



PATIENT

Dougal Nixon

SPECIES

Canine

BREED

Irish Wolfhound

SEX

Neutered Male

AGE

10 Years

WEIGHT

80 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Robyn Lantz

HOSPITAL NAME

Eastgate Vet Clinic

REFERRING VET

Dr. Robyn Lantz

INVOICE

26877

DATE

11/5/21

PRESENTING CLINICAL SIGNS

Intermittent vomiting, diarrhea, decrease appetite over the last couple months. Recently having another episode again. Also having behavior changes and acting intermittently uncomfortable and lethargic, but not consistent. Patient sedated with dexmedetomidine and torbutrol for ultrasound.

Abnormal PE/Chem/CBC/UA Results: Vitals all wnl. Overall exam wnl. Abdominal palpation wnl and not apparently painful. LNs all wnl. Some hesitation to extend shoulders and hips, mildly reactive on spinal palpation at mid-thoracic location. CP wnl all limbs. Patient was on sucralfate, last dose yesterday mid-morning. Vomited fluid/mild with specks of possible blood yesterday afternoon and diarrhea.

Bloody liquid diarrhea produced today. No more vomiting after Cerenia inj last night. Fasted for ultrasound this AM. Senior labwork and Precision PSL on 11/4/2021 all wnl except 1.8 creatinine. Still waiting on urine and fecal results.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder 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. The prostate urethra was mildly dilated, which is non-specific, with normal structure and tone noted in the post-prostatic urethra to a depth of 4.0 cm.

The residual prostate was without overt pathology.

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 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 6.7 cm. The right kidney measured 6.5 cm.

Adrenal Glands

The left adrenal gland was indistinctly visualized, yet without overt pathology, subjectively measuring 0.63 cm at the cranial pole and 0.65 cm at the caudal pole. The right adrenal gland was not definitively visualized.

Spleen

The spleen was mildly enlarged with mild folding, likely owing to sedation. It exhibited primarily finely textured parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Mild generalized parenchyma heterogeneity was present without evidence of nodular changes. 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. The parenchymal heterogeneity is likely consistent with benign changes such as extramedullary hematopoiesis or age related remodeling with minor potential for inflammatory or neoplastic disease.

Liver

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to benign parenchymal remodeling. 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. No overt evidence of hepatic neoplastic criteria.



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Gastrointestinal

The stomach exhibited intact and sonographically unremarkable wall layering with generalized moderate gastric distention exhibited by retained, primarily anechoic fluid with a mild amount of non-specific, non-shadowing chyme and mucus or potential ingesta. No evidence of mechanical pyloric outflow obstruction. Gastric body wall measured 0.49 cm. Pylorus wall measured 0.36 cm.

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. Wall width measured 0.47 cm.

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 overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Gastric hypomotility exhibited by moderate retained, primarily anechoic fluid with a mild amount of non-shadowing echogenic chyme, mucus, or potential ingesta.
- Suspect structurally insignificant enterocolitis
- Mild age related kidneys

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Aside from the hypomotile stomach, largely mild geriatric abdomen without evidence of significant visceral pathology. Dietary indiscretion/dietary intolerance/food hypersensitivity, occult parasitism, or structurally insignificant to recurrent inflammatory gastroenterocolonopathy are possible. No overt evidence of gastrointestinal neoplastic criteria or obvious ulceration. Further assessment may include GI panel to include PLI, TLI, cobalamin and folate, fresh fecal analysis to assess for parasitic ova/giardia, and resting cortisol +/- ACTH stimulation test to rule out occult Addison's disease given the patient's vague waxing and waning gastrointestinal signs and potential for gastrointestinal microulceration.

Empirically, a limited antigen or hydrolyzed diet trial with potential long term dietary therapy, prophylactic deworming (Panacur 50 mg/kg SID x 5 consecutive days with repeat protocol in 3 weeks even if fecal testing is negative), high colony count probiotic (Provable or Visbiome), antibiotic trial and as needed gastrointestinal support with assessment of clinical response may prove beneficial. Intestinal biopsies may be indicated if GI signs continue despite empirical therapy. Hospitalization with 24-hour supportive IV fluids to correct any potential dehydration as well as sonographic reassessment of the stomach is likely ideal.



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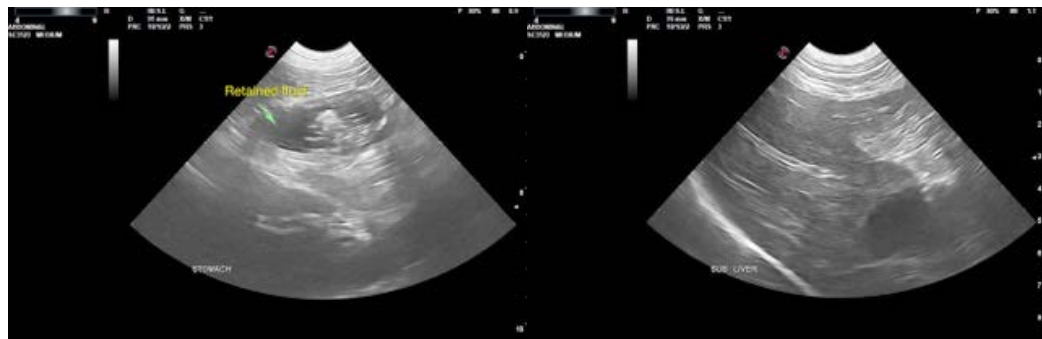
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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