SonoPath
Clinical Sonography & Telecytology
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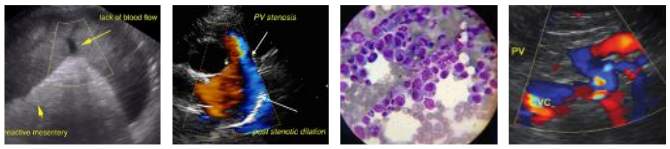

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Samson Wales

SPECIES

Canine

BREED

Basset Hound

SEX

MN

AGE

2yr

WEIGHT

37.6lb

INTERPRETED BY

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

IMAGING PERFORMED BY

Wymard

HOSPITAL NAME

Brookswood Animal Clinic

REFERRING VET

Wymard

INVOICE

13423ag

DATE

04/05/2023

PRESENTING CLINICAL SIGNS

P seen on 3-29-23 for vomiting, inappetence, and lethargy of about 2-3 days duration. CBC: Mild neutrophilia with left shift, mild monocytosis --> inflammatory leukogram Chem 17 + lytes: decreased amylase, hypokalemia (3mmol/L), hypochloremia (107mmol/L) --> suspect secondary to gastric vomiting/upper GI obstruction (Mechanical vs functional) Snap CPL: Negative/normal Ab rads: stomach - thickened wall with possible foreign material in stomach, region of intestine (C-shaped) that is abnormally distended and possible region of intestine adjacent to this with abnormal looking material in mid abdomen. P had FB sx. on 3-30-23. Several tampons removed w/ linear material from caudal duodenum. 2 enterotomy sites. Sx. Report: Enterotomy preformed in ileum: Doyen clamps placed. #15 blade used to make incision orad to foreign material. Removed piece of cotton material consistent with tampon with string attached. Able to milk a second piece of foreign material. Cut string as it was anchored and unable to extrude through site. Closed site with 3-0 monoweb using simple interrupted pattern. Leak tested with sterile saline. Section lavaged. Mesenteric rent was noted at site of Doyan retractors - apposed with simple interuppted suture using 3-0 monoweb. Second enterotomy site made in duodenum - able to extrude long segment of string and cotton material. Closed site with 3-0 monoweb in simple interrupted pattern. Leak tested with saline. Lavaged and returned to abdomen. Gloves changed and reran bowels with no further foreign material palpated. Intestinal segments evaluated with improved color, good pulses, poor peristalsis. The abdomen was lavaged using 1 L warm sterile saline and removed with suction. Omental patches draped over enterotomy sites. P was hospitalized the day after FB sx. Not super interested in food but stable. After that, P did great at home. Then, yesterday (4-4-23) evening P seemed uncomfortable. HR was elevated and P had "abnormal" shallow breathing per O which has since resolved. Lethargic. P is still E/D/U/D normally. Tried to bite O yesterday. On PE today, P is moderate to markedly painful in abdomen (along entire length of abdomen). Incision looks great. No fever.

Abnormal PE/Chem/CBC/UA Results: Painful abdomen. BW not performed yet today.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

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 no uroliths or 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 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 5.5 cm in length. The right kidney measured 6.2 cm in length.

The area of the aortic trifurcation was free of pathology.

The area of the residual prostate appeared normal and free of pathology.

Adrenal Glands

The left and right adrenal glands were not definitively visualized. No obvious pathology was present in the area of the bilateral adrenal glands.

Spleen

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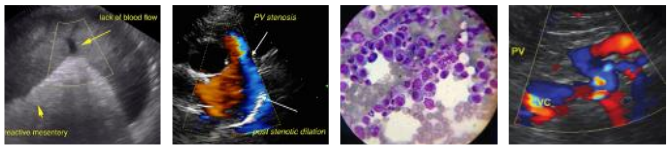

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The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver/Gallbladder

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.

Gastrointestinal

The stomach presented mild to moderate wall thickening secondary to echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. Mild gastric distension with mild retained primarily anechoic fluid was present.

The intestinal walls demonstrated primarily intact wall layering and maintained 1:3 muscularis / mucosa ratio. The mucosa exhibited mild decreased echogenicity with occasional mucosal speckling. A segmental non-obstructive ileus pattern consisting of mild fluid accumulation in the intestinal lumen was present without obstruction or foreign material. Mild intestinal corrugation was present.

A solitary ill-defined rounded hypoechoic fluid cavity was noted directly adjacent to mid abdominal intestine and suspected to be deriving from mid abdominal intestinal wall measuring 4.0 cm in diameter.

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 was evident.

Free Abdomen

No overt lymphadenopathy was present.

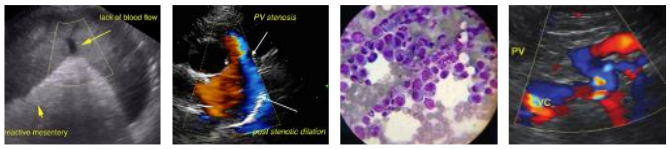
Generalized mild hyperechoic omentum and mild volume peritoneal free fluid was present.

ULTRASONOGRAPHIC FINDINGS

- Generalized gastroenteritis pattern with mild gastric hypomotility.
- Focal peri intestinal fluid filled cavity-subserosal seroma at previous enterotomy site, possible emerging abscess.
- Generalized hyperechoic omentum and mild volume peritoneal free fluid-residual inflammatory secondary to previous surgery, potential for emerging peritonitis possible.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given that the patient is non-febrile, septic peritonitis owing to intestinal dehiscence may be considered less likely yet cannot be definitively excluded. If possible, abdominocentesis for effusion analysis cytology +/- C/S is suggested. Hospitalization with empirical peritonitis protocol and sonographic reassessment of the GI tract including the peri intestinal fluid filled cavity would be reasonable.



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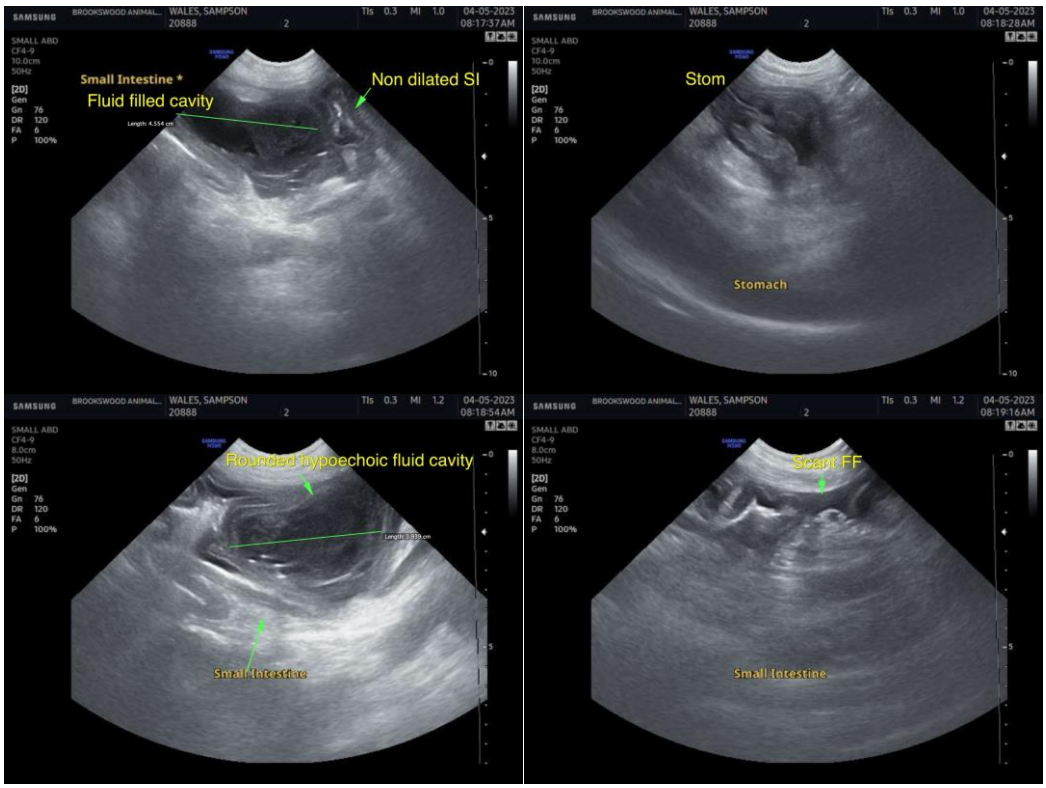
As needed GI support, analgesia +/- some or all of the following protocol based on the clinical impression of the patient is suggested. Serial sonographic monitoring is considered essential in this patient.

Colloids/Hetastarch
10 to 20 mL per kilogram per hour and dogs
10 to 15 mL per kilogram per hour cats
(Can bolus first 1/3 of dose over 15 minutes)
Plasma 10 mL / kilogram IV over 4 hours
Buprenorphine 0.02 mg/kg IV IM SC q4-6 hours **Or CRI Lidocaine** 30-50 ug/kg/min
Dolasetron for nausea: 0.6-1 mg/kg/day Iv or PO
Famotidine 1 mg/kg IV IM p.o. dc s.i.d. /b.i.d.
Sucralfate 0.5-1 g p.o. t.i.d. dogs, 0.5 g bid cats in slurry **Or Misoprostol** 1-5 ug/kg po tid
Clindamycin 10mg/kg IV p.o. bid
Enrofloxacin 10-15 mg/kg IV p.o. s.i.d. dogs, 5 mg/kg Iv po Sid cats
Metronidazole 10-20 mg/kg IV p.o. b.i.d.
Dexamethasone physiological 1 mg/kg to treat adrenal burnout if long standing sickness, shock dose 4-10 mg/kg.



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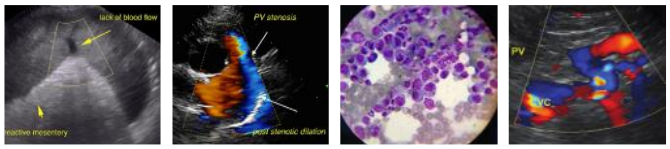

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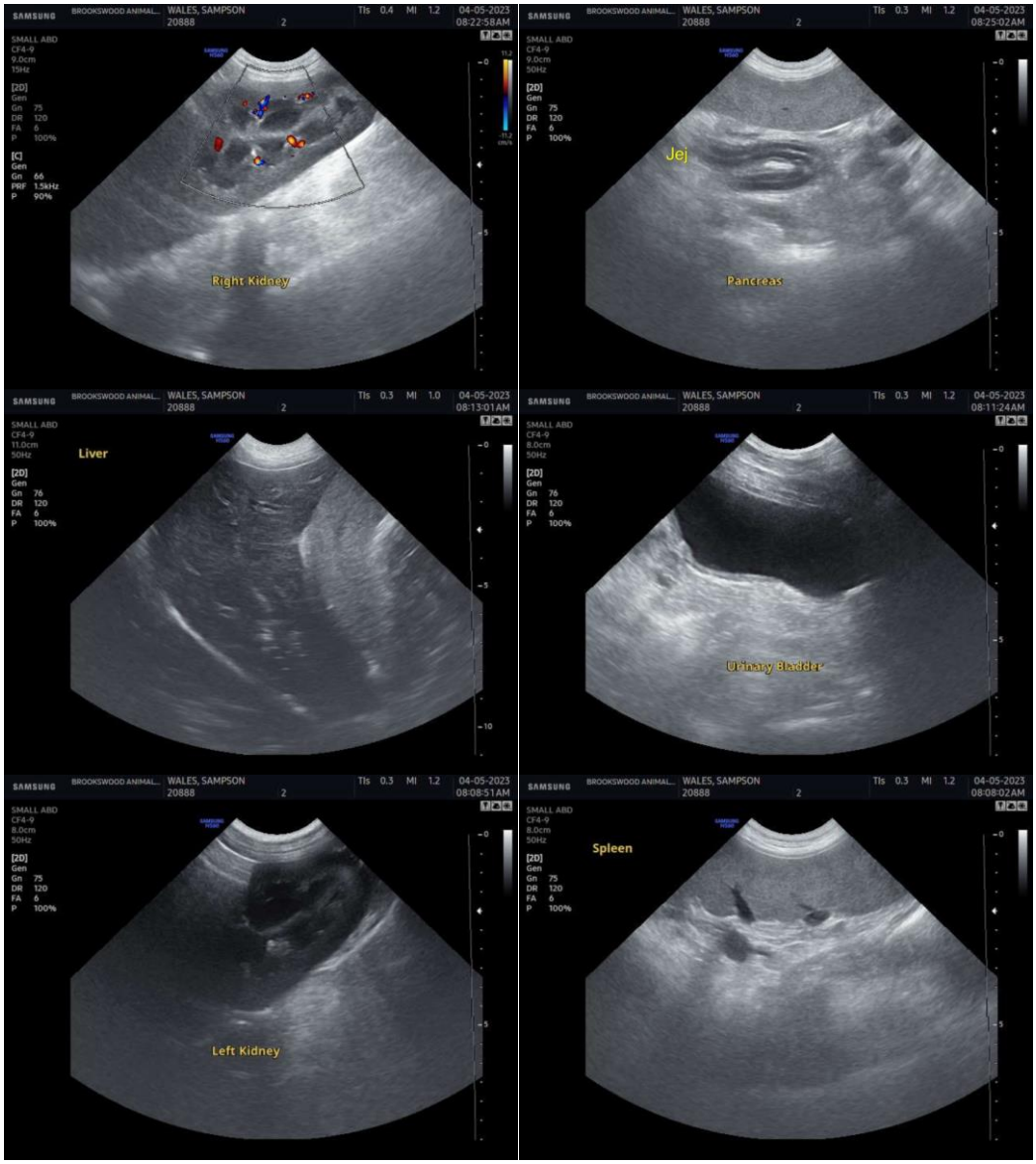

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
mac.daniel@sonopath.com