



PATIENT

Freyja Cox

SPECIES

Canine

BREED

Welsh Corgi

SEX

FS

AGE

16 months

WEIGHT

9 kg.

PRESENTING CLINICAL SIGNS

• 16 month old SF corgi with acute vomiting 3/26/23; went to local ER, owners declined everything but supportive care. • Still inappetent Tuesday (3/28), came in for rads and bw. • Rads nsf except for stool retention • labs showed elevated cpl and elevated liver values and a bacterial cystitis confirmed with direct microscopy. • Treated with sq fluids, denamarin, enro and cerenia and improved 50% by the weekend (4/1) but still hyporexic. • 4/3, Patient looks icteric and refusing water, completely anorexic again. Intermittent regurgitation and intermittent yellow mucoid diarrhea Treatments: — completed 5 days of Enrofloxacin — started doxycycline on 4/3 — Denamarin — Cerenia — IVF with Vit B • No known exposure to xylitol, NSAIDs or other Rx meds, mushrooms, toxins. • patient traveled to OR coast with family ~1 week before clinical signs started • patient had wellness exam and vaccines, including Lepto update ~ 5 days prior to onset of clinical signs

Abnormal PE/Chem/CBC/UA Results: PE: — icteric, occasional nausea on palpation. Blood work; 3/28: CBC: — mild hemoconcentration — mild monocytosis, 1730/uL (160-1120) — Plt: 121,000/uL (148,000-484,000) CHEM: — PHOS: 2.1 mg/dL (2.5-6.8) — K: 2.9 mmol/L (3.5-5.9) — ALT: 737 U/L (10-125) — ALP: 594 U/L (23-212) — T bili: 1.0 mg/dL (0-0.9) — cPL reported elevated UA: USG: 1.026, proteinuria, hematuria (6 RBC/HPF), Pyuria (13 WBC/HPF), bacteria identified on direct microscopy, no casts/no crystals Recheck blood: 4/3: — BUN: 4 mg/dL (7-27) — K: 3.1 mmol/L — ALT: 762 — AST: 462 U/L (0-50) — ALP: 835 U/L Rads 3/28: reportedly unremarkable aside from dry fecal retention

INTERPRETED BY

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

IMAGING PERFORMED BY

Patti Mayfield DVM

HOSPITAL NAME

Highland VH

REFERRING VET

Rachel Poet DVM

INVOICE

16515

DATE

4/5/23

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.

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 5.2 cm in length. The right kidney measured 5.7 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 2.0 cm length x 0.61 cm width at the caudal pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 2.1 cm length x 0.63 cm width 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



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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.

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Liver/ Gallbladder

The liver was subjectively normal in size, structure, and contour. The liver exhibited subjective mild decreased parenchyma echogenicity and a mild coarse echotexture with subtle increased prominence of the portal vascular borders. Normal hepatic vascular volume was noted. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The common bile duct was indistinctly visualized without evidence of post hepatic obstructive criteria.

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Gastrointestinal

The stomach presented sonographically unremarkable wall layering. The stomach contained a mild to moderate amount of retained fluid and nonshadowing chyme.

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The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. Mild nonshadowing duodenal chyme was noted.

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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.

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Free Abdomen

No omental masses, lymphadenopathy, or evidence of peritoneal effusion were noted.

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ULTRASONOGRAPHIC FINDINGS

- Hepatopathy
- Sonographically unremarkable gallbladder and common bile duct
- Mild hypomotile stomach, sonographically unremarkable small bowel - potential for mild gastroduodenitis
- Sonographically unremarkable pancreas - no signs of active inflammation

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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Given the significantly elevated ALT/AST combination, suspect nonspecific hepatitis, i.e., viral, bacterial, Leptospirosis, unknown toxin, etc., with potential for concurrent vacuolar hepatic changes, nonobstructive cholestasis, or other hepatopathy are possible with occult infiltrative hepatic neoplasia considered less likely. Correlation with pending hepatic FNA cytology is suggested.

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If clinical concern for Leptospirosis exposure, PCR (which may exhibit higher titers if active disease compared to titers secondary to a vaccine,) may be considered. However, PCR could potentially be affected by recent antibiotic therapy. If Leptospirosis testing is elected, consultation with internal medicine or lab would be recommended.



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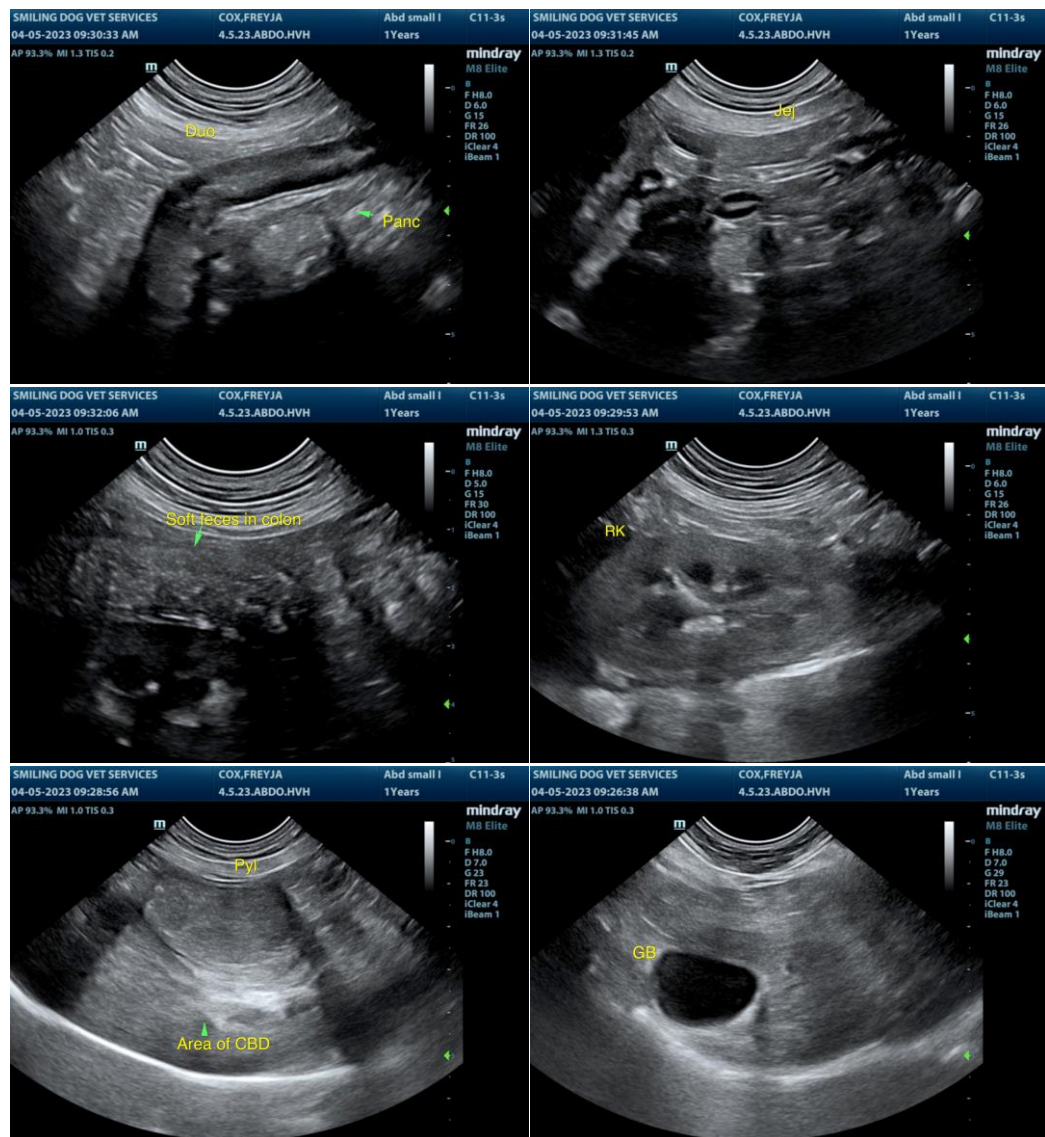
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Empirically, hospitalization with IV fluid therapy, hepatosupportive medications, and broad spectrum antibiotics to potentially cover for Leptospirosis, with as-needed gastrointestinal support, clinical monitoring, and assessment of hepatic response would be reasonable. No overt suspicion of a portosystemic shunt, given the lack of renal or cystic calculi. Bile acid testing is warranted given decreased BUN levels and for further assessment of hepatic function. Hepatic core surgical biopsy may be required for a definitive diagnosis.





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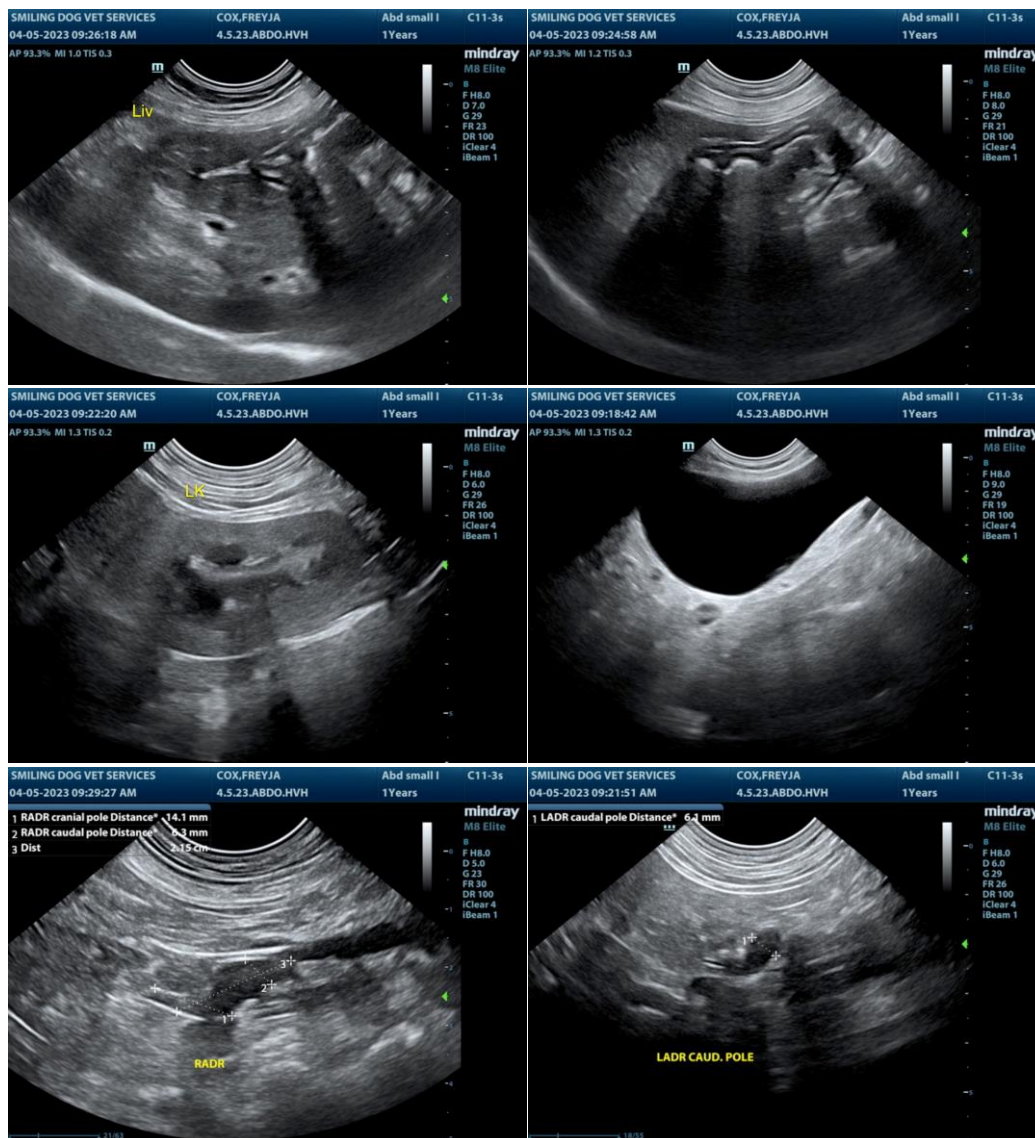
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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