



PATIENT

Gracie Elias

SPECIES

Canine

BREED

Australian Cattle Dog

SEX

Spayed Female

AGE

9.5 Years

WEIGHT

50.9 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Wymard

HOSPITAL NAME

Brookwood AC, LLC

REFERRING VET

Dr. Wymard

INVOICE

14133

DATE

2/28/22

PRESENTING CLINICAL SIGNS

History: Chronic vomiting of ~3-4-week duration. Most of the time vomits after eating/drinking but other times it is random. Vomits ~6-10x / week but there are days she doesn't vomit at all. BM are normal. P did well for a couple of weeks and then vomiting returned. Energy normal. Appetite good. Meds - Proin BID. Diet - goats milk, chicken, rice, broth, egg, sweet potato, pumpkin. O is feeding small amounts frequently.

Abnormal PE/Chem/CBC/UA Results: 2.722 - ALT (160), Creatinine (1.5), BUN (9), K (3.3) Glu (131), HCT 57% - otherwise normal ALT in 8.2021 was 293. Repeat lab work in October 2021 showed ALT at (76), GGT (8), cholesterol (317) - other liver values normal. CBC/Chem/UA repeated again today but do not have results yet.

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. Aortic trifurcation was normal.

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 5.9 cm in length. The right kidney measured 6.9 cm in length.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.59 cm.

The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.69 cm.

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 normal in size and contour. Normal overall hepatic parenchyma echogenicity, exhibiting minor subjective parenchymal remodeling. No hepatic masses or nodules noted.

The gallbladder was non distended in size with mild nondependent yet nonorganized gallbladder debris. The cystic duct and common bile ducts were normal without evidence of dilation.

Gastrointestinal



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The stomach exhibited intact to regionally indistinct wall layering with mild mural thickening. In the area of the gastric body, subjectively extending into the area of the pylorus. The gastric body wall measured 0.78 cm.

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The upper duodenum also appeared to be mildly prominent to thickened, exhibiting subjective mild decreased mural echogenicity and indistinct wall layering. The upper duodenum measured 0.49 cm. The jejunum and ileum to the level of the colon were sonographically unremarkable without evidence of mechanical/metabolic ileus.

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

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.

Free Abdomen

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Subtle evidence of perigastric to periduodenal reactive mesentery was present. No overt lymphadenopathy or effusion present.

ULTRASONOGRAPHIC FINDINGS

WEIGHT

50.9 Pounds

- Mildly thickened stomach and upper duodenum, associated mild perigastric and periduodenal reactive mesentery
- Mildly heterogeneous pancreas
- Low-grade hepatopathy
- Minor gallbladder debris (non-mucocele)- likely incidental, potentially owing to fasting in this case or mild nonclinical cholestasis

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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The overall appearance of the stomach and upper duodenum may suggest gastritis or gastroduodenitis, although the possibility of emerging infiltrative gastric or gastroduodenal process cannot be definitively excluded. Ideally, endoscopic biopsies recommended for further clarification, biopsies and histopathology.

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The liver may indicate concurrent low-grade reactive hepatopathy, potentially owing to upper gastrointestinal inflammation or low grade inflammatory hepatopathy.

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Potential for low-grade to chronic pancreatitis, which may present essentially sonographically normal could be possible, correlation with a spec CPL would be warranted.

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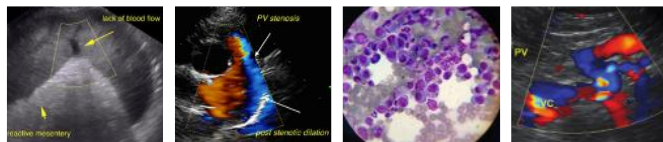
Empirically, some or all of the following protocol or alternative helicobacter protocol could be considered with assessment of clinical response and recheck sonogram. Correlation with recheck lab work suggested. If not done, three-view chest radiographs suggested to rule out occult thoracic or esophageal pathology as a contributing factor to the patients vomiting.

Helicobacter/Gastritis protocol

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2/28/22

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



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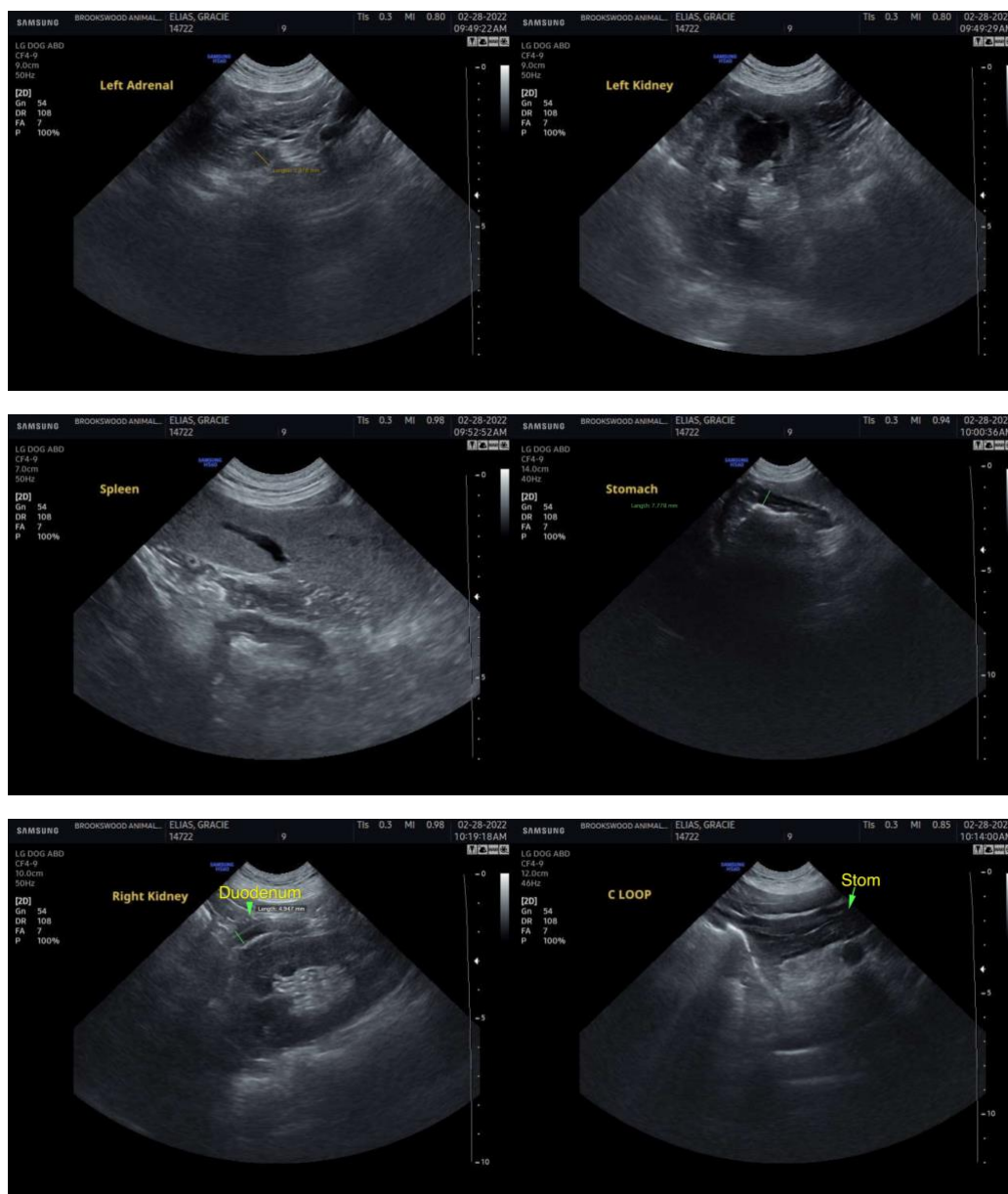
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Sucralfate (0.5-2 g/dog PO) or **Omeprazole** (1 mg/kg p.o. s.i.d.) over the next 3 weeks along with a **novel-protein or hydrolyzed diet** with slurry feeding b.i.d./t.i.d. over the next 2-4 days and then increase to canned diet bid. Dry food should 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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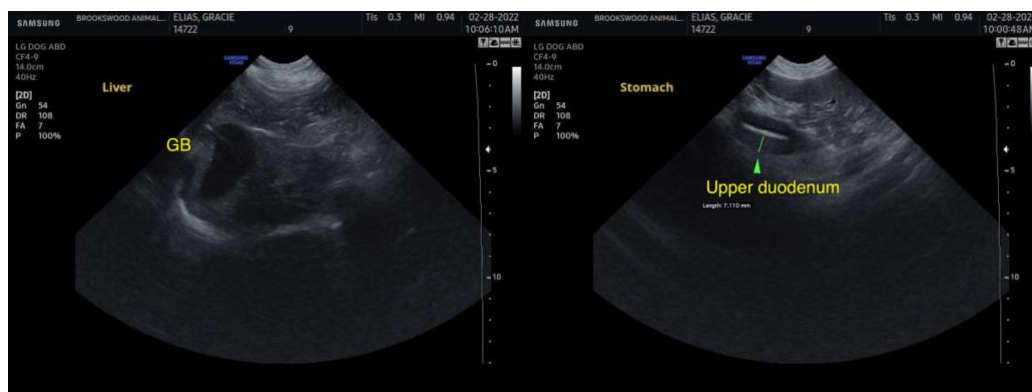
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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