



PATIENT

Frankie Wallwork

SPECIES

Canine

BREED

Boxer

SEX

M

AGE

1 year 2 months

WEIGHT

24.7

INTERPRETED BY

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

IMAGING PERFORMED BY

Donna Markland,
DVM

HOSPITAL NAME

Island Mobile Paws
VS

REFERRING VET

Central Island
Veterinary Emergency
Hospital

INVOICE

16539

DATE

4/6/23

PRESENTING CLINICAL SIGNS

Presented 4/2 to emergency for vomiting. Chronic soft stool for over six months. The client has had Frankie for a year. Various diets tried, but no real food trial as there are always multiple foods given. Frankie was positive for giardia until a repeat test at the end of March. The regular veterinarian has been managing the clinical signs with prn metronidazole, 375 mg q 12 hrs. At the time of presentation, Frankie had been on metronidazole for 6 days with no improvement in stool quality. Folate is reportedly low on recent test. PE on 4/2 was unremarkable. CBC/Chem showed marked neutrophilia. Since the exam on 4/2, Frankie has not been vomiting. He is active. Stool is still soft with some blood noted. Frankie was sedated with dexdomitor/butorphanol for this exam.

Abnormal PE/Chem/CBC/UA Results: 4/2/23: WBC=39.27 (5.05-16.76) Neutrophils=34.93 (2.95-11.64)

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 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 residual prostate was of the expected size and presentation for a young intact male canine. There is no evidence of prostatic pathology. The prostate measured 2.1 cm 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 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 6.1 cm in length. The right kidney measured 6.5 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 0.47 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 2.3 cm length x 0.66 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 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



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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

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction, or foreign material. The gastric body wall width measured 0.40 cm.

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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. The duodenum wall measured 0.48 cm width. The jejunum wall measured 0.42 cm width. No evidence of pathology was noted at the level of the ileocolic junction.

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Sonographically normal intact visualized colon wall layers were present containing soft fecal matter consistent with patient history. The descending colon wall width measured 0.24 cm.

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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

Intermittent 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). An example lymph node measured 3.0 cm x 0.55 cm. No evidence of peritoneal effusion was noted.

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ULTRASONOGRAPHIC FINDINGS

- Sonographically unremarkable gastrointestinal tract / colon
- Intermittent mild benign / reactive mesenteric lymphadenopathy

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is no sonographic evidence of structural gastroenterocolic pathology, i.e., intussusception, etc., as an obvious cause of the patient's gastrointestinal signs and chronic soft stool.

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At times, the gastroenterocolic appearance may not correlate with a history of chronic to recurrent gastrointestinal signs. Dietary intolerance / food allergy, persistent occult parasitism, structurally insignificant inflammatory bowel, less likely occult Addison's Disease, or other enteropathy are all possible. CBC pathology review is suggested, given the degree of neutrophilia.

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The sonographic appearance of the colon in conjunction with the patient's clinical signs is not overtly suggestive of granulomatous (boxer) colitis. Empirically, a hydrolyzed diet trial with long-term dietary therapy, high colony count probiotic such as Provable, potential fiber supplementation, empirical re-deworming i.e., Panacur 50 mg/kg PO SID for 5 consecutive days +/- antibiotic therapy with consideration for possible long term adverse effects on normal gastrointestinal flora with an assessment of clinical response could be considered. Folate supplementation may prove beneficial



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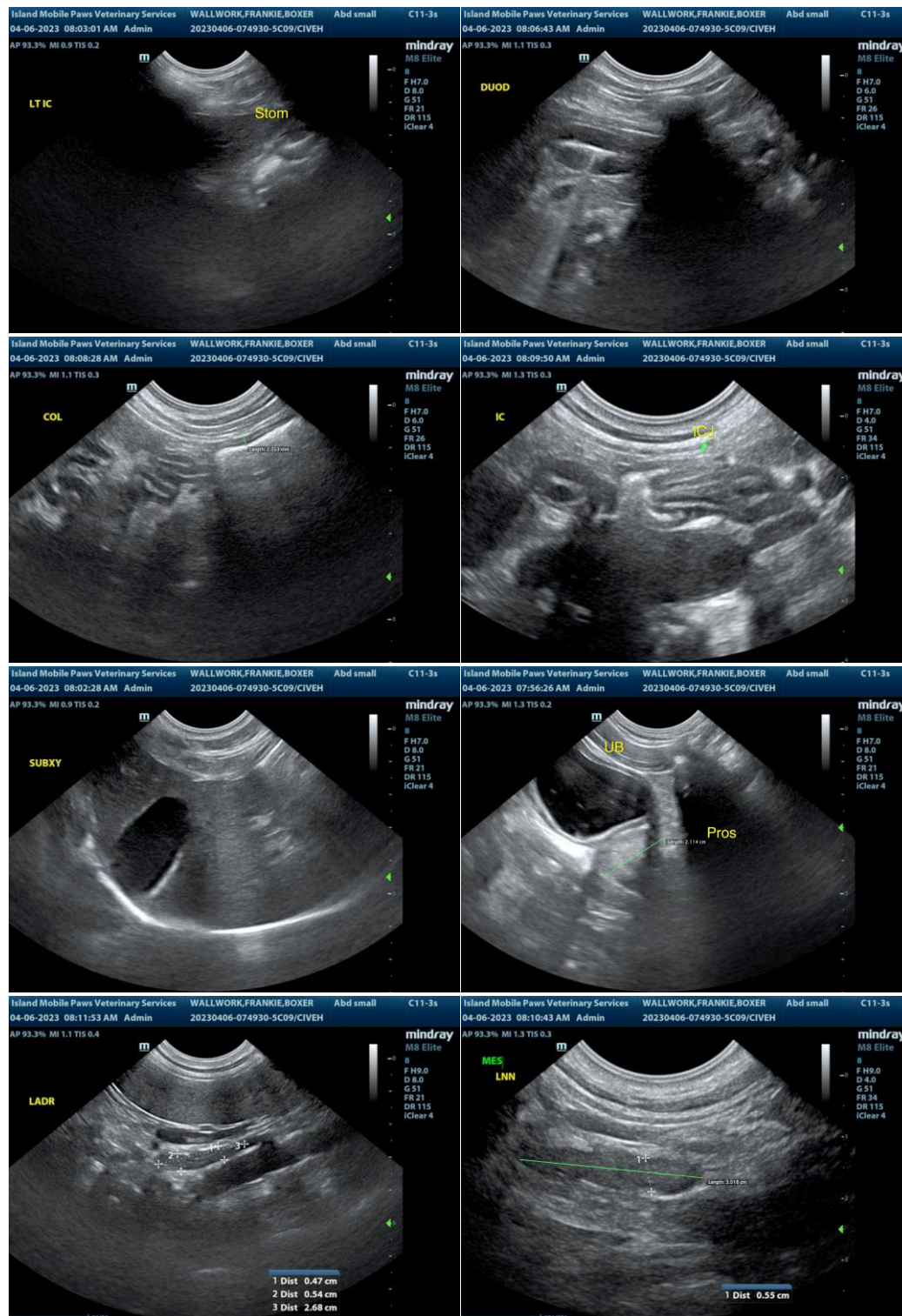
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given the reported low-folate, or if persistent. Endoscopic upper and lower intestinal biopsies may be required for a definitive diagnosis.





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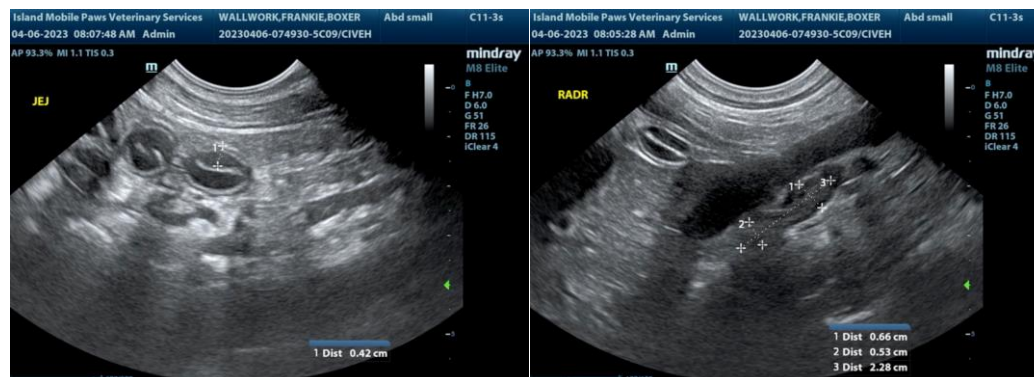
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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