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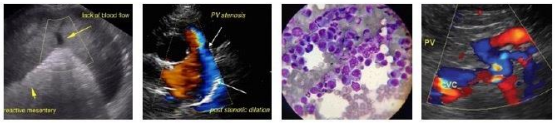


THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Jamie Middleton

SPECIES

Canine

BREED

Cocker Spaniel

SEX

MN

AGE

12yr

WEIGHT

17kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

Upper Canada AH

REFERRING VET

Harkness

INVOICE

13199ag

DATE

03/17/2023

PRESENTING CLINICAL SIGNS

Presented on March 10th for lethargy, vomiting, hyporexia, diarrhea and flatulence - Historically has been known to get into the garbage - PE revealed 5% dehydration, cranial abdominal pain, flatulence, soft dark stool in rectum, grade IV/VI left systolic heart murmur (pre-existing mitral valve disease) - Previously on Metacam for arthritis and Apoquel for allergies - last doses given March 9th, 2023 - Bloodwork revealed mild non regenerative anemia, elevated band neutrophils and abnormal cPL - Thoracic radiographs revealed left atrial enlargement - Abdominal radiographs revealed a moderately fluid filled stomach, gas filled colon, caudal lumbar spondylosis - Started on outpatient supportive care for acute pancreatitis (cerenia, gabapentin, SQ fluids, probiotics, low fat canned diet) - good response in first 24 hours then relapsed - appetite remained poor, ongoing diarrhea/lethargy, no further vomiting - Hospitalized on March 16th for IV fluids and supportive care (cerenia, pantoprazole, methadone, tylosin) - Hydration status improved, no improvement in appetite/lethargy, remains uncomfortable in cranial abdomen

Current Medications Enterio-aid 5mL BID, Tylosin 200mg PO BID, Pantoprazole 1 mg/kg IV BID, Cerenia 1 mg/kg SID IV, Methadone 0.2 mg/kg IV q4-6 hrs, Trazodone 75mg PO as needed, Acepromazine 0.03 mg/kg IV as needed

Abnormal PE/Chem/CBC/UA Results: Bloodwork revealed mild non regenerative anemia, elevated band neutrophils and abnormal cPL: 581 (0-200) Radiographic Findings - Thoracic radiographs revealed left atrial enlargement - Abdominal radiographs revealed a moderately fluid filled stomach, gas filled colon, caudal lumbar spondylosis please see attached labs and rads

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra exhibited normal thickness and tone. Anechoic urine was present in the lumen with minor non-dependent particulate sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

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. Pinpoint medullary mineral was present. The left kidney measured 5.9 cm in length. The right kidney measured 5.7 cm in length.

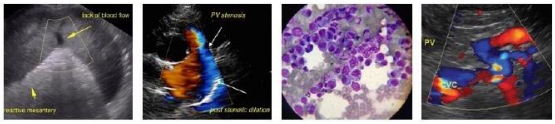
The area of the aortic trifurcation was free of pathology.

Adrenal Glands

The bilateral adrenal glands were normal in size. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The left adrenal gland measured 0.74 cm width in the cranial pole and 0.66 cm width in the caudal pole. The right adrenal gland measured 0.9 cm width in the caudal pole.

Spleen

The spleen exhibited primarily finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Several to multiple multifocal, well-defined, symmetrical, hyperechoic nodules were present adjacent to the hilus. 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 or neoplastic changes were not noted. The



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hyperechoic nodules tend to trend benign and are most consistent with benign hyperplasia or myelolipomas.

Liver/Gallbladder

The liver was mildly enlarged with normal contour and mild non-homogenous parenchyma exhibiting discrete non-disruptive nodules, an example measured 1.6 cm in diameter. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was mildly distended in size with thin walls and primarily anechoic luminal content with mild non-organized debris. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained non-shadowing ingesta consistent with food with no signs of ileus, obstruction or foreign material.

The small intestine presented intact variably thickened wall layering with duodenal and segmental jejunal corrugation. Segmental variably hyperechoic non-shadowing ingesta was present with no signs of ileus, obstruction or foreign material. Segmental wall thickening with loss of wall layering was present in the jejunum. No evidence of intestinal mural hypertrophy, loss of intestinal wall layering or intestinal masses.

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

Pancreas

The pancreas was mild to variably prominent in size exhibiting minor asymmetry with non-homogenous to mixed echogenic parenchyma.

Free Abdomen

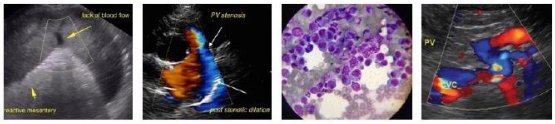
Intermittent scant pocket of peri-intestinal to peritoneal free fluid and mild peri-intestinal increased omental echogenicity was present.

ULTRASONOGRAPHIC FINDINGS

- Mild hepatomegaly with non-specific discrete nodules-suspect benign nodular criteria.
- Mild gallbladder debris.
- Gastric ingesta-consistent with food opacity.
- Enteropathy with segmental moderate duodenojejunitis.
- Prominent heterogenous to mild mixed echogenic pancreas.
- Benign splenic nodules.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The GI presentation is non-specific and may indicate persistent inflammatory criteria i.e. IBD, enterotoxin, etc. while the possibility of infiltrative intestinal neoplasia cannot be excluded. The appearance of the pancreas is not obviously consistent with active pancreatitis although persistent mild low-grade to possibly resolving pancreatitis is suspected. Continued aggressive GI support and therapy for inflammatory gastroenteropathy and pancreatitis would be reasonable. Intestinal biopsies would be required for a definitive diagnosis. Recheck sonogram recommended if persistent/progressive GI signs despite supportive care.



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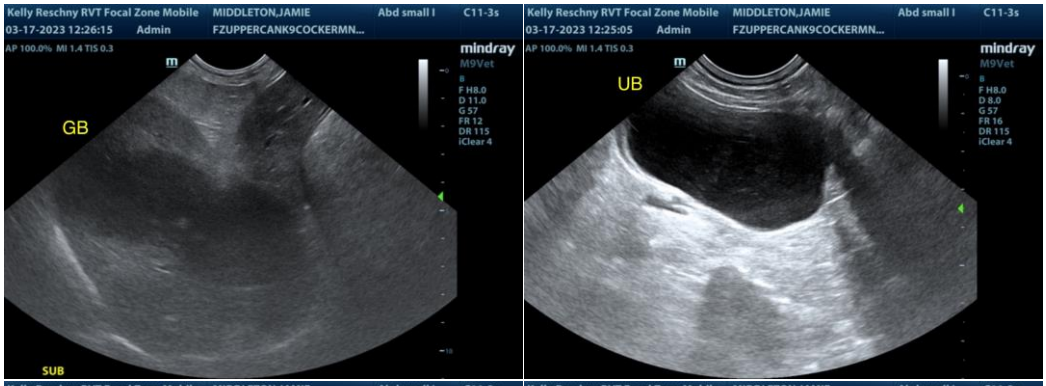

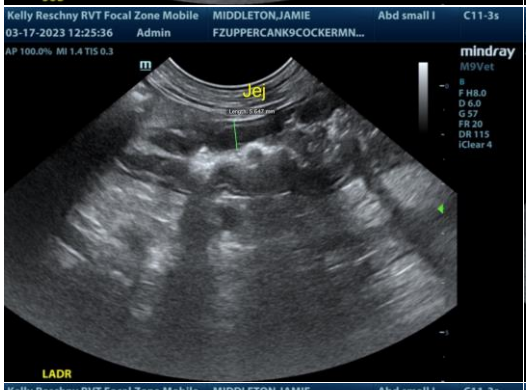

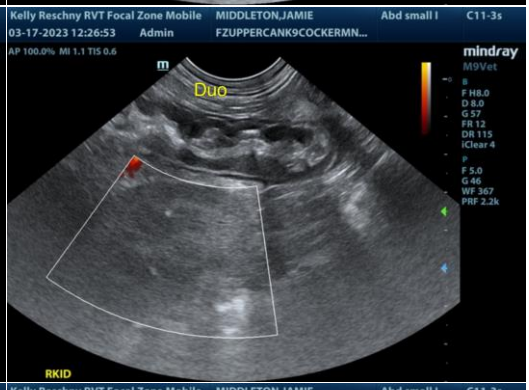

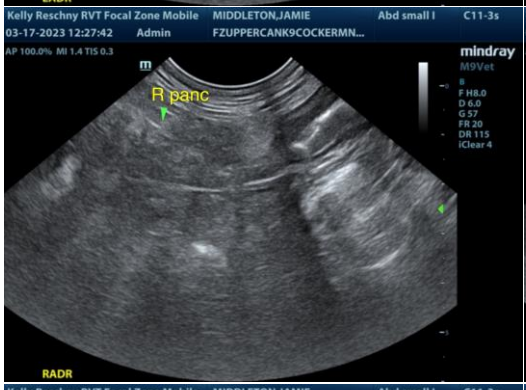

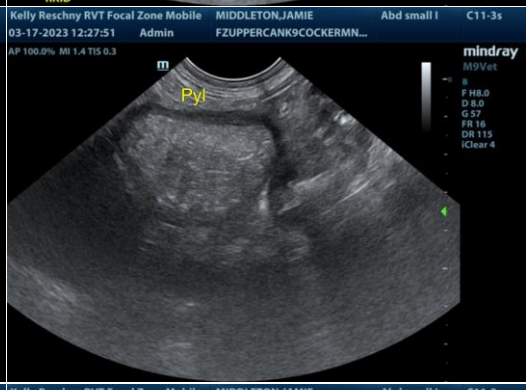

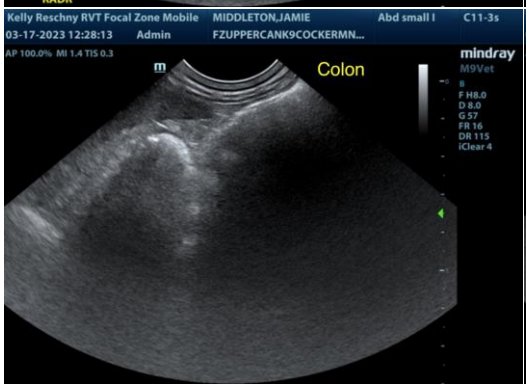

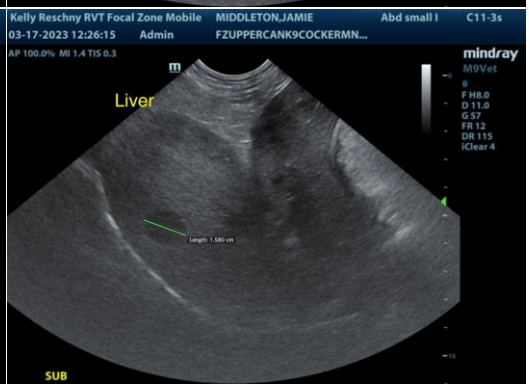

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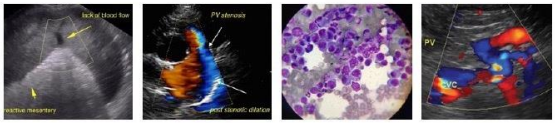

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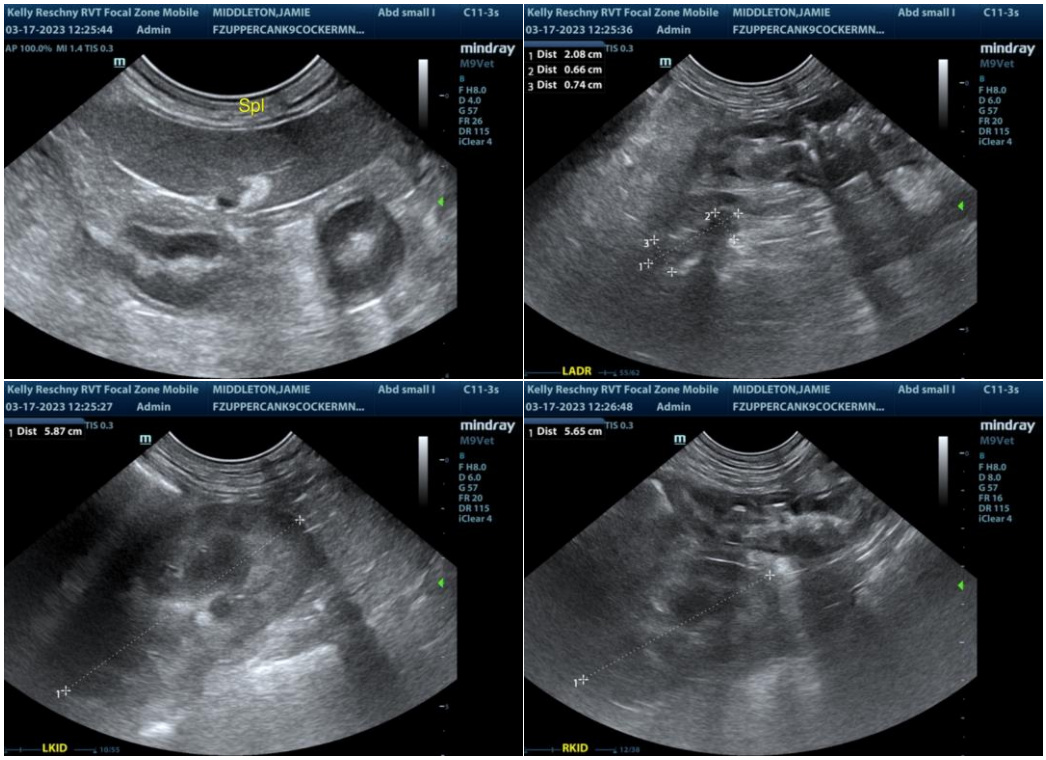

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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