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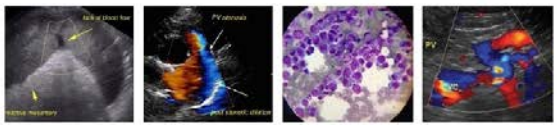


THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Gibson Hoffman

SPECIES

Canine

BREED

Golden Retriever

SEX

Neutered Male

AGE

7-8 Years

WEIGHT

47.6 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Victoria Road AH

REFERRING VET

Dr. Rojman

INVOICE

33518

DATE

12/17/21

PRESENTING CLINICAL SIGNS

QAR, lethargic, tacky, inappetance, febrile, abdominal pain/splinting, vomiting and mucousy malodorous small volume diarrhea Hx of pancreatitis 2 weeks ago (spec 636), on GI LF Metronidazole, Cerenia, Gabapentin - plan to add on Clavaseptin
Abnormal PE/Chem/CBC/UA Results: WBC 26.7 - neut 23.5, mono 1.6 BUN 2.5, Alb 22, AG ratio 0.6 ALP 511 (was 707) spec 135 (was 636)..please see attached rads and bloodwork

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 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 were noted.

No overt pathology in the area of the residual prostate.

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 loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. A focal caudolateral cortical infarct was noted in the left kidney. The left kidney measured 6.9 cm. The right kidney measured 7.2 cm.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 3.1 cm length x 0.56 cm at the caudal pole. The right adrenal gland was not definitively visualized owing to regional periadrenal omental artifact.

Spleen

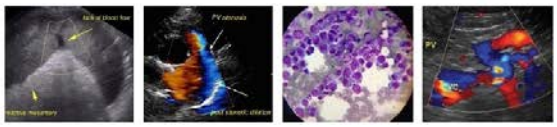
The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute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

Liver

The liver presented normal in size. The hepatic parenchyma revealed diffuse reduced echogenicity compared to the spleen and renal cortical parenchyma with a mild coarse echotexture. Increased portal vein prominence was evident. The capsule of the liver was normal in margination. Distinct masses or nodules were not evident. The hepatic and portal vasculature were normal in appearance. The gallbladder was indistinctly visualized, potentially owing to mild volume contraction given the presence of mild retained gastric ingesta. Subjectively, the gallbladder appeared to exhibit mildly prominent to echogenic walls. No overt evidence of post-hepatic obstruction given lack of reported clinical cholestasis.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained echogenic ingesta/chyme exhibiting progressive distal acoustic shadowing. No evidence of gastric foreign material. Ventral gastric body wall meaurd 0.36 cm.



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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. Jejunum wall measured 0.32 cm.

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. No signs of active inflammation or neoplasia.

Free Abdomen

Intermittent, mildly prominent to enlarged mesenteric nodes were present. Example measured 0.4 cm in width. The lymph node was essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). These lymph nodes were not consistent with inflammatory or neoplastic criteria, and are likely reactive/benign.

Generalized, primarily mid to cranial abdominal non-uniformly echogenic mesentery was noted along with mild peritoneal free fluid. No overt evidence of omental masses.

Brief sonographic assessment of the heart revealed no evidence of left or right heart chamber enlargement or definitive cardiac masses. A mild amount of pericardial effusion is suspected.

PRIMARY FINDINGS

- Hepatopathy exhibiting hypoechoic parenchyma echogenicity – hepatic congestion, acute hepatitis, reactive hepatopathy, or occult neoplasia possible.
- Heterogeneous pancreas – non-specific, potential for resolving low-grade chronic to chronic active pancreatitis. No overt evidence of pancreatic neoplastic criteria.
- Mild retained gastric ingesta – sonographically unremarkable small bowel.
- Generalized, primarily mid to cranial abdominal non-uniform to echogenic mesentery and mild peritoneal free fluid – potential for unspecified peritonitis.
- Subjective normal heart with suspected mild concurrent pericardial effusion.

SECONDARY FINDINGS

- Focal left kidney cortical infarct

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The mild peritoneal free fluid may indicate non-septic (increased vascular permeability, decreased hydrostatic pressure, portal hypertension) or septic/inflammatory effusion. Assuming normal clotting status, ultrasound guided FNA of the liver using 25-gauge needle as well as ideally effusion analysis, cytology +/- culture and sensitivity (if evidence of inflammatory effusion cells are present). Potential for unspecified neoplasia such as carcinomatosis, lymphomatosis or similar could not be definitively excluded. 3-view chest radiographs recommended to assess for or rule out concurrent occult thoracic pathology. Empirically, some or all of the following protocol could be considered with continued as needed gastrointestinal support and therapy for potential persistent low-grade to chronic pancreatitis.

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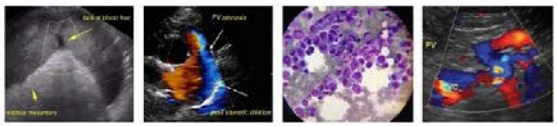

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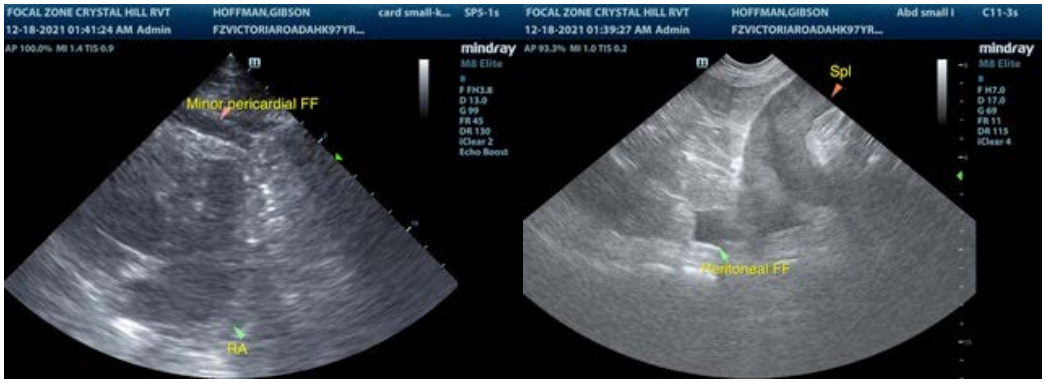
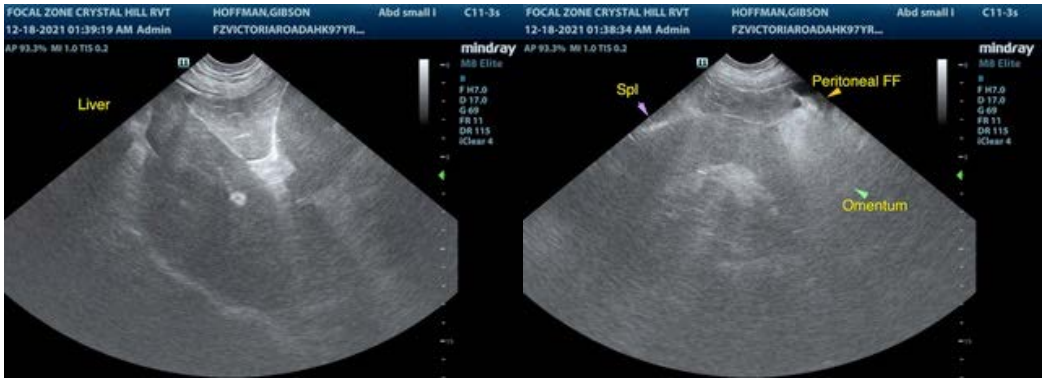
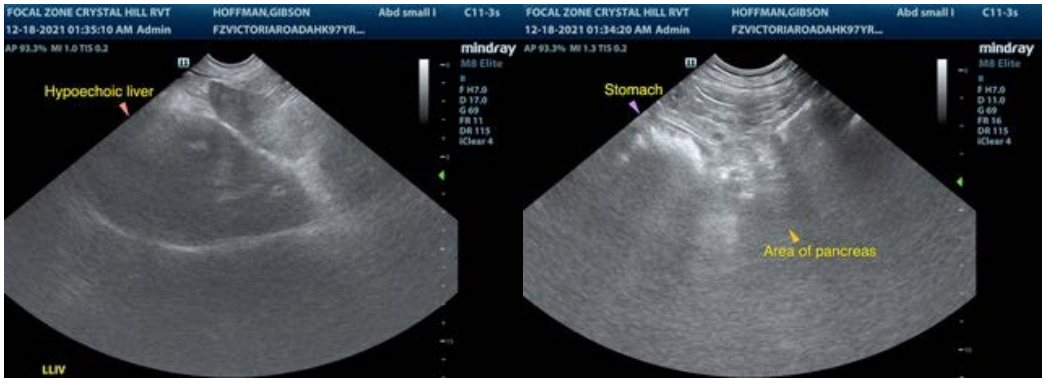
Peritonitis Protocol
Colloids/Hetastarch
10 to 20 mL per kilogram per hour and dogs
10 to 15 mL per kilogram per hour cats
(Can bolus first 1/3 of dose over 15 minutes)
Plasma 10 mL / kilogram IV over 4 hours
Buprenorphine 0.02 mg/kg IV IM SC q4-6 hours **Or CRI Lidocaine** 30-50 ug/kg/min
Dolasetron for nausea: 0.6-1 mg/kg/day Iv or PO
Famotidine 1 mg/kg IV IM p.o. dc s.i.d. /b.i.d.
Sucralfate 0.5-1 g p.o. t.i.d. dogs, 0.5 g bid cats in slurry **Or Misoprostol** 1-5 ug/kg po tid
Clindamycin 10mg/kg IV p.o. bid
Enrofloxacin 10-15 mg/kg IV p.o. s.i.d. dogs, 5 mg/kg Iv po Sid cats
Metronidazole 10-20 mg/kg IV p.o. b.i.d.
Dexamethasone physiological 1 mg/kg to treat adrenal burnout if long standing sickness, shock dose 4-10 mg/kg.







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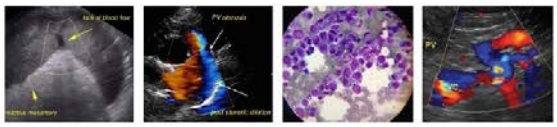

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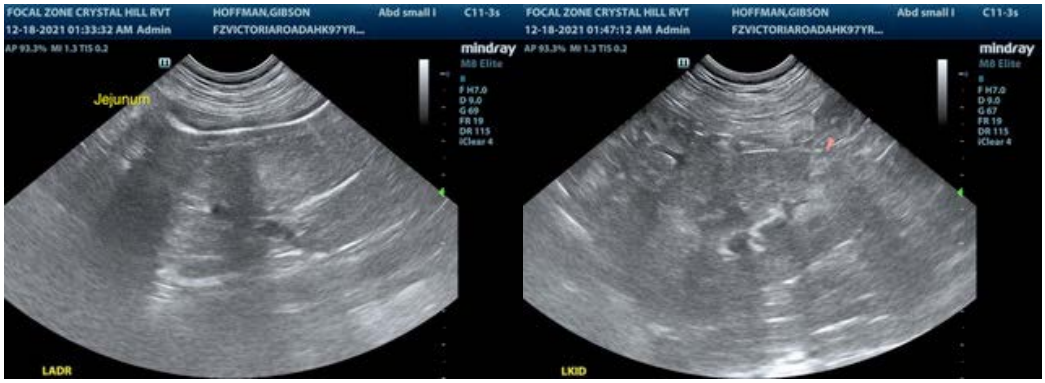

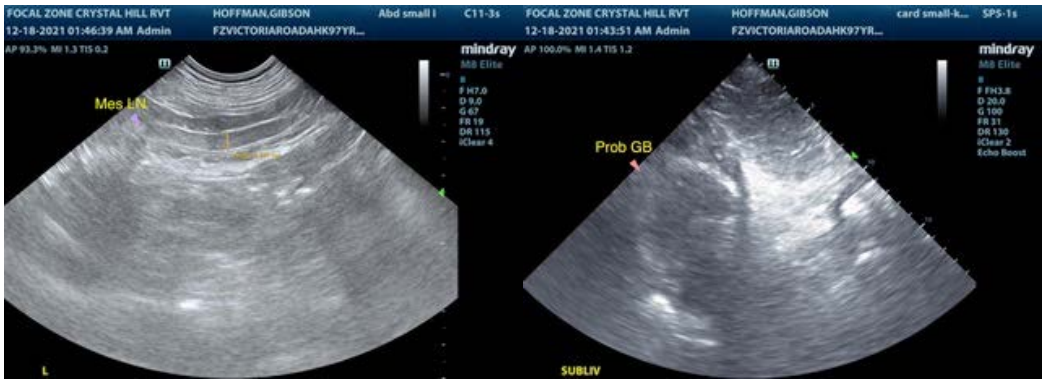

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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