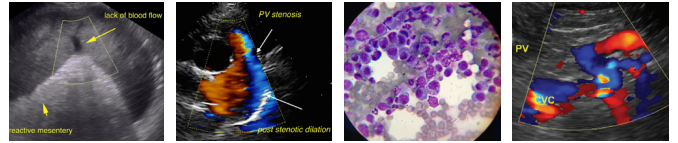
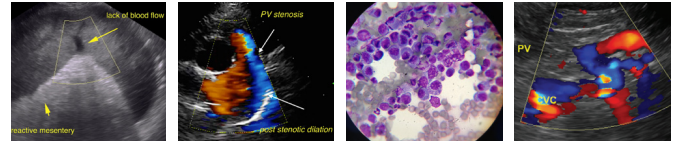


<b>PATIENT</b>	<b>PRESENTING CLINICAL SIGNS</b>
Gwen Bowman	Presented at our hospital for distended and hard abdomen. O states that P has been nauseous and vomiting 'nonstop'. O states that abdomen has been distended for the past week and felt hard today. O states that P has been having diarrhea and vomiting for the past month. O states that P has been on carprofen for the past month. O feels that P is weaker this evening than normal and vomiting/diarrhea has progressively been getting worse. O states that P has not been interested in food for two weeks. No diagnostics per O from rDVM - Happy Tails recommended AUS. Previous Health Concerns: None Current Medications: Tylosin Capsule; Carprofen Appetite/When did they eat last: inappetent; ate an egg earlier today
<b>SPECIES</b>	
Canine	
<b>BREED</b>	
Beagle	Abnormal PE/Chem/CBC/UA Results: Tense on abdominal palpation. Bloodwork: Chem Ca 6.5; TP 2.8; ALB < 0.1; GLOB***; Chol 77; Lipase 648; EPOC: pO2 123.0; cSO2 99.1; pCO2 17.8; Bicarb 12.6; TCO2 13.5; iCa 0.95; HCT 33; CBC: WBC 23.6; NEU 21.81; LYM 0.5; NEU% 92.8; LYM% 2.2 Rads: plural effusion in chest, mild loss of detail in abdomen.
<b>SEX</b>	<b>ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN</b>
Spayed Female	<i>Urinary System</i>
<b>AGE</b>	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.
11 Years	
<b>WEIGHT</b>	The aortic trifurcation was unremarkable.
14.4 kg	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. The left kidney measured 5.0 cm. The right kidney measured 5.5 cm.
<b>INTERPRETED BY</b>	<i>Adrenal Glands</i>
R. McKenzie Daniel, DVM, DABVP (Canine and Feline)	The left adrenal gland was uniform in size and contour with a uniformly hypochoic parenchyma. The left adrenal gland measured 0.40 cm at the cranial pole and 0.63 cm at the caudal pole. The right adrenal gland was not definitively visualized.
<b>IMAGING PERFORMED BY</b>	<i>Spleen</i>
Erin Wicks	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.
<b>HOSPITAL NAME</b>	<i>Liver</i>
Shores VEC	The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypochoic 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.
<b>REFERRING VET</b>	<i>Gastrointestinal</i>
Dr. Slenbaker	The stomach presented mild wall thickening secondary to echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. Mild gastric distension with primarily anechoic fluid was present. Gastric body wall measured 0.65 cm.
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<b>PATIENT</b>	The small intestine presented intact wall layering with generalized propensity for prominent mucosal layer. Intermittent focal areas of indistinct, mildly hyperechoic mucosal speckling noted. No overt evidence of mechanical obstruction or foreign material. No overt evidence of loss of intestinal wall layering or distinct masses. Jejunum wall measured 0.47 cm. Duodenum wall measured 0.57 cm.
Gwen Bowman	
<b>SPECIES</b>	Normal visible colon wall layers were present with apparent formed feces in lumen.
Canine	<i><b>Pancreas</b></i>
<b>BREED</b>	The pancreas was normal in size and contour with heterogeneous to mildly echogenic parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.
Beagle	<i><b>Free Abdomen</b></i>
<b>SEX</b>	No overt lymphadenopathy. Generalized reactive mesentery noted with small pockets of scant peritoneal free fluid.
Spayed Female	Transdiaphragmatic view of the caudal thorax revealed concurrent pleural effusion.
<b>AGE</b>	<b>ULTRASONOGRAPHIC FINDINGS</b>
11 Years	<ul style="list-style-type: none"> <li>Generalized gastroenteritis pattern with mild gastric stasis – suspect probable PLE.</li> <li>Sonographically unremarkable liver – no overt congestion.</li> </ul>
<b>WEIGHT</b>	<ul style="list-style-type: none"> <li>Age related kidneys</li> <li>Generalized reactive mesentery and scant peritoneal free fluid</li> <li>Concurrent pleural free fluid</li> </ul>
14.4 kg	
<b>INTERPRETED BY</b>	<b>INTERPRETATION OF THE FINDINGS &amp; FURTHER RECOMMENDATIONS</b>
R. McKenzie Daniel, DVM, DABVP (Canine and Feline)	Given the gastrointestinal signs in this patient, concurrent panhypoproteinemia and sonographic appearance of the gastrointestinal tract, PLE is suspected. Chronic inflammatory bowel disease, lymphangiectasia, infiltrative gastrointestinal disease also possible. Ideally, brief or full echocardiogram recommended to rule out evidence of cardiomyopathy as well as full urinalysis to rule out proteinuria. Obvious evidence of gastrointestinal ulceration was not noted, yet cannot be definitively excluded. Intestinal biopsies are required for definitive diagnosis, yet contraindicated given albumin levels <2.0. Pending additional diagnostics, some or all of the following protocol may be considered.
<b>IMAGING PERFORMED BY</b>	<b>PLE Therapy</b>
Erin Wicks	Part or all of this protocol may be considered based on your clinical impression of the patient:
<b>HOSPITAL NAME</b>	<b>OBJECTIVE: keep albumin levels &gt; 2 g/dl, avoid thromboembolism and cavitory effusions, monitor concurrent PLN (Wheaton Terrier PLE/PLN) and liver disease:</b>
Shores VEC	<b>Plasma</b> 10 mL / kilogram IV over 4 hours Or <b>Human albumin</b> 2 ml/kg/h over 10 hours. Total daily volume 20.l/kg/day <b>And Colloids/Hetastarch</b>
<b>REFERRING VET</b>	10 to 20 mL per kilogram per day and dogs 10 to 15 mL per kilogram per day cats (Can bolus first 1/3 of dose over 15 minutes) & maintain on LRS maintenance otherwise.
Dr. Slenbaker	<b>Metronidazole</b> (10-20 mg/kg po bid) <b>Famotidine</b> 1 mg/kg Iv Im po dc Sid /bid <b>Sucralfate</b> 0.5-1 g po tid dogs, 0.5 g bid cats in slurry Or <b>Misoprostol</b> 1-5 ug/kg po tid
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**PATIENT**

Gwen Bowman

**Diet:** Highly digestible high quality protein, low fiber, low fat diet (< 15% of dry matter). Hydrolyzed protein or novel protein. Purina HA or Royal Canine HP or similar.  
**Prednisone** or prednisolone 2 mg/kg bid x 3-5 days then 2 mg/kg sid. **Chlorambucil** in refractive severe IBD/alimentary lymphoma cases (monitor cbc for rare bone marrow suppression) 4 mg/m<sup>2</sup> Q 24-48 hours.

**SPECIES**

Canine

**Cobalamine** (B12) 250-1500 ug/dog weekly x 6 weeks.

**Calcium** supplementation if necessary.

**Aspirin** 0.5-1 mg/kg/day or **Clopidrel** (Plavix) 1-5 mg/kg/day.

**BREED**

Beagle

**SEX**

Spayed Female

**AGE**

11 Years

**WEIGHT**

14.4 kg

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Erin Wicks

**HOSPITAL NAME**

Shores VEC

**REFERRING VET**

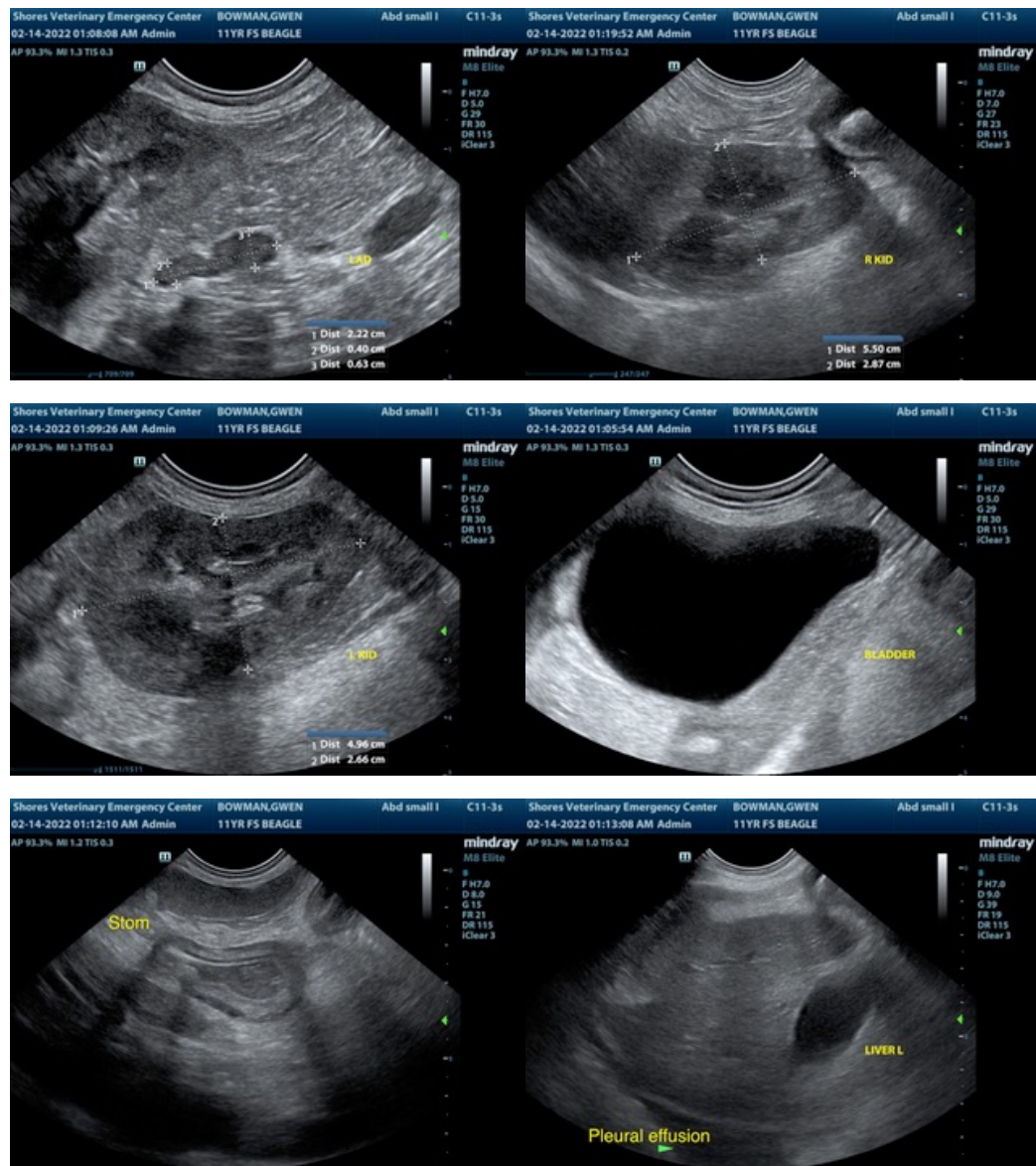
Dr. Slenbaker

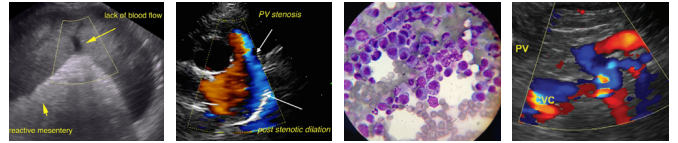
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**PATIENT**

Gwen Bowman

**SPECIES**

Canine

**BREED**

Beagle

**SEX**

Spayed Female

**AGE**

11 Years

**WEIGHT**

14.4 kg

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Erin Wicks

**HOSPITAL NAME**

Shores VEC

**REFERRING VET**

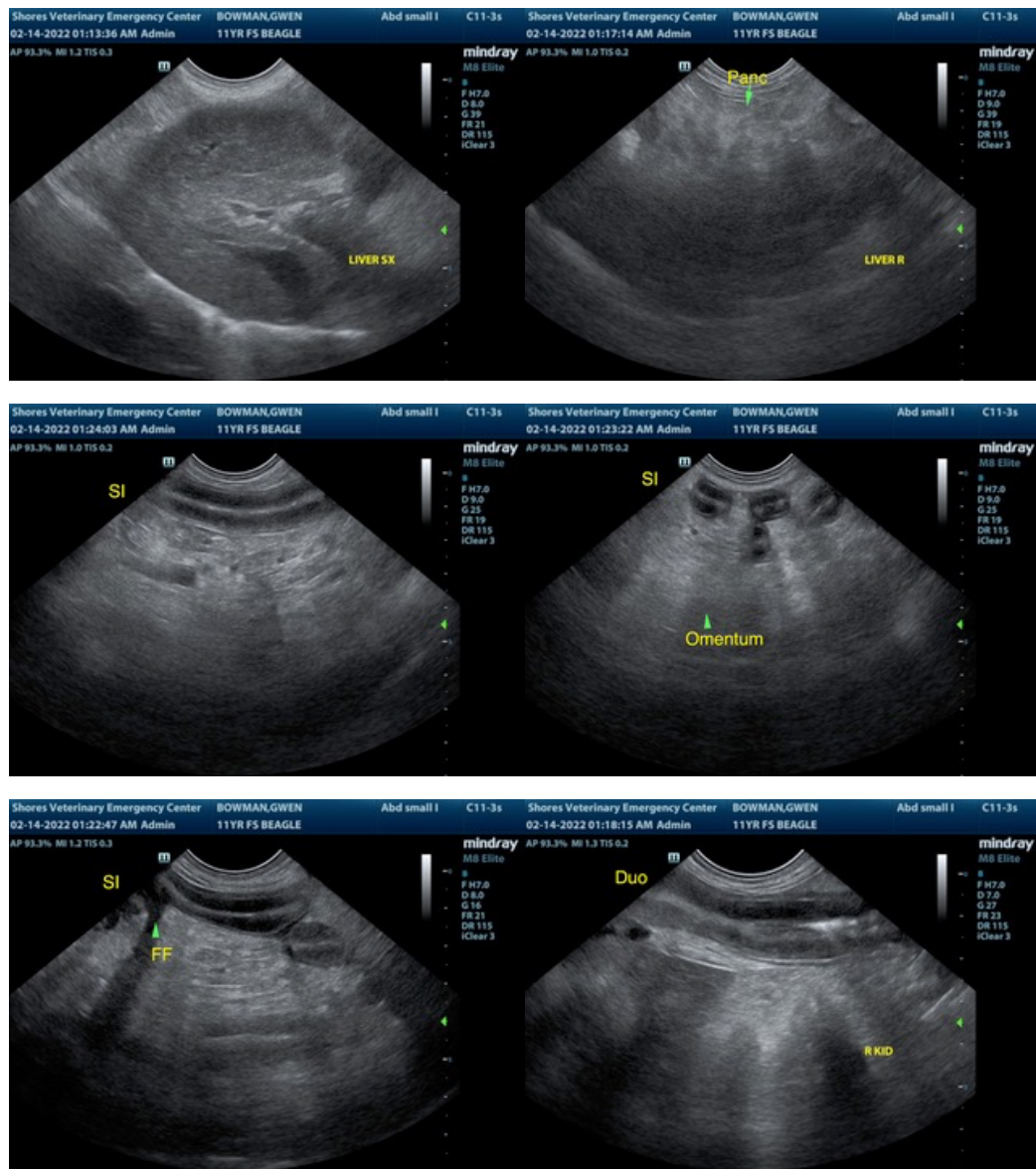
Dr. Slenbaker

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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