



PATIENT

Juna Aronona

PRESENTING CLINICAL SIGNS

Chronic diarrhea sometimes with blood

SPECIES

Canine

Abnormal PE/Chem/CBC/UA Results: Distended abdomen Blood work–hypocalcemia, low creatinine, hypoalbuminemia, low total protein, low globulin, leukocytosis, neutrophilia
Abdominocentesis–clear fluid Urine specific gravity–1.004

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

BREED

Yorkie

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2 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.

SEX

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Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 2.6 cm in length. The right kidney measured 3.2 cm in length.

AGE

11

The area of the aortic trifurcation was free of pathology.

WEIGHT

6.3

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.

INTERPRETED BY

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

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.

IMAGING PERFORMED BY

Dr.Sharkaway

Liver/Gallbladder

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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. Normal hepatic vascular volume was present. The hepatic and portal vasculature were normal in appearance without signs of congestion.

REFERRING VET

Dr.Sharkaway

The gallbladder was non-distended in size. The gallbladder wall was mildly thickened in appearance consisting of an echogenic double rim corresponding to the inner and outer portions of the wall. This is consistent with gallbladder wall edema. The gallbladder wall measured ~ 0.2 cm in width. Possible causes may include acute inflammation, edema and anaphylaxis. The cystic and common bile ducts were normal.

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Gastrointestinal

The stomach presented intact mildly edematous wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material.

DATE

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The small intestine presented intact prominent wall layering with a prominent mucosa layer. Segmental to generalized variable hyperechoic mucosal fogging was present. No evidence of loss of



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intestinal wall layering or intestinal masses. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material.

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The colon walls presented intact yet prominent wall layering with mild thickened to echogenic submucosa. Semi formed fecal matter was present in the colon lumen with lumen dilation.

Pancreas

The pancreas was indistinctly visualized exhibiting potential for mild pancreatic edema. No overt evidence of active pancreatitis.

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Free Abdomen

No omental masses or overt lymphadenopathy was present.

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Moderate volume anechoic peritoneal effusion was present. Generalized mildly hyperechoic omentum was present.

AGE

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- Mild edematous stomach.
- Intact generalized mild thickened small bowel with mucosal fogging- consistent with PLE.
- Minor gallbladder wall edema-likely owing to decreased hydrostatic pressure secondary to hypoalbuminemia.
- Moderate volume anechoic peritoneal effusion and generalized mild uniform hyperechoic omentum.

WEIGHT

6.3

ULTRASONOGRAPHIC FINDINGS

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

INTERPRETED BY

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

The small intestine appearance is consistent with PLE with considerations including inflammatory bowel, lymphangiectasia or similar with infiltrative intestinal neoplasia considered less likely. A full thickness intestinal surgical biopsy is required for a definitive diagnosis yet is contraindicated if ALB level is <2.0. Three view chest radiographs are recommended if not done to assess for occult thoracic pathology as a contributing factor to the effusion.

IMAGING

PERFORMED BY

Dr.Sharkaway

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 cavitory effusions, monitor concurrent PLN (Wheaton Terrier PLE/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.

Metronidazole (10-20 mg/kg po bid)

Famotidine 1 mg/kg lv lm 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/m²Q 24-48 hours.

Cobalamin (B12) 250-1500 ug/dog weekly x 6 weeks.

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Calcium supplementation if necessary.
Aspirin 0.5-1 mg/kg/day or Clopidogrel (Plavix) 1-5 mg/kg/day.

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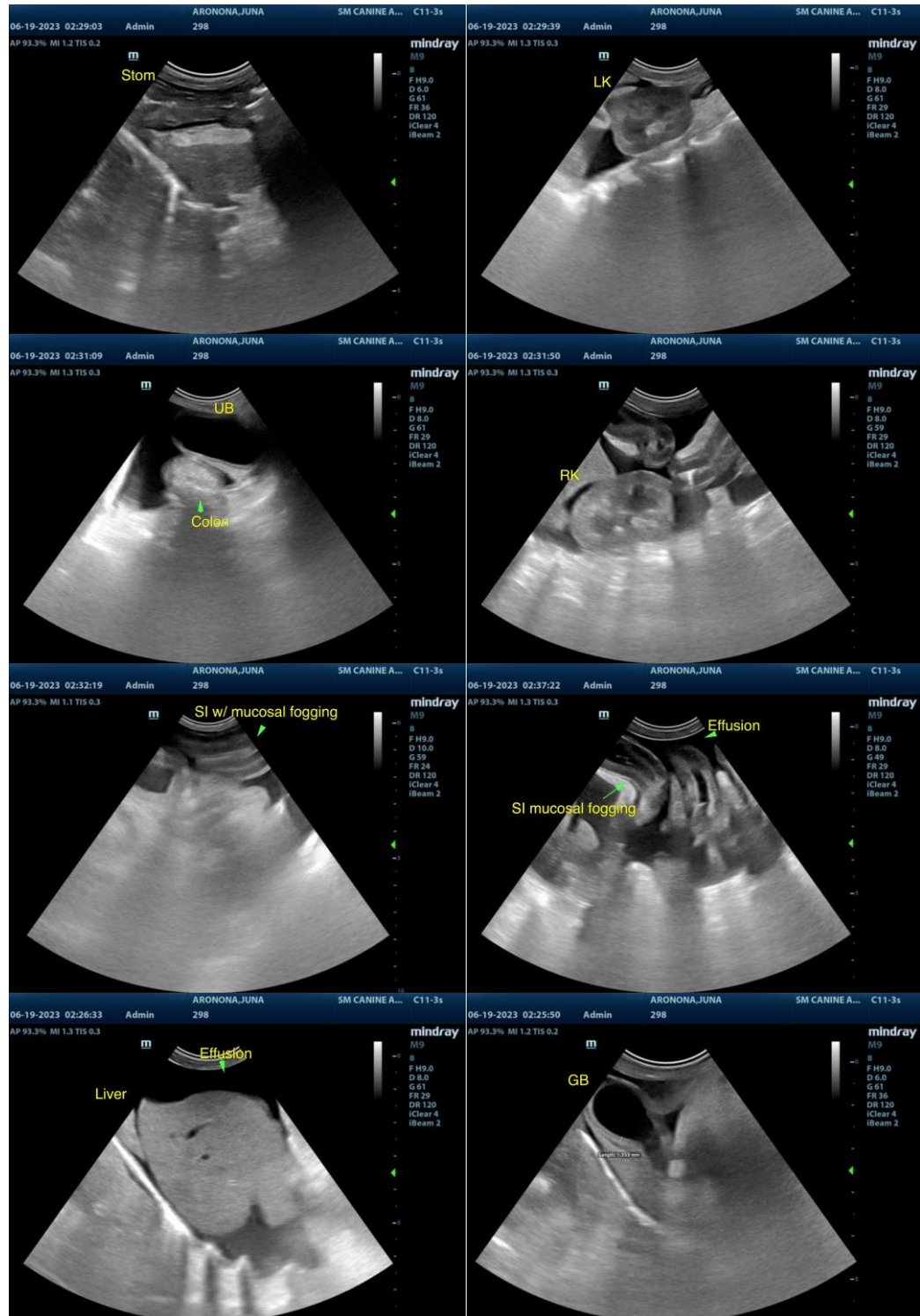
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The information and recommendations provided are based on the images presented by the referring



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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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R. McKenzie Daniel, DVM, DABVP (Canine/Feline Practice)
info@sonopath.com

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