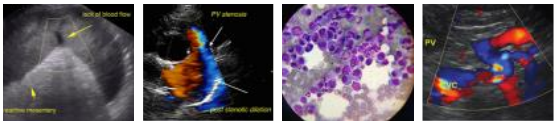


PATIENT

Wicket Shew

SPECIES

Canine

BREED

Border Collie

SEX

MN

AGE

13 years

WEIGHT

55 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Jenna Walsh, CVT

HOSPITAL NAME

Pawsitive Wellness VC

REFERRING VET

Dr. Hardy

INVOICE

14345

DATE

3/17/22

PRESENTING CLINICAL SIGNS

QAR, Pale mm, tight abdomen with ropey loops of intestine. Exhausted at home per O. Will walk ten feet and then collapse Current Medications Cerenia, I/D low fat (P barely eating)
Abnormal PE/Chem/CBC/UA Results: Slowly progressing non regenerative anemia

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 was noted.

No overt pathology in the area of the residual prostate. The residual prostate measured 0.95 cm in diameter.

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 mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 5.8 cm in length. The right kidney measured 6.1 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 2.7 cm length x 0.54 cm at the caudal pole.

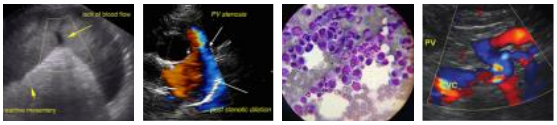
The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 2.6 cm length x 0.53 cm width at the caudal pole.

Spleen

The spleen exhibited primarily finely textured parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Mild generalized parenchyma heterogeneity was present without evidence of nodular changes. 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. The parenchymal heterogeneity is likely consistent with benign changes such as extramedullary hematopoiesis or age-related remodeling with minor potential for inflammatory or neoplastic disease.

Liver/ Gallbladder

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.



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

Gastrointestinal

The stomach exhibited regional mild to moderate yet variable mural hypertrophy, exhibiting loss of discernable wall layer detail and mild non-uniform to echogenic walls in the area of the subjective gastric body. The dorsal gastric body wall measured 0.81 cm. Minor retained non-shadowing chyme and fluid were present in the stomach.

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.

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 were evident.

Free Abdomen

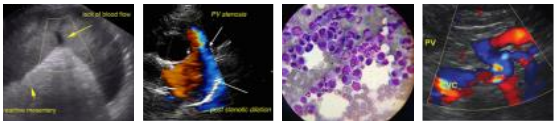
Subtle evidence of regional perigastric reactive mesentery and indistinct mildly hypoechoic to nonhomogeneous cranial omental to perigastric lymphadenopathy. An example measured 0.60 cm. No evidence of peritoneal effusion.

ULTRASONOGRAPHIC FINDINGS

- Thickened to mildly hypomotile stomach
- Associated mild regional perigastric reactive mesentery and nonspecific lymphadenopathy
- Normal spleen
- Overtly normal small bowel
- Bilateral mild chronic renal changes
- Mild gallbladder debris (non-mucocele)
- Mild hepatic parenchymal remodeling- subjectively benign

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The patients inappetence is suspected to be owing to the thickened stomach with considerations, including chronic gastritis, infectious gastroenteropathy (helicobacter) or neoplastic infiltrative gastroenteropathy, potential for ulceration cannot be excluded given the patients anemia or if evidence of hematemesis, elevated BUN levels or melena. Overt evidence of gastric foreign material or mechanical outflow obstruction was not present.



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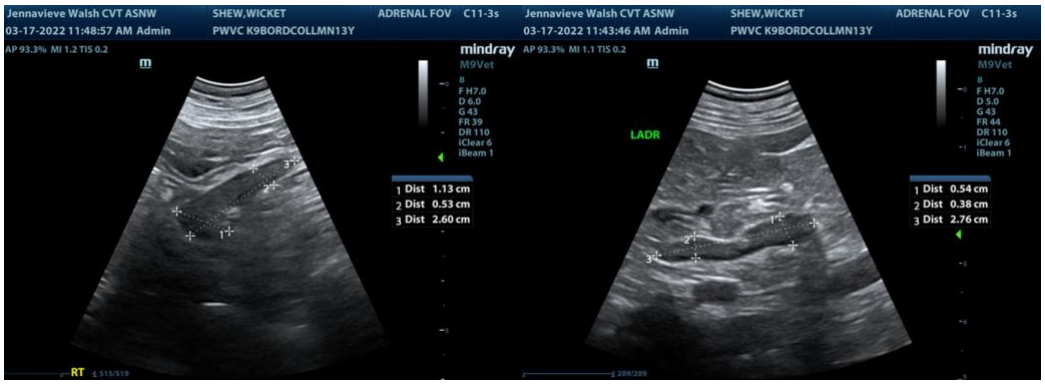
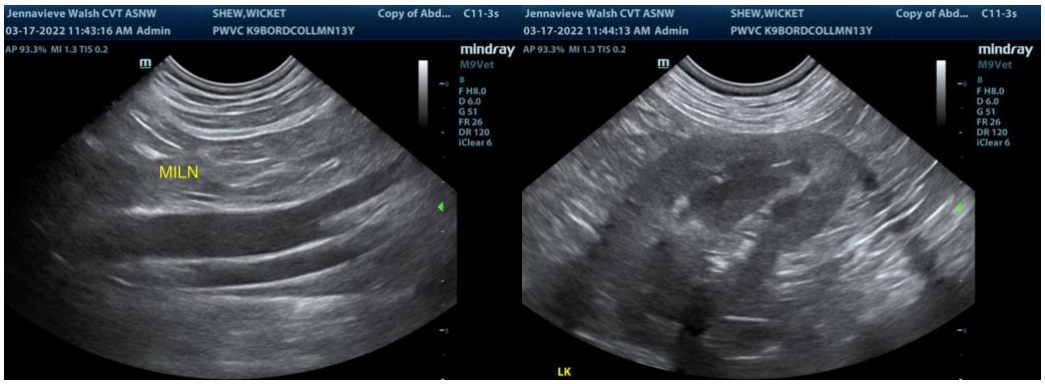
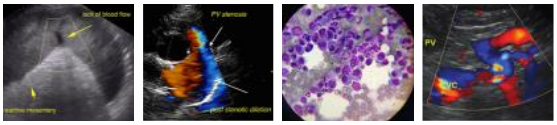
Some or all of the following protocol could be considered empirically. Upper gastrointestinal endoscopy is likely ideal for further assessment and potential for biopsies. Three-view chest radiographs are suggested to rule out concurrent occult thoracic or esophageal pathology.

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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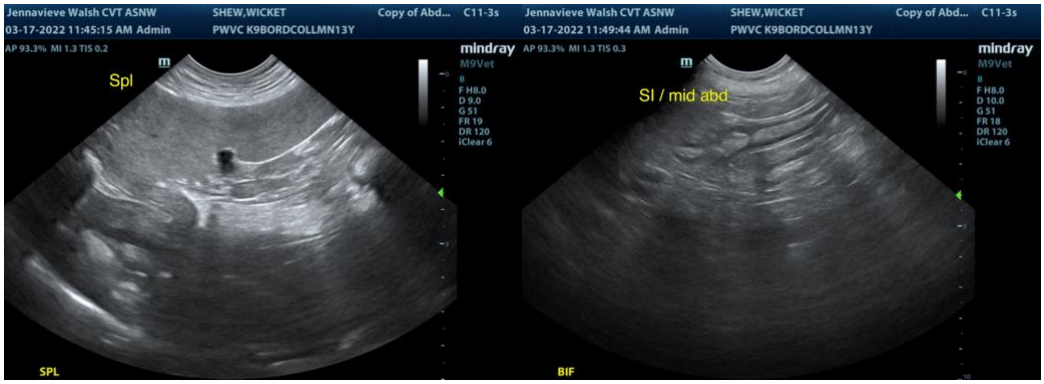

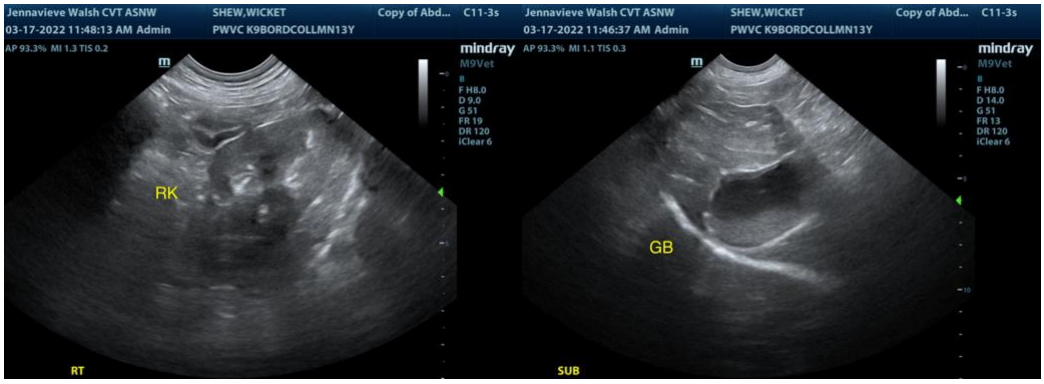

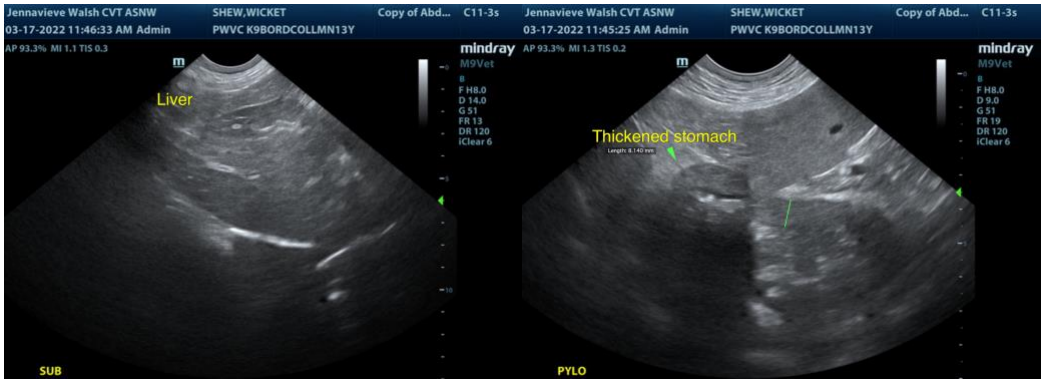

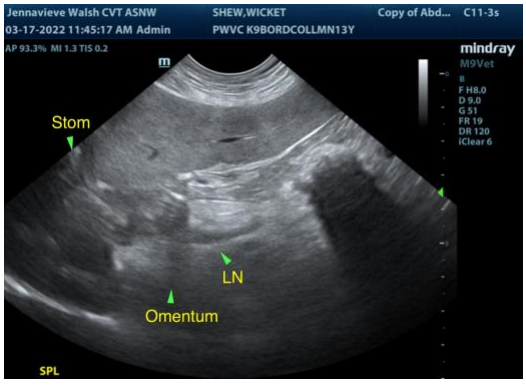

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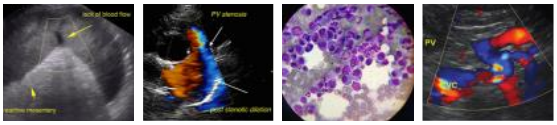

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@SonoPath.com