



PATIENT PRESENTING CLINICAL SIGNS

Zoey Hill PPH: Intermittent, waxing/waning hyporexia, anorexia and vomiting. Previous work-up included blood work, wherein liver values were slightly elevated and a course of antibiotics, cerenia, and supportive meds were prescribed by primary care DVM. Patient presented on 4/15/23 to EVH with Dr. McKay for the following: Weight loss and in the last 24 hours, has repeated episodes of vomiting. Anorexic. Urinary accidents are occurring. Working diagnosis ** see diagnostics below**: -- Suspected IMHA -- Possible foreign material within the stomach -- Infectious cystitis TREATMENTS (4/15): -- Dex SP, Cerenia RX Prednisone 10 mg PO q 12 hrs until otherwise directed RX Azathioprine 25 mg PO q 24 hrs until otherwise directed. RX Amoxi/Clav 125 mg PO q 12 hrs x 5 days Rec famotidine 10 mg PO q 12 hrs x 1 week 4/16/23: -- patient returned for re-evaluation to EVH with Dr. Mayfield for icterus, anorexia, evidence of discomfort.

SEX

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AGE

8yr

WEIGHT

9.4kg

Abnormal PE/Chem/CBC/UA Results: 4/15/2023: PE: white sclera OU, 2/6 L heart murmur, Blood work: -- CBC: HCT 33.8% (L), regenerative - Retics 182.4K. WBC and PLT normal, no overt stress leukogram --PCV/TS: 37%/5.4 g/dL, icteric serum --Chem: BUN 2 (L), K 3.2 (L), ALT 338 (H), Tbili 2.7 (H); otherwise NSF -- Saline agglut - negative -- Slide review - Large number of spherocytes. - - AFAST - No FAF. Gall bladder appears normal, no evidence of sediment or mucocele. -- Radiographs, thorax and abdomen, 2 view: Unremarkable thorax. Stomach is moderately distended with ingesta. There is some ingesta that is more organized/linear in appearance - r/o gastric foreign material vs. rugal folds. No evidence of small intestinal obstructive pattern or foreign material. -- Urine collected via US-guided cystocentesis. Very yellow to orange in color. UA: USG 1.026, pH 7.0, bilirubinuria. Sedivue: WBC 16/hpf, RBCs >50/hpf, no bacteriuria or crystalluria Manual slide review: Cocci+++ (clumps); non-granular casts- rare; debris 4/16/23: PE: slightly obtunded, afebrile, grade I/VI L holosystolic parasternal murmur, icteric sclera and mmm's. -- Re-check PCV/TP: 34%/5.6 g/dL (3+ icterus) was previously 37%/5.4 g/dL (1+ icterus) -- CHEM-10: ALT: 362 U/L (10-125), previously 328 U/L (4/15) - 3-view abdominal rads: Moderate gastric distention with increased opacity and loss of serosal detail (possibly mural) and evidence of intra-luminal substance that is either ingesta or mass effect. No obvious gastric distention or dilation that would support obstruction. Mild loss of serosal detail in the cranial abdomen.

INTERPRETED BY

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

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

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Patti Mayfield

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with moderate non-dependent particulate sediment. Focal minor dependent luminal mineral was present. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

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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 5.7 cm in length. The right kidney measured 6.0 cm in length.

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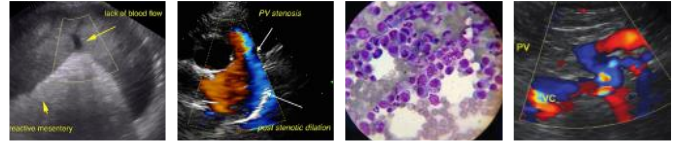
The area of the aortic trifurcation was free of pathology.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.46 cm width at the caudal pole and 1.7 cm length. The right adrenal

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gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.53 cm width at the caudal pole and 1.8 cm length.

Spleen

SPECIES

Canine

The spleen exhibited normal size and contour with subtle generalized parenchyma heterogeneity. No splenic masses or nodules. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis.

BREED

Terrier Mix

Liver/Gallbladder

The liver was subnormal in size with asymmetrical contour. Diffuse non-uniform nodular parenchyma was present. 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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Gastrointestinal

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The stomach presented variably thickened wall layering with indistinct wall layer detail. The lumen of the stomach was moderately distended with retained variably echogenic fluid and non-specific mildly shadowing ingesta extending to the area of the pyloric outflow. Intact variably thickened pylorus wall was present measuring 0.93 cm in wall width.

WEIGHT

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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 semi formed to soft feces in lumen.

Pancreas

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The left limb, right limb, and base of the pancreas presented hypoechoic to heterogeneous echogenicity compared to adjacent omental fat. Mild asymmetrical capsule margination was present with mild variable parenchymal swelling and mild peripancreatic reactivity / inflammation. No overt evidence of neoplasia.

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Free Abdomen

Intermittent prominent to enlarged mesenteric lymph nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5).

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Mid to cranial abdominal, primarily perigastric mild non-uniform hyperechoic omentum was present.

An intermittent scant pocket of peritoneal free fluid was present.

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ULTRASONOGRAPHIC FINDINGS

- Variably thickened gastric walls with moderate retained gastric fluid and non-specific focally shadowing ingesta-hypomotile gastritis, metabolic/functional ileus, early infiltrative neoplasia, infectious gastropathy i.e., helicobacter or other.
- Sonographically unremarkable small bowel.
- Chronic active pancreatitis pattern.
- Subnormal liver with generalized marked nodular parenchyma-chronic active hepatitis, hematopoiesis, hyperplasia, fibrosis or infiltrative/metastatic neoplasia possible.
- Moderate urinary bladder sediment with focal minor dependent luminal mineral.
- Intermittent subjective benign/reactive mesenteric lymphadenopathy, primarily perigastric non-uniform hyperechoic omentum and scant peritoneal free fluid.

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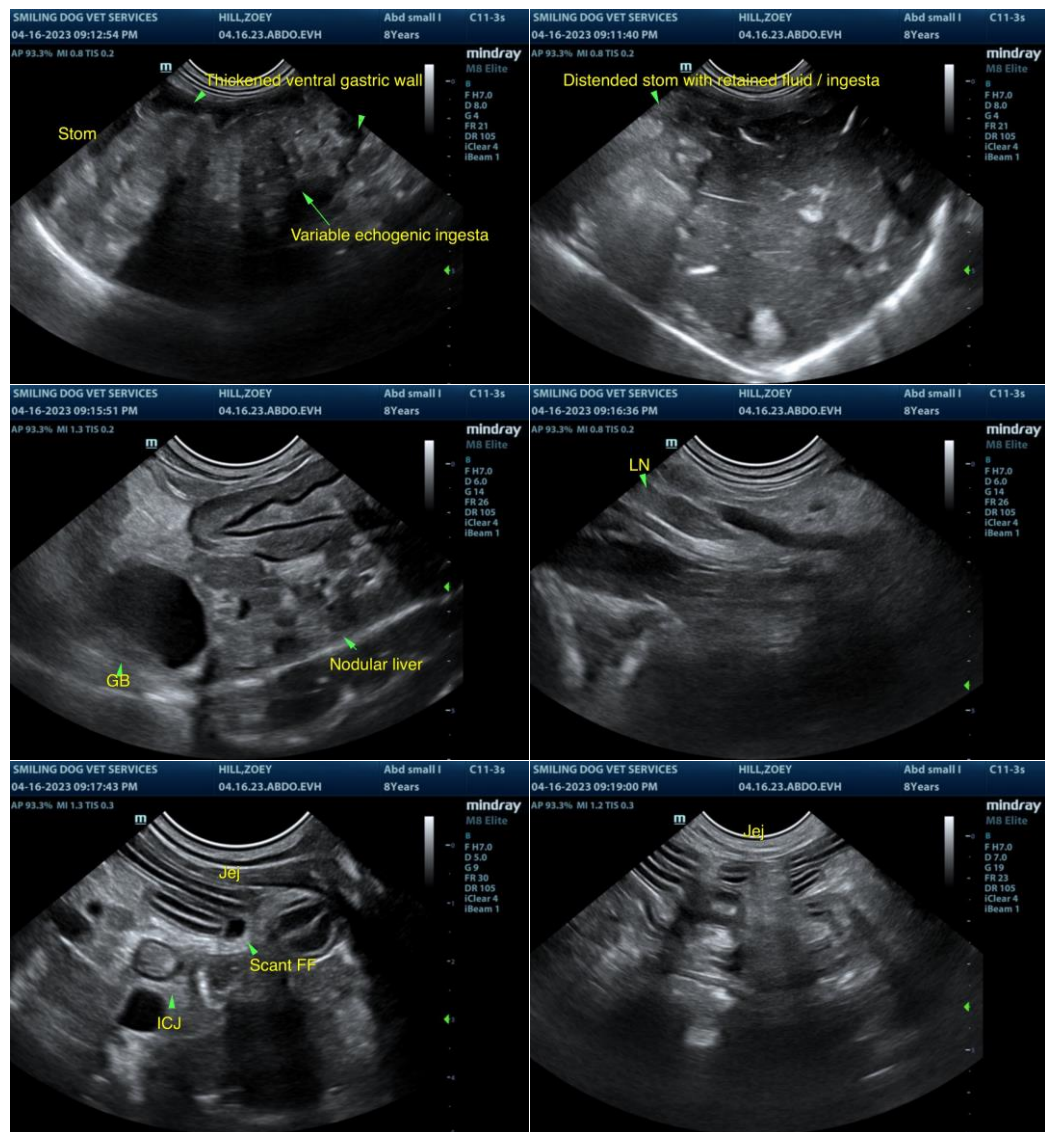
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Concern for gastric foreign material is warranted. Hepatogastric sampling would be required for a definitive diagnosis. Assessment for evidence of cranial abdominal/subxiphoid discomfort on palpation which may allude to chronic active pancreatitis is recommended. The urinary bladder sediment may suggest cellular / crystalline debris or mucus. Cystocentesis for UA +/- C/S if evidence of inflammatory cells is recommended. Recent corticosteroid used may be masking gastric/gastrointestinal mural changes.

If the patient is stable and assuming normal clotting status, exploratory laparotomy with GI and hepatic biopsies considered essential may be considered. Continued empirical therapy for hypomotile gastritis/pancreatitis with as needed GI and hepatic support with continued close monitoring would be a more conservative approach.

A guarded prognosis is indicated.





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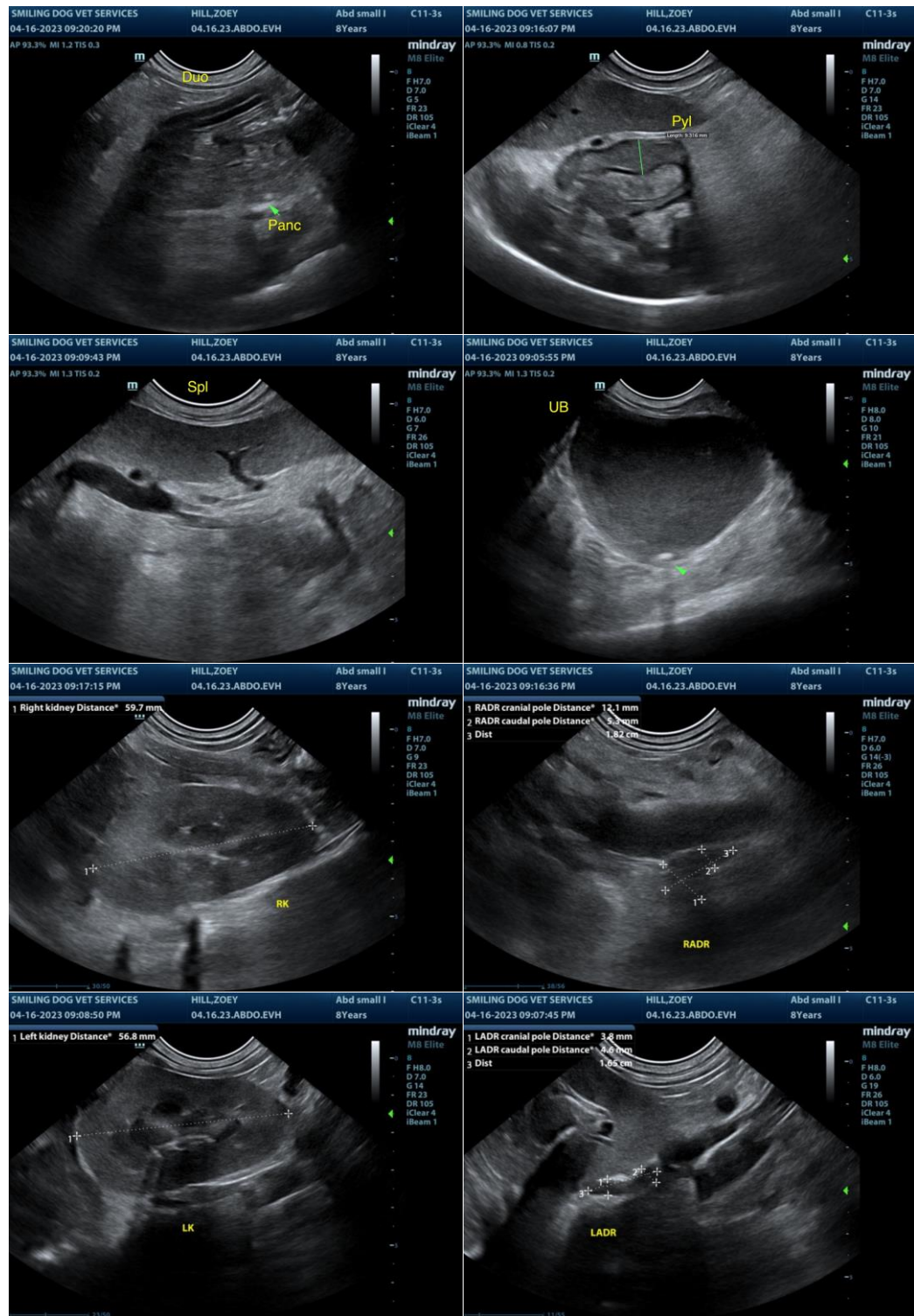
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I



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can be of any further assistance, please contact me.

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