



PATIENT PRESENTING CLINICAL SIGNS

Ruby Lane

SPECIES

Canine

BREED

Soft Coated Wheaten
Terrier

SEX

Spayed Female

AGE

1 Year

WEIGHT

12.8 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Hamilton Region
Emergency Clinic

REFERRING VET

Dr. Bourque

INVOICE

33161

DATE

12/1/21

Acute vomiting since Tues, vomits despite cerenia administration. Vomited 6h postprandial - what seemed like all of the food ingested Yesterday vomited what was eaten 12 hours prior and then again later projectile vomited despite being fasted in the AM - still with food in it. Did defecate 2x yesterday - feces dry but completely formed Vomited 2 more times yesterday before 11am appt at rDVM but was only bile, no food Last night ate small amt boiled chicken/rice, at 10pm became restless/lip licking/drooling and nausea all night and vomited again today 6am Often ingests coyote feces. No known dietary indiscretion otherwise. Exam today: Patient anxious so hard to assess if painful in abdomen. Normal examination otherwise. maropitant (11am yesterday & today), methadone 10am today.

Abnormal PE/Chem/CBC/UA Results: Please see attached bloodwork and xrays. Rads were sent to IDEXX for review and conclusions were: The consistency of the ingesta within the gastric lumen is uncertain. This could represent normal food. Foreign material cannot be completely ruled out. No evidence of a complete mechanical obstruction is identified in the small intestines. A nonspecific gastroenteritis is not excluded based on the results of the study. RECOMMENDATIONS: Consider providing supportive care, including intravenous fluid therapy, and repeating fasted 3 view abdominal radiographs in 8-12 hours for reevaluation and to assess for evidence of gastrointestinal clearance. Abdominal ultrasound may be of benefit if more immediate diagnostic information is required.

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. 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 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 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 5.3 cm.

Adrenal Glands

The adrenal glands were uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 1.5 cm length x 0.55 cm at the caudal pole. The right adrenal gland measured 1.6 cm length x 0.77 cm at the caudal pole.

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 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



PATIENT 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.

Ruby Lane

Gastrointestinal

SPECIES The stomach exhibited moderate to marked distention with retained anechoic to echogenic fluid and chyme with potential for non-specific ingesta. The retained chyme extended into the area of the pylorus and pyloric outflow tract, yet without overt evidence of mechanical pyloric outflow obstruction. Then non-specific ingesta was hyperechoic with subtle areas of distal acoustic shadowing.

Canine

BREED

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. Duodenum wall measured 0.40 cm. Jejunum wall measured 0.38 cm.

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

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Pancreas

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The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

1 Year

Free Abdomen

WEIGHT

Subtle evidence of perigastric reactive mesentery noted.

12.8 kg

At least one enlarged mesenteric lymph node was present, measuring 1.2 cm x 0.27 cm. These lymph nodes were homogenous, mildly hypoechoic and smoothly margined. A normal width: length ratio was maintained (<0.5). Evidence of perilymphatic inflammation was evident. No evidence of concurrent free fluid.

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ULTRASONOGRAPHIC FINDINGS

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- Moderate to marked gastric distention with retained anechoic to echogenic fluid/chyme and mild non-specific, focally shadowing ingesta – metabolic versus mechanical gastric ileus.
- Sonographically unremarkable small bowel
- Focal to potential intermittent mesenteric lymphadenopathy – lymphoid hyperplasia, reactive lymphadenitis, immunologic immaturity possible.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

An overt mechanical obstruction in the upper gastrointestinal tract or pyloric outflow tract was not definitively evident. This may indicate significant metabolic gastric stasis, potentially owing to gastric or generalized gastrointestinal inflammatory episode. However, given the degree of gastric distention and retained fluid, the possibility of a non-obvious pyloric or upper gastrointestinal outflow obstruction cannot be definitively excluded. Hospitalization with 24-hour IV and gastrointestinal supportive protocol with documented NPO and monitoring of gastric emptying may be considered. However, if continued gastric distention with retained fluid, or for further clarification, exploratory laparotomy with gross inspection of the upper gastrointestinal tract should be considered in this patient. GI biopsies suggested if laparotomy is elected and despite findings.

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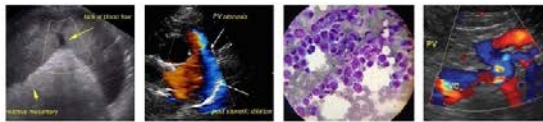
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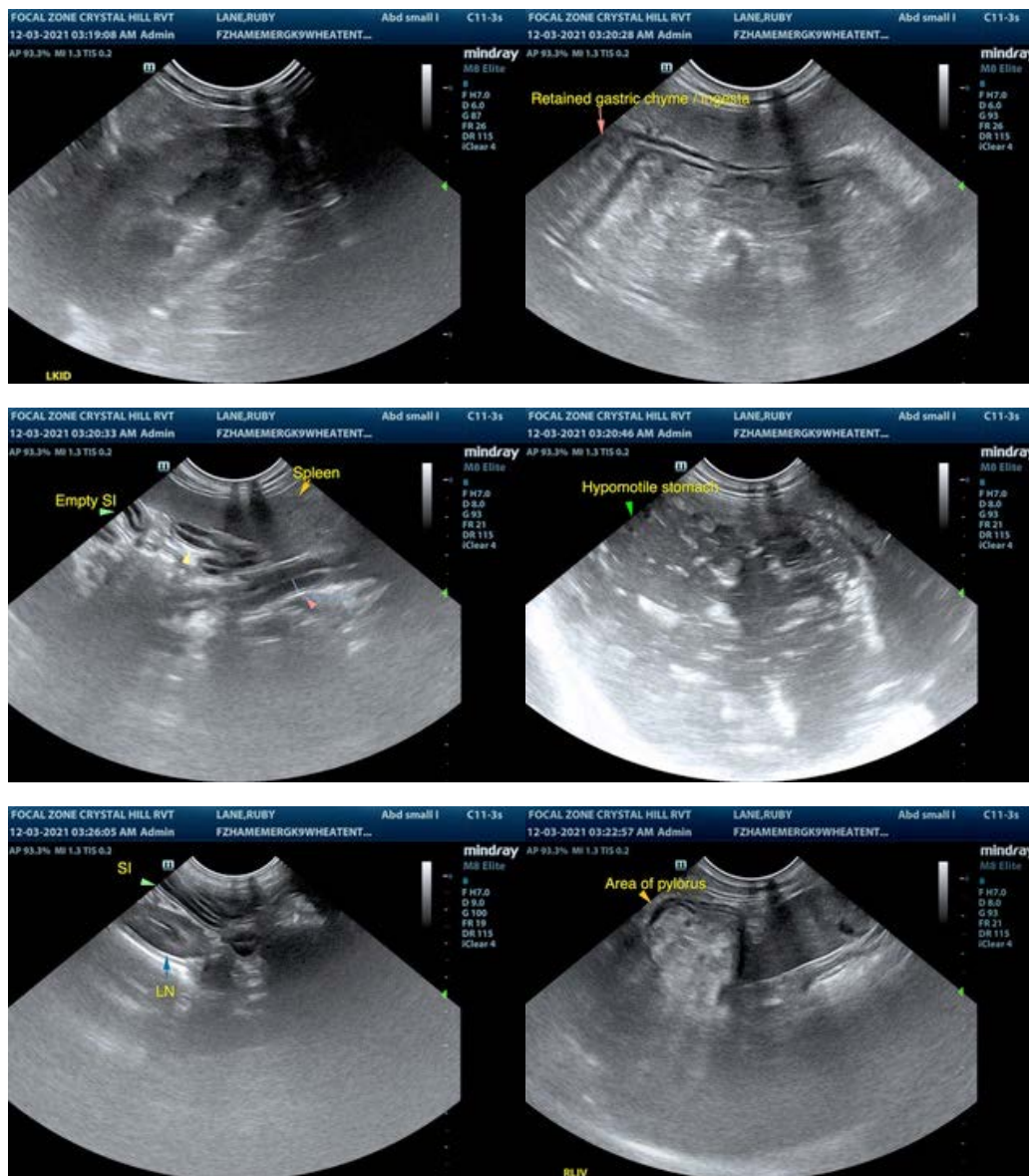
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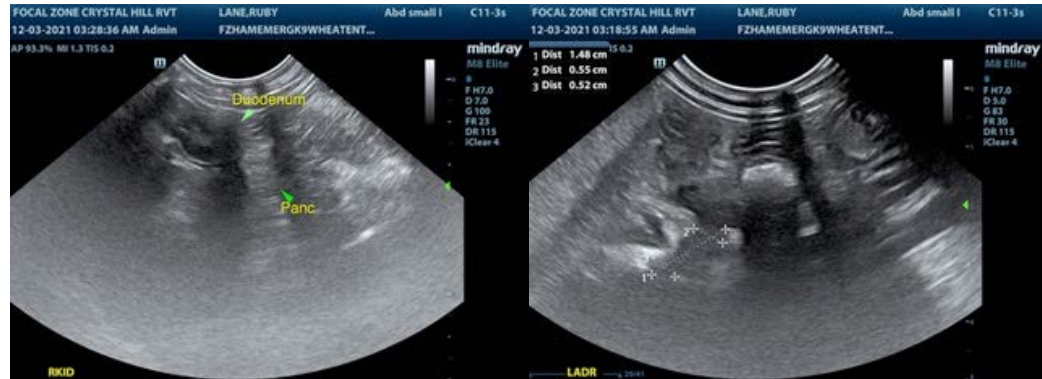
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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