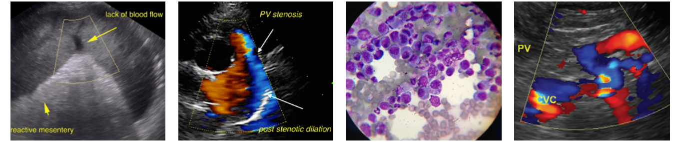
SonoPath

Clinical Sonography & Telecytology

EDUCATIONAL TELECONSULTATION SERVICES™



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1-800-838-4268 info@sonopath.com

PATIENT

Sandy Abecassis

SPECIES

Canine

BREED

Wheaten

SEX

Spayed Female

AGE

13 Years 3 Months

WEIGHT

45.9 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Michaleen

HOSPITAL NAME

DPC Vet Hospital

REFERRING VET

Dr. Duke

INVOICE

35934

DATE

2/26/22

PRESENTING CLINICAL SIGNS

Reason for Visit: adr History: 13y 3m old SF Wheaten Terrier presents ADR x 2 days. O reports pet has had a decreased appetite, yesterday did not eat at all. Groaning when laying down, overall appears lethargic. Vomited once this morning. Unknown BMs. Not on any medications
Abnormal PE/Chem/CBC/UA Results: Hydration: Appropriately hydrated Mentation: QAR EENT: No nasal discharge; clear no discharge OU; clean no exudate AU; No cough on tracheal palpation. Oral Cavity: grade 1 dental tartar present Lymph Nodes: Symmetrical, no changes in size, shape, consistency Skin: Good hair coat, no signs of ectoparasites. No lesions noted. CV/Respiratory: No murmur/arrhythmia or crackles/wheezing auscultated. Synchronous pulses, normal rate. Normal bronchovesicular sounds. Abd/GI: Soft non painful abdomen, suspected splenomegaly Uro/Perineum: N Musculoskeletal: Normal ambulation, no lameness noted. Good musculature. Decreased ROM on extension of the right coxofemoral joint. BCS 6/9 Neurological: Appropriate Fecal - Nps

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.

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. Minor pyelectasia noted in the left kidney. The left kidney measured 6.6 cm. The right kidney measured 7.4 cm.

Adrenal Glands

The adrenal glands were indistinctly visualized. Overt adrenal pathology was not evident. The left adrenal gland subjectively measured 0.62 cm at the caudal pole. The right adrenal gland subjectively measured 0.53 cm at the caudal pole

Spleen

The spleen exhibited primarily finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Multifocal, well-defined, symmetrical, echogenic nodules were present, primarily around the hilus and medial parenchyma. Potential for mild splenomegaly, yet overall maintained symmetrical capsule contour and finely textured homogeneous parenchyma. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. No splenic masses or overt neoplastic criteria. Acute to chronic inflammatory or neoplastic changes were not noted. The echogenic nodules tend to trend benign and are most consistent with benign hyperplasia or myelolipomas.

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 moderate primarily dependent to mildly non-dependent yet non-organized debris. No evidence of inflammatory criteria. The cystic duct and common bile ducts were normal without evidence of dilation.

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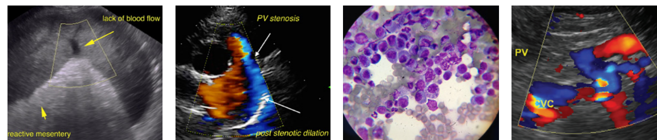

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Gastrointestinal

The stomach presented intact yet subjective prominent wall layering. The lumen of the stomach was primarily empty with mild luminal gas and without evidence of retained ingesta, fluid 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. Jejunum wall measured 0.38 cm. Duodenum wall measured 0.45 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

- Suspect gastritis, sonographically unremarkable small bowel/colon
- Moderate gallbladder debris (non-mucocele) – non-specific yet potentially owing to fasting or non-clinical cholestasis.
- Bilateral mild chronic renal changes with minor left kidney pyelectasia
- Benign splenic nodules – consistent with probable myelolipomas.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The left kidney pyelectasia may be owing to chronic renal changes, potential pelvic scarring possibly owing to previous calculi passage, IV fluid therapy (if applicable). Urine C/S and protein: creatinine ratio on sterile urine sample is recommended.

Aside from suspected gastritis, an obvious cause of the patient's gastrointestinal and overall clinical signs was not definitively evident. Potential for structurally insignificant concurrent enteropathy or low-grade to chronic pancreatitis, both of which may present sonographically normal, cannot be excluded. Clinical signs associated with the gallbladder are not anticipated. However, correlation with full lab work to assess hepatic enzymes is suggested if not done. Potential for very early infiltrative gastric disease considered a less likely differential diagnosis.

3-view chest radiographs as well as thorough musculoskeletal examination to rule out occult pathology as contributing factors to the patient's clinical signs is recommended. Resting cortisol level to rule out occult Addison's Disease could be considered. Some or all of the following protocol may be considered with assessment of clinical response.

Helicobacter/Gastritis protocol
A clinical trial of **Zithromax (*Dogs:*** 5-10 mg/kg p.o. q24h. May increase dosing interval to q48h after 3-5 days of treatment), **Metronidazole** (10-20 mg/kg p.o. b.i.d.), **Pepcid** (0.5-1 mg/kg s.i.d.) and **Sucralfate** (0.5-2 g/dog PO) or **Omeprazole** (1 mg/kg p.o. s.i.d.) over the next 3 weeks along with a **novel-protein or hydrolyzed diet** with slurry feeding b.i.d./t.i.d. over the next 2-4 days and then increase to canned diet bid. Dry food should be avoided over the next 4 weeks. A recheck sonogram to assess GI improvement or progression would be ideal in 4 weeks.

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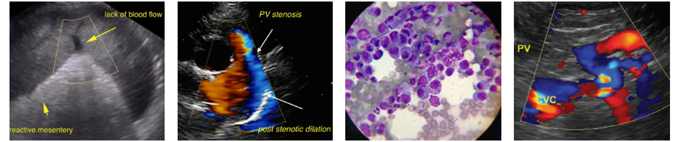

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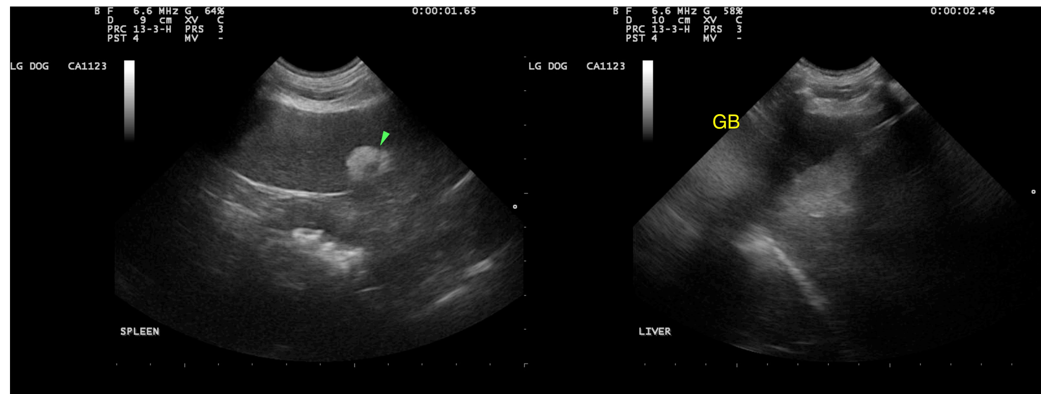

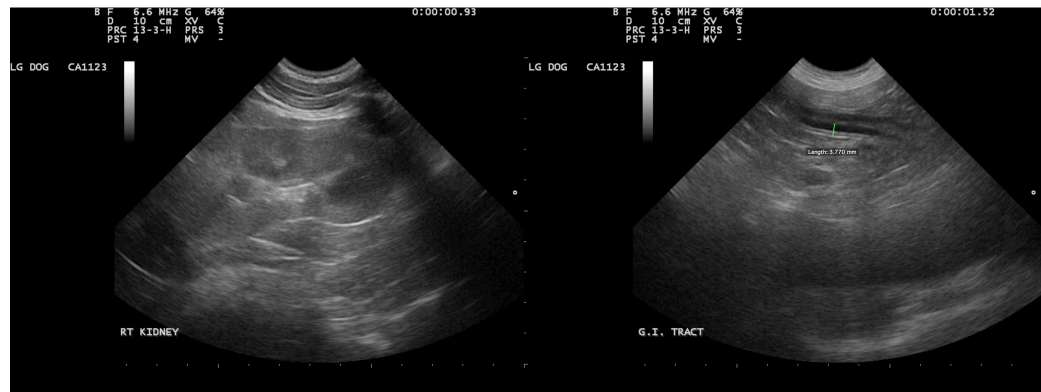

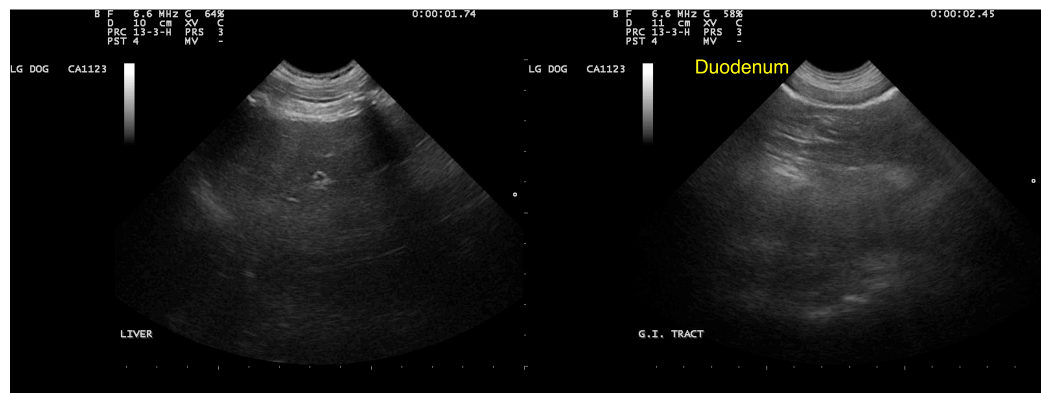

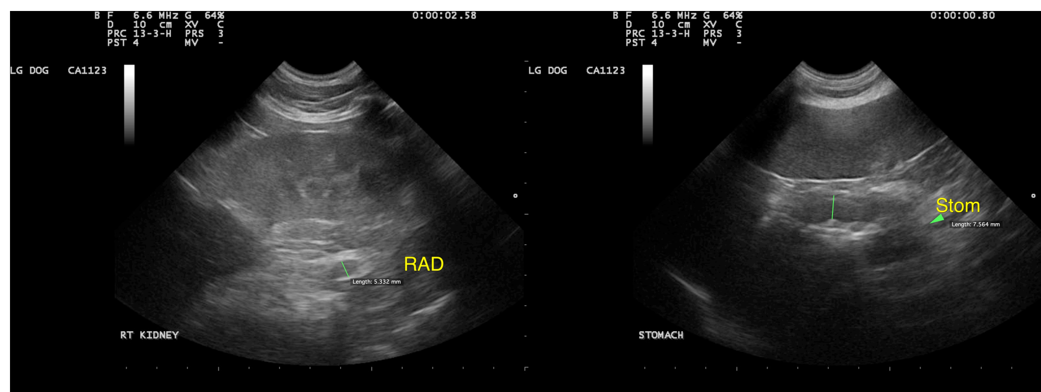

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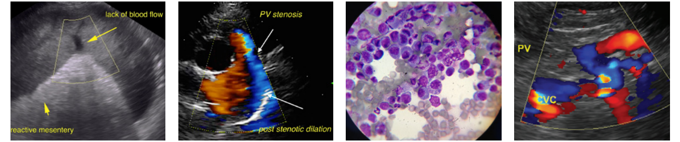

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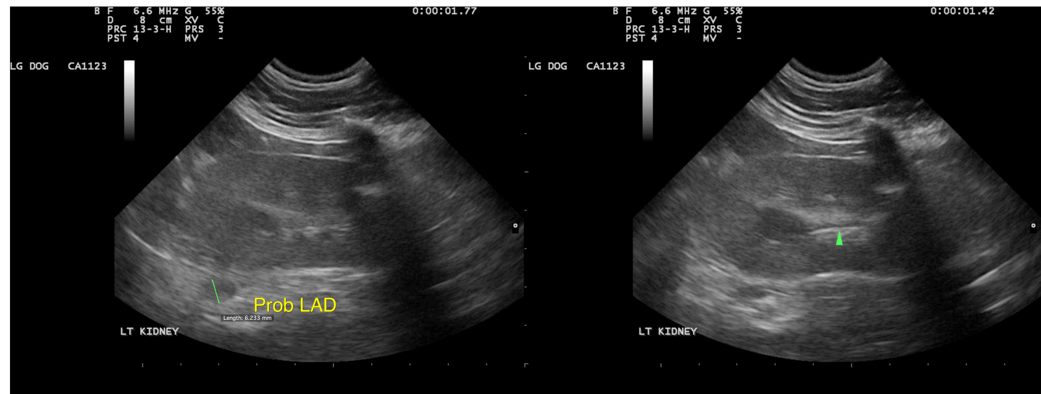

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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