



PATIENT

Mia Ramirez

SPECIES

Canine

BREED

Weimaraner Mix

SEX

FS

AGE

6yr

WEIGHT

26.4kg

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

Patti Mayfield DVM

HOSPITAL NAME

Pawtown Veterinary
Care

REFERRING VET

Erin Miller DVM

INVOICE

12382ag

DATE

12/05/2022

PRESENTING CLINICAL SIGNS

Patient presented to Dr. Miller on 12/2/22 for evaluation of the following: -- belly has been distended for about a week. O also noted that P has been limping on the right hind limb. -- She has been PU/PD with dark stools Patient received 4 mg butorphanol IV to facilitate AUS

Abnormal PE/Chem/CBC/UA Results: 12/2/22 PE: Body Condition Score: 3 /9 - underweight body condition but abdomen distended Heart: ABNORMAL - Grade 1/6 systolic heart murmur, normal rhythm with synchronous femoral pulses Lungs: ABNORMAL - slightly increased rate/effort with normal lung sounds bilaterally. Suspect change in RR/RE is secondary to increased abdominal pressure. Abdomen: ABNORMAL - markedly distended, feels like fluid, no overt pain on palpation but patient is uncomfortable with increased pressure Musculoskeletal/Neuro: ABNORMAL - lame grade 4/5 RH. R stifle thickened on palpation with moderate joint effusion. Positive tibial thrust and cranial drawer. Rest of limb normal on palpation. CBC = mild lymphopenia and monocytosis consistent with glucocorticoid response Chem = Low BUN 5, hypoproteinemia 5.1 and hypoalbuminemia 2.0, elevated ALT 420, ALP 243, GGt 16 and T Bili 2.1 Brief AUS confirmed free fluid, FNA = pale yellow watery fluid, specific gravity of fluid is 1.003 No visible large abdominal masses but too much fluid for good AUS. patient is uncomfortable on her back so did AUS in lateral recumbancy Abdominocentesis: sterile collection of sample in lavender top and white top tube - held in case needed for analysis Removed 5010 ml (5 L) of pale yellow watery fluid from abdomen. Post body weight= 13 # less than intake

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra exhibited normal thickness and tone. Anechoic urine was present in the lumen with mild non-dependent particulate sediment to potential pinpoint dependent mineral. 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 6.0 cm in length. The right kidney measured 6.6 cm in length.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

The left adrenal gland was uniform in size with mild irregular contour and subtle non-homogenous parenchyma. The left adrenal gland measured 0.54 cm width at the caudal pole and 2.3 cm length. The right adrenal gland was uniform in size with mild irregular contour and subtle non-homogenous parenchyma. The right adrenal gland measured 0.49 cm width at the caudal pole and 2.2 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. 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



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The liver exhibited subnormal size and irregular capsule contour. Generalized non-uniform to nodular hepatic parenchyma was present. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size and potentially displaced owing to subnormal liver size with thin walls and primarily anechoic luminal content with subjective mild congealed hyperechoic luminal debris. The cystic and common bile ducts were normal.

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The stomach presented intact mildly prominent wall layering with mildly prominent rugal folds. The lumen of the stomach contained moderate echogenic to focally shadowing ingesta with no signs of ileus, obstruction or foreign material.

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.

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

Pancreas

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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

WEIGHT

26.4kg

Significant volume anechoic peritoneal free fluid was present. Subtle generalized hyperechoic mesentery was present.

ULTRASONOGRAPHIC FINDINGS

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- Mild urinary bladder sediment and pinpoint dependent mineral
- Subnormal liver with irregular to nodular parenchyma
- Variably echogenic to focally shadowing gastric ingesta with suspect mild gastric wall edema
- Sonographically unremarkable small bowel/spleen
- Significant volume anechoic peritoneal free fluid

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The liver presentation is sonographically consistent with progressive to likely end stage hepatopathy with considerations including end stage chronic active hepatitis, fibrosis, cirrhosis or other with neoplasia considered unlikely. Hepatic cirrhosis is considered most probable with secondary portal hypertension owing to significant progressive to end stage hepatopathy.

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The presence of gastric ingesta is nonspecific and likely indicates post-prandial presentation. The potential for non-obstructive focal gastric foreign material possibly secondary to pica cannot be definitively excluded.

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Monitoring for gastric emptying or for evidence of retained ingesta/gastric stasis over the next 24 hours could be considered. A likely poor long-term prognosis is indicated although empirically in the short term, hepatosupportive medications, as needed GI support and abdominocentesis could be considered.

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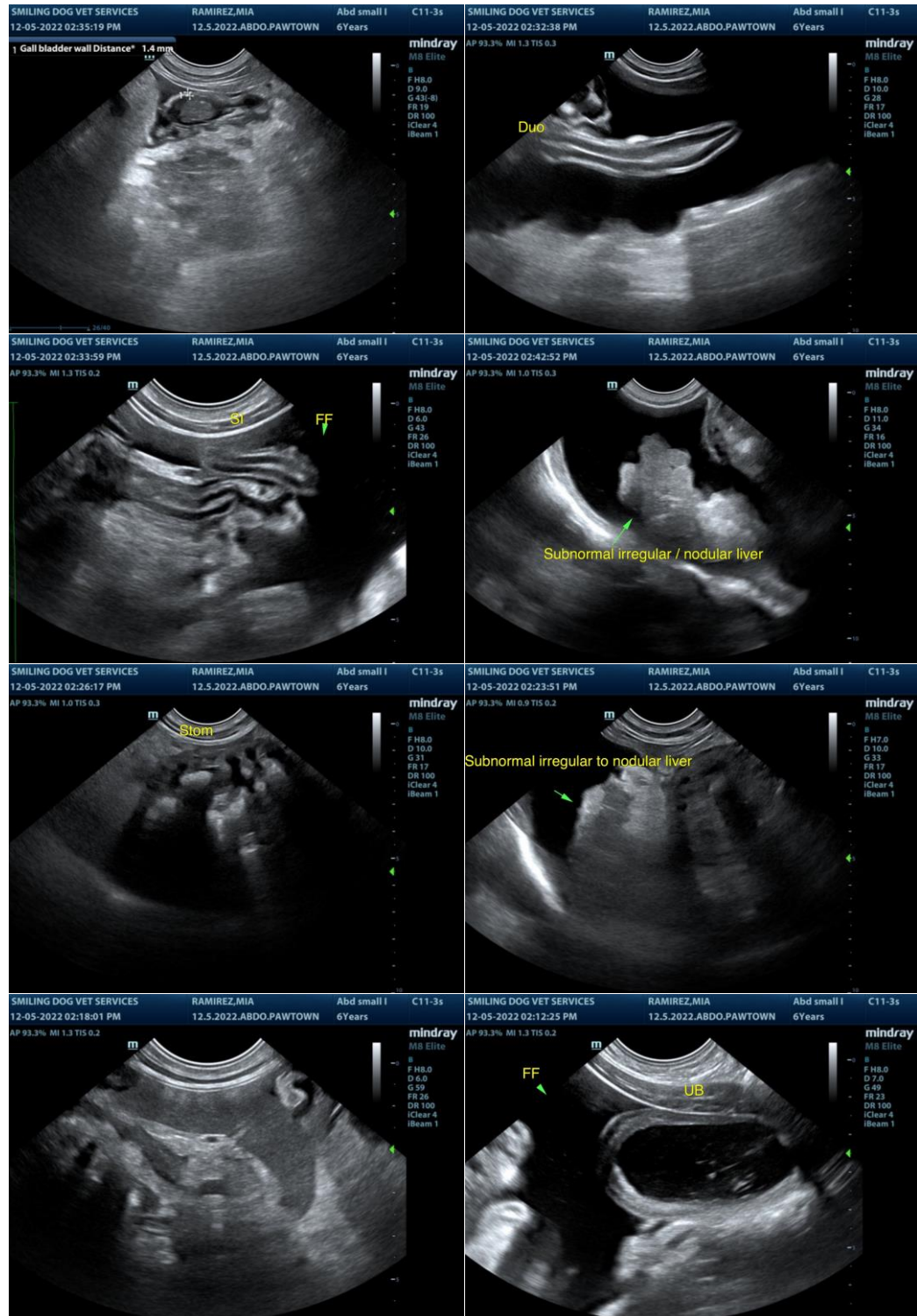
Erin Miller DVM

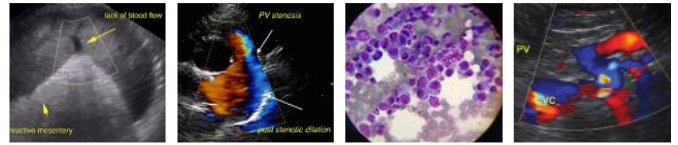
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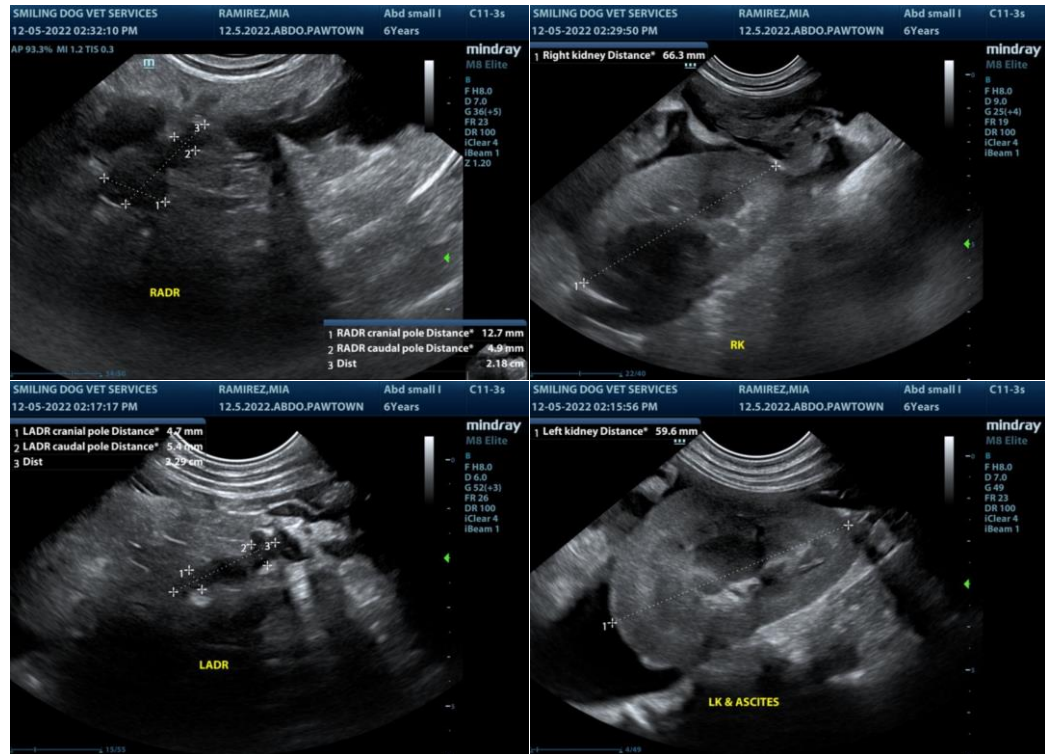
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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.

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