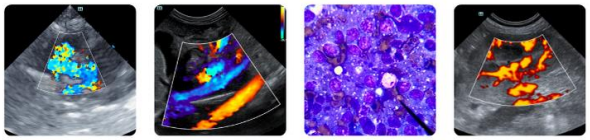

PATIENT

Ruger Pearson

SPECIES

Canine

BREED

German Shepard Mix

SEX

MN

AGE

5

WEIGHT

42 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Alyssa Huntington DVM

HOSPITAL NAME

Wilvet South

REFERRING VET

Alyssa Huntington DVM

INVOICE

10870

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PRESENTING CLINICAL SIGNS

Vomiting since Saturday. Started abx on 4/20 - Cefpodoxime - for wounds on legs; finished Sunday. Bilateral TPLOs. Pt got hot spots on both legs, seem improved now from abx.
Appetite has been normal, started doing broth/ ground beef + rice per rDVM, but would vomit up ~1 hour after. This happens after every meal since Saturday.
Yesterday went outside, vomited twice, and laid outside. Outside of after meals, vomit is liquid w/ grass, some bile. Some brown vomiting today + in car. Some retching without vomiting. O feels like he seems bloated. Also had complete liquid diarrhea since starting abx.

Abnormal PE/Chem/CBC/UA Results: CBC/Chem10: Lymphopenia 0.85 K/uL, TP L 3.7 g/dl, ALB L 1.3 g/dl, Globulin L 2.3 g/dl, ALKP L 11 U/L Pancreatic Lipase: EPOC: pH L 7.329, K+ L 2.9 mmol/L, Glu H 131 mg/dl f.a.s.t scan: scant amount of FAF, large anechoic fluid filled bladder no stones or masses identified. Stomach mild/moderately filled with gas and fluid. Small intestines appear diffusely dilated, suspect enlarged mesenteric LN mid-abdomen. Spleen/liver WNL.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder was mildly distended in size with anechoic urine. The urinary bladder, trigone, and cystourethral junction 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. The urethra exhibited normal structure and tone to a depth of 3.0 cm.

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

No evidence of pathology in the area of the aortic trifurcation.

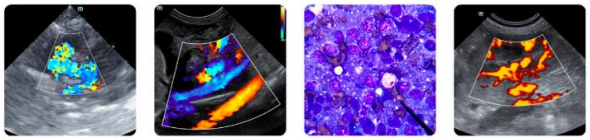
Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. The left kidney measured 7.6 cm in length. The right kidney measured 7.1 cm in length, with suspect mild underestimation of right kidney size.

Adrenal Glands

The left adrenal gland was indistinctly visualized yet overtly normal in size, position, and shape. The left adrenal gland subjectively measured 0.65 cm width at the caudal pole. The right adrenal gland was not definitively visualized.

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.



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Liver/ Gallbladder

The liver was subjectively normal in size, structure, and contour. Normal hepatic vascular volume was present. 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 mildly thickened, hyperechoic, non-edematous wall and containing anechoic bile. The common bile duct was not definitively visualized.

Gastrointestinal

The stomach presented overtly normal intact visible wall. The stomach exhibited moderate distention with retained echogenic fluid and nonshadowing chyme. No obvious visualized obstruction to pyloric outflow was noted.

Intact intestinal wall was noted, presenting propensity for mildly thickened mucosa exhibiting duodenojejunal mild hyperechoic mucosal speckling to segmental fogging. There was no evidence of an obstructive pattern or foreign material. The appearance of the small intestine is most consistent with protein losing enteropathy or lymphangiectasia. There was no evidence of infiltrative or neoplastic intestinal disease which is considered unlikely but cannot be ruled out without full thickness or endoscopic biopsies.

Normal visible colon wall layers were present. The colon was nondistended with non-formed fecal matter.

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

Minor peritoneal effusion was present. No obvious visualized significant or swollen mesenteric lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

- Moderate hypermobile stomach
- Enteropathy exhibiting duodenojejunal mucosal speckling / fogging
- Non formed fecal matter in colon
- Normal area of pancreas
- Minor peritoneal effusion

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The enteropathy is most suggestive of protein-losing enteropathy in conjunction with panhyperproteinemia, gastrointestinal signs, and without evidence of hepatic pathology, assuming no evidence of significant proteinuria as a contributing factor to the decreased serum protein levels. Considerations may include IBD or other inflammatory disease, lymphangiectasia, or infiltrative

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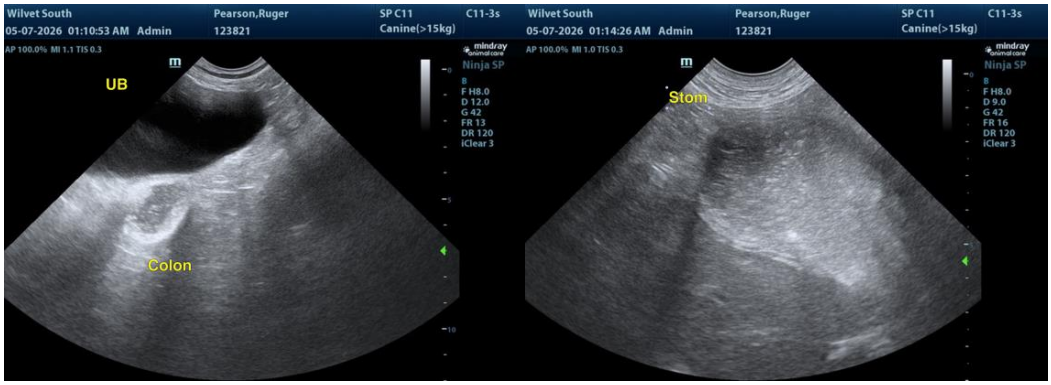
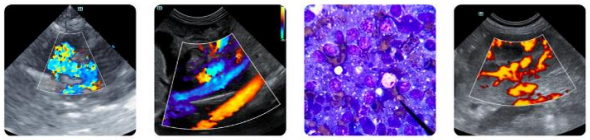
intestinal disease as primary considerations. There is no evidence of overt mechanical pyloric or upper intestinal obstruction visualized, suggesting associated or secondary metabolic gastric ileus. Potential for non-visualized obstruction is technically not excluded yet thought less likely.

Gastrointestinal support and empirical therapy for PLE is recommended with clinical monitoring and sonographic reassessment, if evidence of progressive gastric ileus or nonresponsive gastrointestinal signs. Screening cortisol level, GI panel and fresh fecal analysis are indicated if not done.

Part or all of this protocol may be considered based on your clinical impression of the patient:

OBJECTIVE: keep albumin levels > 2 g/dl, avoid thromboembolism and cavitary effusions, monitor concurrent PLN and liver disease:
Plasma 10 mL / kilogram IV over 4 hours
Or **Human albumin** 2 ml/kg/h over 10 hours. Total daily volume 20.l/kg/day
And Colloids/Hetastarch
10 to 20 mL per kilogram per day and dogs
10 to 15 mL per kilogram per day cats
(Can bolus first 1/3 of dose over 15 minutes)
& maintain on LRS maintenance otherwise.
High colony count probiotic Proviable or Visbiome
Famotidine 1 mg/kg Iv Im po dc Sid /bid
Sucralfate 0.5-1 g po tid dogs, 0.5 g bid cats in slurry **Or Misoprostol** 1-5 ug/kg po tid
Diet: Highly digestible high quality protein, low fiber, low fat diet (< 15% of dry matter). Hydrolyzed protein or novel protein. Purina HA or Royal Canine HP or similar.
Prednisone or prednisolone 2 mg/kg bid x 3-5 days then 2 mg/kg sid. **Chlorambucil** in refractive severe IBD/alimentary lymphoma cases (monitor cbc for rare bone marrow suppression) 4 mg/m^2 Q 24-48 hours.
Cobalamine (B12) 250-1500 ug/dog weekly x 6 weeks.
Calcium supplementation if necessary.
Aspirin 0.5-1 mg/kg/day **or Clopidrel** (Plavix) 1-5 mg/kg/day.





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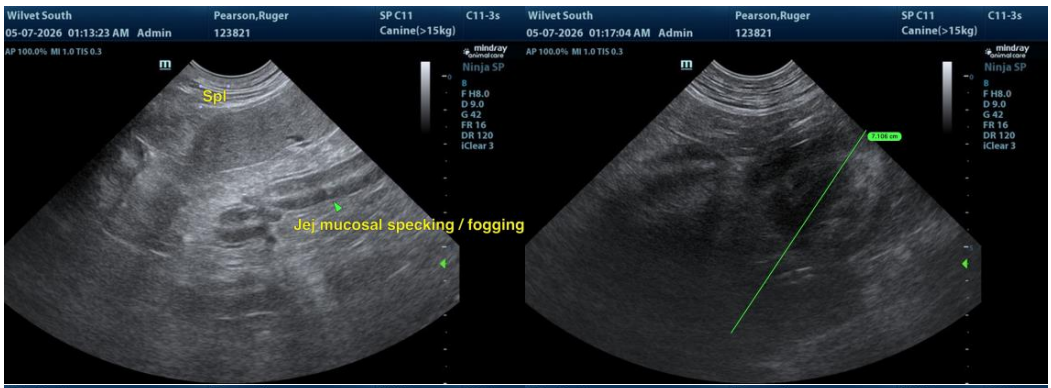

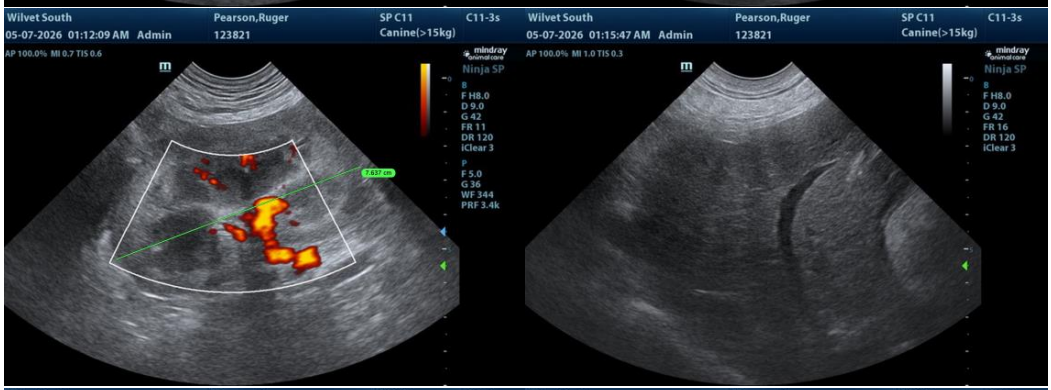

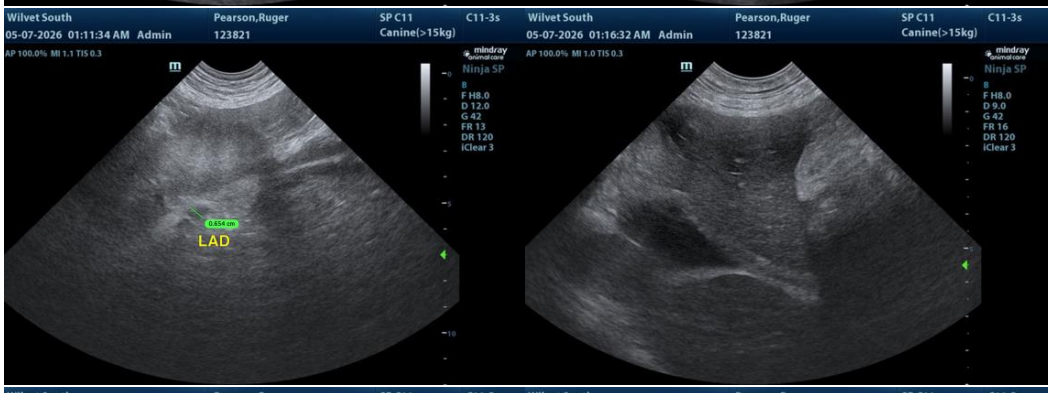

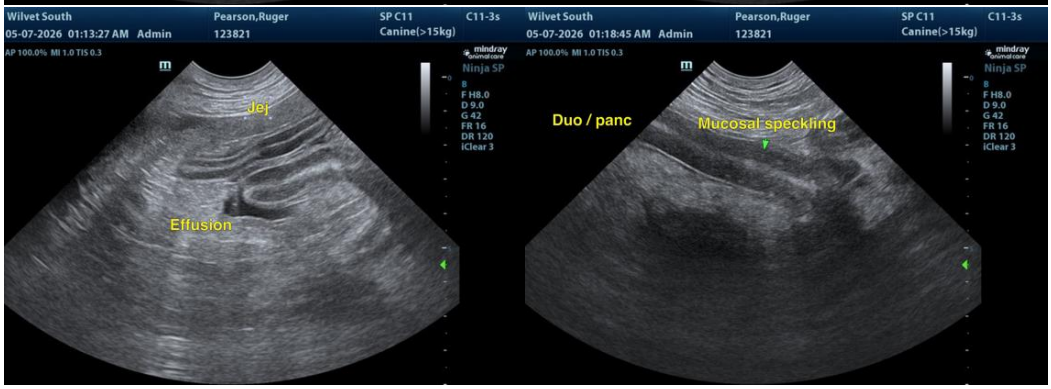

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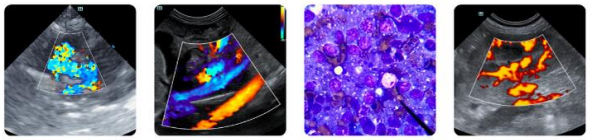

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@sonopath.com