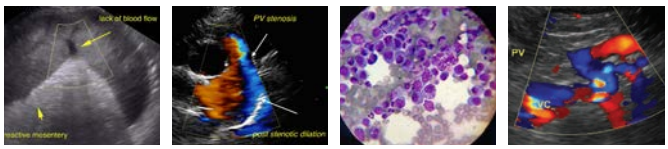
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Lily Snowflake Carrera

SPECIES
Canine

BREED
Poodle

SEX
Spayed Female

AGE
7 Years

WEIGHT
4.45

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

IMAGING PERFORMED BY
Dr. Anna Wepprich

HOSPITAL NAME
Wilvet Salem

REFERRING VET
Dr. Anna Wepprich

INVOICE
45850

DATE
3/12/23

PRESENTING CLINICAL SIGNS

Presented to VCA Salem 3/8 for vomiting/diarrhea. Was dehydrated with elevated cPL, radiographs showed gastroenteritis. Outpatient treatment - Cerenia, SQF, probiotic. 3/9 pt was hospitalized briefly and discharged, eating and diarrhea improving. 3/11 stopped eating and per owner skin appeared bright red. Strictly eats Hill's i/d

Abnormal PE/Chem/CBC/UA Results: VCA Salem 3/8 CBC - hct 59% slight lymphopenia chem - ALb 3.1, amy 3100, ALP 205, cPL abnormal (snap) Rads - gastroenteritis (submitted to AIS radiology) fecal - negative 3/9 CBC - hct 56%, lymphopenia chem - Alb 2.0, amy 1800, ALP 133 normal 3/11 Erythema and bruising on forelimbs, erythema ears and abdomen CBC - lymph 0.7k, Hct 52% chem - Alb 1.9, glob 3.5, TP 5.5 PT 6.64s (low), PTT 103.4s (slightly low) 3/12 4dx-negative ALB 2.3 BAR, MM pk crt<2s, no petechia visible. EENT wnl. Thorax auscults wnl, eupneic. Abd tense on palpation, small amt diarrhea, urinating well. amb x 4 inside of ear, axilla and inguinal areas mildly red - no petechia or ecchymoses_ progressive hypoalbuminemia lack of stress leukogram abnormal cPL diarrhea, not eating erythema - abdomen, ears hx skin disease.

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. Primarily anechoic urine was present in the lumen. Mild to moderate dependent to non-dependent particulate sediment was present without evidence of calculus formation. The sediment may indicate cellular debris/protein, crystalline debris, or mucus. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural 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 3.9 cm. The right kidney measured 4.0 cm.

Adrenal Glands

Both adrenal glands were overtly normal in size, position, and shape. The left adrenal gland measured 0.46 cm at the caudal pole. The right adrenal gland measured 0.39 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 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.

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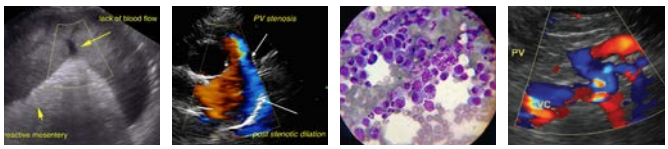

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Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material. Mild luminal gas.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. Minor duodenal corrugation with intermittent discrete hyperechoic duodenojejunal mucosal speckling. No obstructive pattern.

The colon walls presented intact yet prominent wall layering with mild thickened to echogenic submucosa. The colon was non-distended, containing semiformed to soft fecal matter, consistent with patient history.

Pancreas

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

Free Abdomen

Intermittent pockets of scant peritoneal free fluid. No evidence of overt lymphadenopathy. No omental masses. Generalized normal omental echogenicity.

The area of the uterine remnant was free of pathology.

ULTRASONOGRAPHIC FINDINGS

- Inflammatory gastroenterocolonopathy pattern - recurrent gastroenterocolitis, IBD, emerging PLE, infectious disease, enterotoxin, occult neoplasia (thought less likely) possible.
- Heterogeneous / mild hypoechoic pancreas - not overtly consistent with significant / active pancreatitis, necrosis or pancreatic neoplastic criteria, persistent mild, chronic / chronic active or potential resolving pancreatitis possible
- Scant peritoneal free fluid
- Urinary bladder sediment

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A GI panel to include PLI/TLI/Cobalamin/Folate and resting cortisol to rule out occult Addison's Disease is warranted. Empirically, hospital stabilization with supportive care +/- plasma expanders if persistent hypoalbuminemia, novel protein or hydrolyzed diet (even with current i/d), prophylactic deworming (Panacur 50 mg/kg SID x 5 consecutive days with repeat protocol in 3 weeks even if fecal testing is negative), high colony count probiotic (Proviable or Visbiome), antibiotic trial and as needed gastrointestinal support with assessment of clinical response is warranted. Intestinal biopsies may be indicated if GI signs continue despite empirical therapy and adequate albumin levels. Urine C/S is suggested if inflammatory cellular debris.

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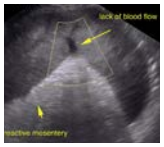
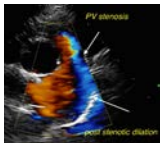
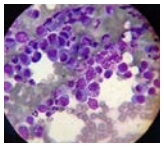
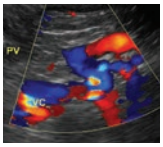

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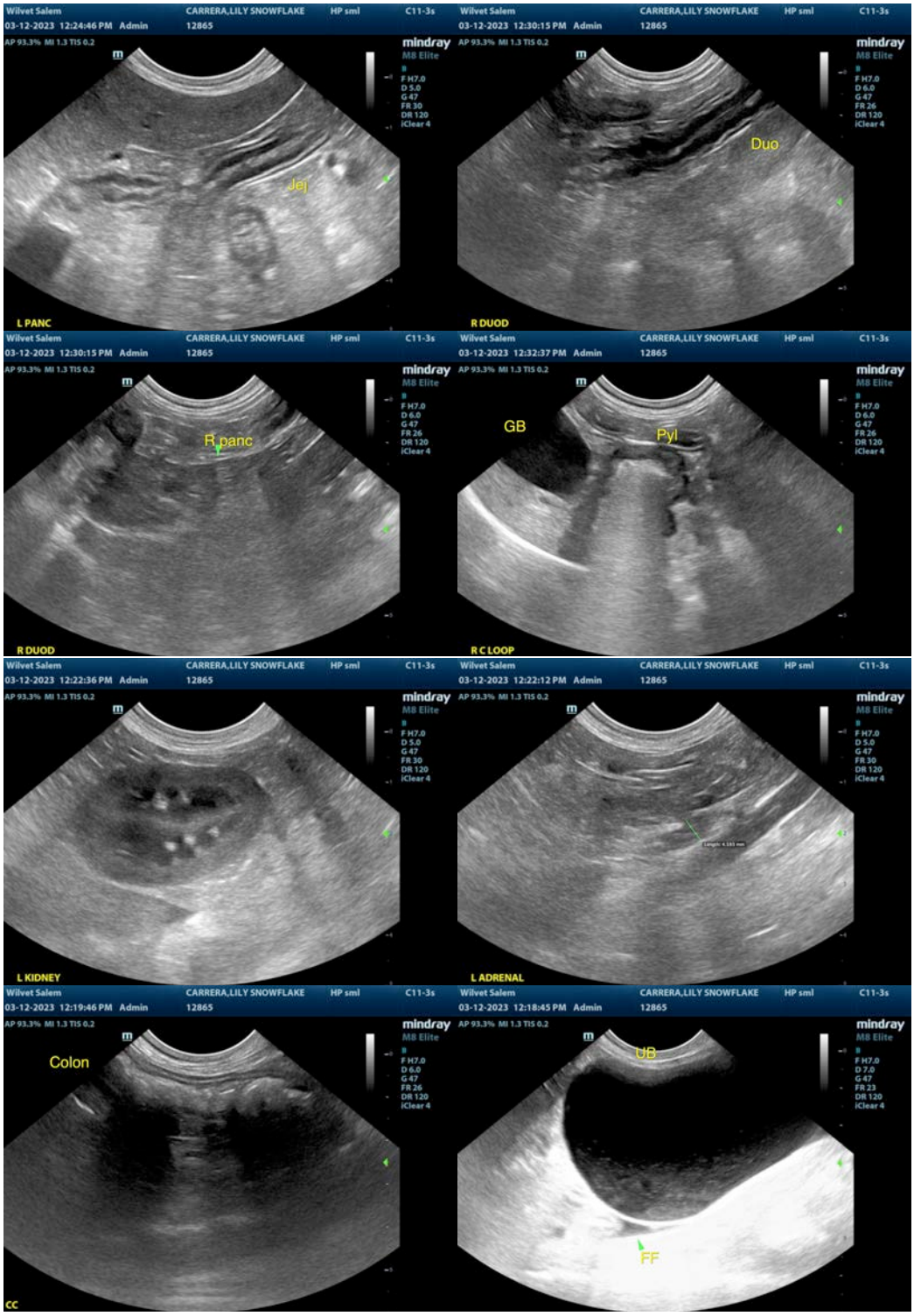

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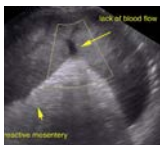
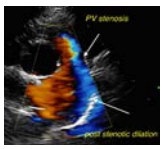
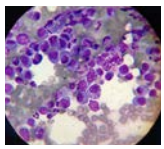
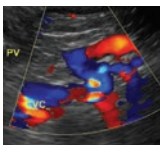

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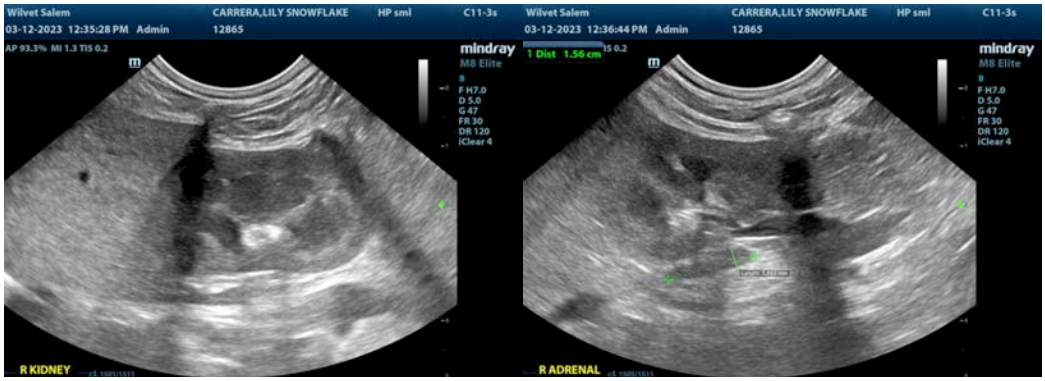

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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