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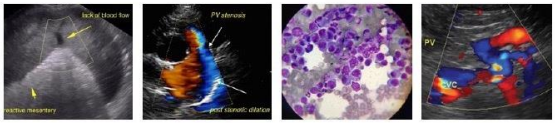


THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT
Simba Scarelli

SPECIES
Canine

BREED
Maltese

SEX
MN

AGE
9yr

WEIGHT
3kg

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

IMAGING PERFORMED BY
Crystal Hill

HOSPITAL NAME
Hamilton Region Emergency Clinic

REFERRING VET
Dr. Grewal

INVOICE
12286ag

DATE
11/28/2022

PRESENTING CLINICAL SIGNS

History of vomiting brown fluid + anorexia + dehydration + having seizures at home? - Marked generalized dental calculus and gingivitis. No oral mass or abscess. - Reduced airflow through right nostril and brown nasal discharge when patient sneezing. - Heart murmur Grade 4/6. - Wheezes auscultated right mid lung field. Harsh lung sounds left side. Labored breathing and tachypnea. SPO2=100% - Tense abdomen. - Moderate generalized loss of muscle mass.), T (99F/37.2C), P (120), R (44), MM (Pink), Patient attitude/demeanor (dull/depressed/lethargic) pantoprazole, cerenia, ampicillin, butorphanol

Abnormal PE/Chem/CBC/UA Results: CPL abnormal Hyponatremia 143, progressed with IVF to 135 Hypokalemia 3.0, now 3.1 after IVF SDMA 16, Creatinine 152 and BUN 10.8 Hyperphosphatemia 3.3 Elevated TP 86 and Globulin 50 Urinalysis USG 1.030 after starting IVF No bacteria in urine, no pyuria or hematuria Suspected non-hyaline casts Marked leukocytosis characterized 35.53 (5.05-16.76x10^9/L) by moderate neutrophilia 22.45 (2.95-11.64x10^9/L) with suspect band cells, lymphocytosis 9.34 (1.05-5.10x10^9/L) and monocytosis 3.64 (0.16-1.12x10^9/L) Rad report: CONCLUSIONS: The distention of the stomach is highly concerning for pyloric outflow obstruction. Severe gastritis or pancreatitis cannot be entirely ruled out for the changes seen on the study however this is considered less likely particularly given the concurrent regurgitation. The esophageal distention is relatively mild, however concurrent esophagitis or esophageal disease may be present. The alveolar disease seen on the study is most consistent with aspiration or bacterial pneumonia. The cardiac silhouette is not enlarged however this does not exclude the possibility of cardiac disease being present. Cardiac decompensation is not seen on this exam. The tracheal luminal changes seen on the study are mild however concurrent tracheomalacia/collapse could be present.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3 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 were noted.

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 3.6 cm in length. The right kidney measured 3.6 cm in length.

The area of the aortic trifurcation was free of pathology.

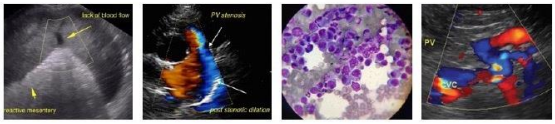
The area of the residual prostate appeared normal and free of pathology.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.5 cm width at the caudal pole and 1.7 cm length. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.43 cm width at the caudal pole and 1.3 cm length.

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.



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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

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 exhibited marked distension with retained anechoic fluid and mild echogenic non-shadowing chyme. The gastric walls presented primarily intact wall layering with a normal wall layer ratio in the fundus and gastric body extending into the area of the pylorus. Mildly prominent pyloric walls secondary to variable mild hyperechoic mucosal hyperplasia potentially extending into the upper duodenum was present. The pyloric outflow wall potentially measured 0.9 cm in width. Normal gastric wall layering measured 0.34 cm in width.

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 ileus, obstruction or foreign material. The duodenum wall measured 0.36 cm width. The jejunum wall measured 0.32 cm width.

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

Pancreas

The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum, likely consistent with age related changes and considered incidental. No signs of active inflammation or neoplasia.

Free Abdomen

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

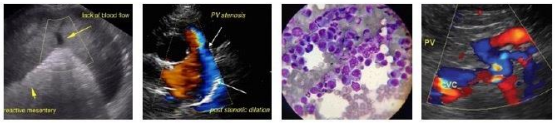
ULTRASONOGRAPHIC FINDINGS

- Marked gastric distension with retained fluid and chyme
- Suspect pyloric mucosal hyperplasia
- Sonographically unremarkable small bowel-no evidence of small bowel mechanical/metabolic ileus
- Mild heterogeneous pancreas

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

General considerations for the marked gastric distension may include metabolic vs mechanical gastric stasis. Some degree of mechanical obstruction owing to suspected pyloric/pyloric outflow mucosal hyperplasia is suspected although the degree of mural thickening and mucosal hyperplasia did not appear to be severe. Neoplastic criteria is considered unlikely yet cannot be definitively excluded. Some degree of metabolic gastric stasis possibly owing to underlying mild gastric inflammation or low-grade pancreatitis could be possible.

Gastric evacuation with as needed GI support and empirical therapy for gastritis/esophagitis +/- helicobacter which may include canned slurry hydrolyzed diet with smaller more frequent feedings and assessment of clinical response would be reasonable. Although considered unlikely a resting cortisol



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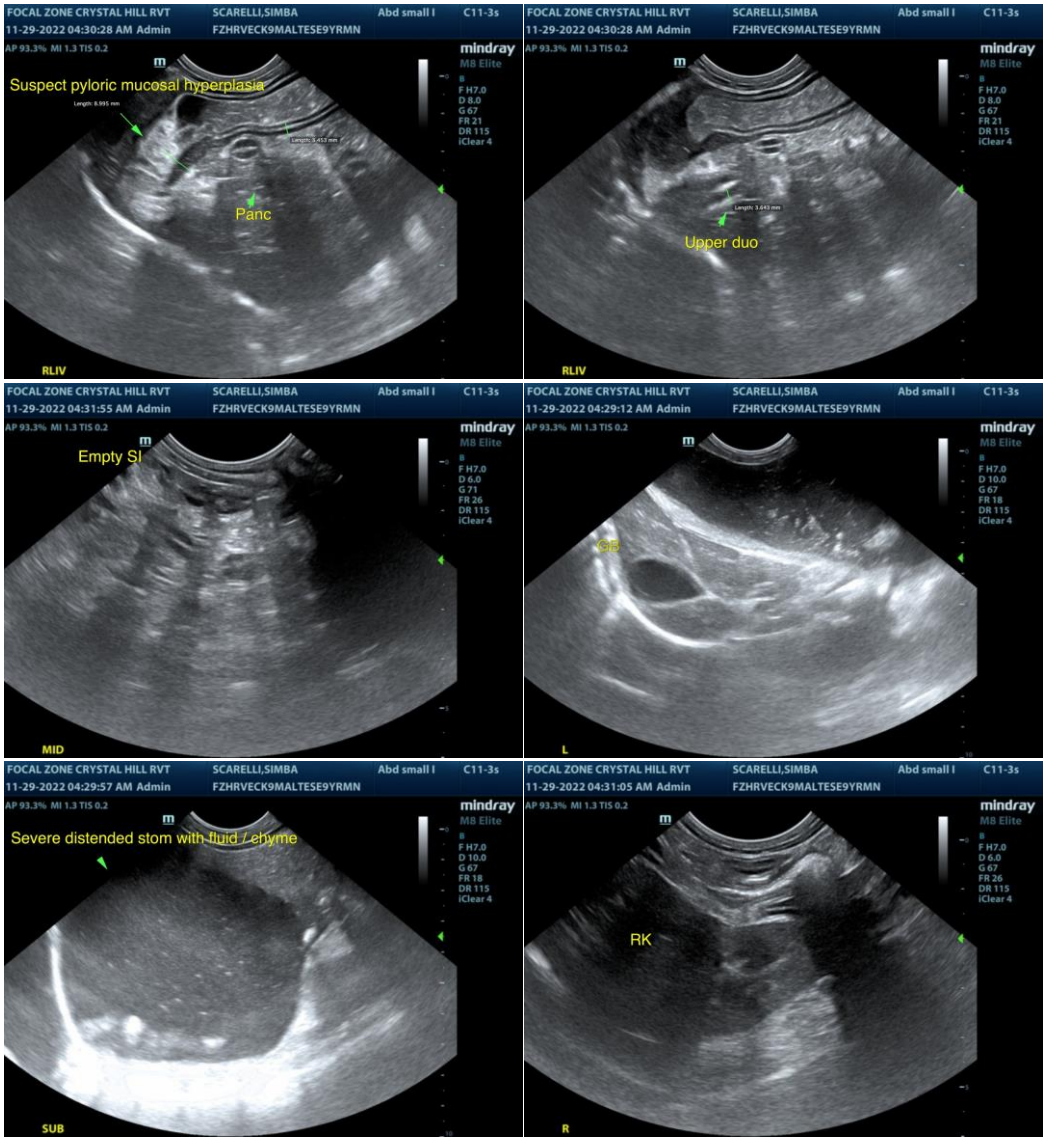
level to rule out occult Addison's disease could be considered. Ultimately upper GI endoscopy with potential for biopsies may be indicated for a definitive diagnosis.



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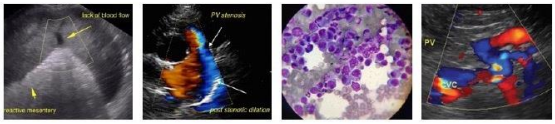

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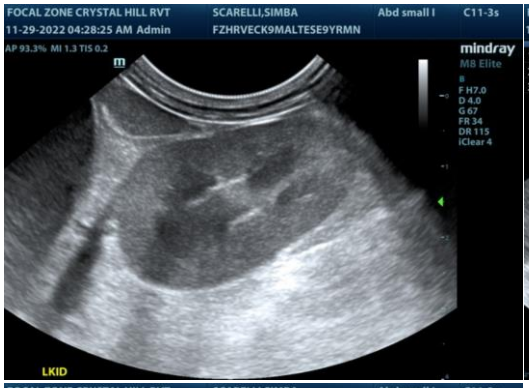

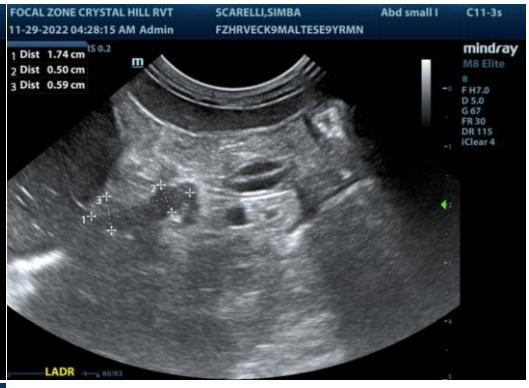

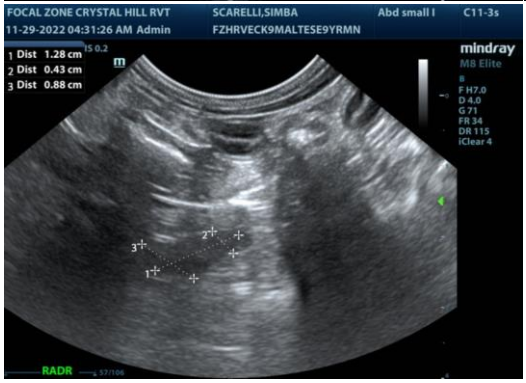

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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