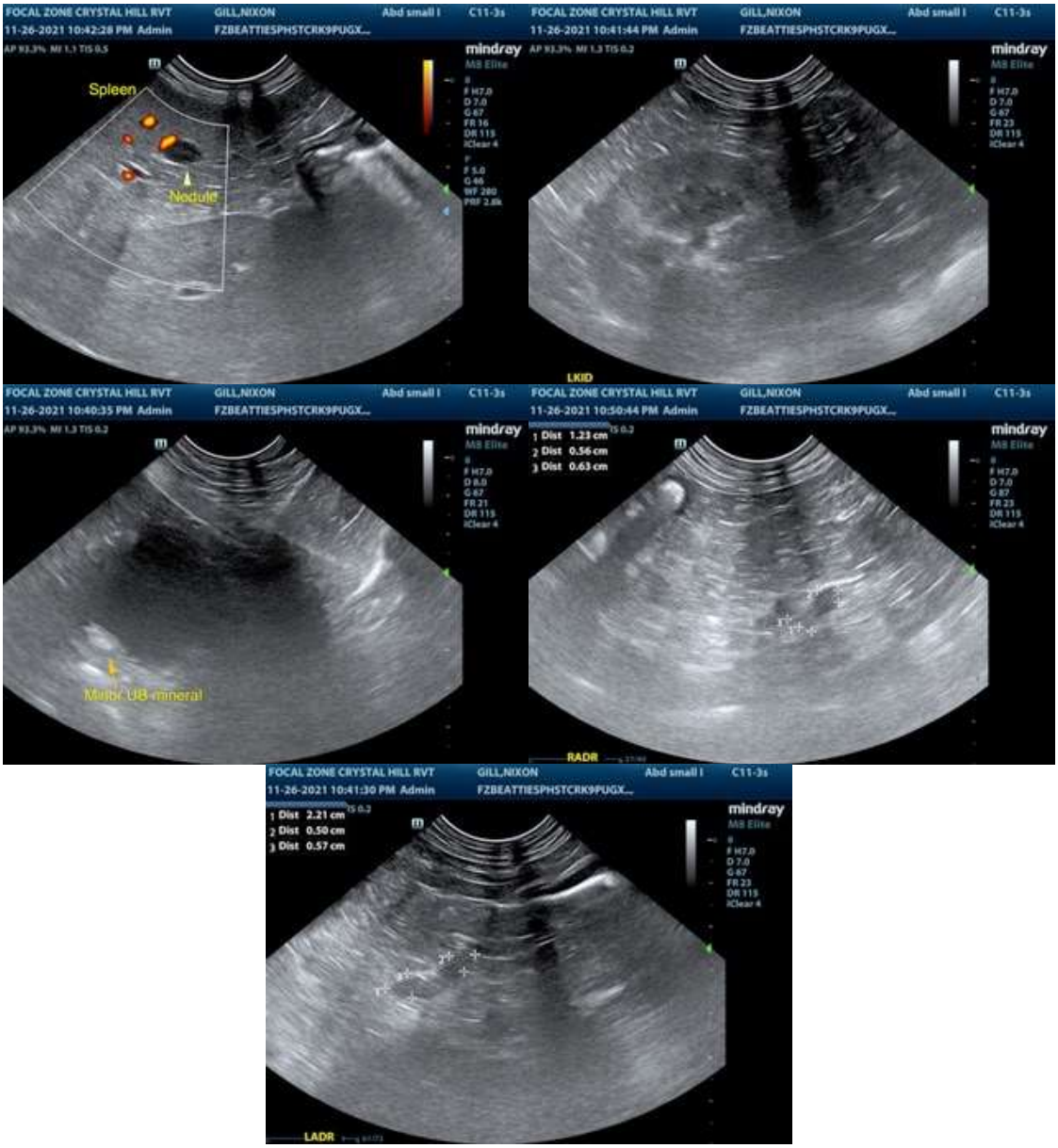

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

info@SonoPath.com