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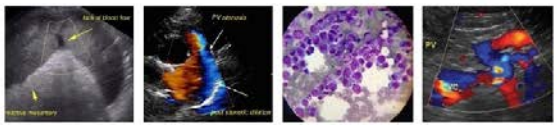


THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Luna Stemenkovic

SPECIES

Canine

BREED

MiniSchnauzer

SEX

Spayed Female

AGE

7 Years

WEIGHT

9.0 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

BPH Stoney Creek

REFERRING VET

Dr. Mellish

INVOICE

39060

DATE

6/23/22

PRESENTING CLINICAL SIGNS

Vomiting constantly, just bile now. Vomits within 1 hour of eating, not drinking. PE NSF. No meds currently.
Abnormal PE/Chem/CBC/UA Results: TP 93 g/L HIGH ALB 57 g/L HIGH ALT 152 U/L HIGH TBIL 91 µmol/L HIGH

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 were 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 4.7 cm. The right kidney measured 4.5 cm.

Adrenal Glands

The adrenal glands were uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 1.5 cm x 0.44 cm at the caudal pole. The right adrenal gland measured 1.4 cm length x 0.50 cm at the caudal pole.

Spleen

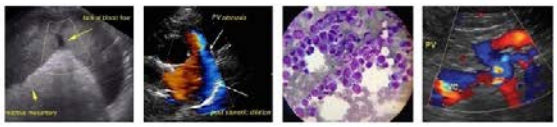
The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute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

Liver

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 intact yet mildly prominent wall layering. Ventral gastric body measured 0.47 cm. The stomach contained a mild amount of retained anechoic to echogenic fluid. Within the fluid were intermittent non-specific mildly hyperechoic linear echoes and mild non-specific retained hyperechoic ingesta. No evidence of pyloric mural pathology or mechanical pyloric outflow obstruction. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material. Pylorus wall measured 0.56 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. Small intestinal wall width measured 0.35 cm.

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.

ULTRASONOGRAPHIC FINDINGS

- Gastritis pattern exhibiting mild retained anechoic fluid and mild non-specific linear-like hyperechoic echoes.
- Sonographically unremarkable small bowel/pancreas
- Low-grade hepatopathy – reactive, metabolic, hepatopathy, potential for low-grade inflammatory hepatopathy.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The appearance of the stomach was sonographically consistent with gastritis. Concurrent metabolic gastric hypomotility owing to gastric inflammation is suspected. No other overt clinical issues such as small intestinal inflammatory mural changes or small intestinal mechanical/metabolic ileus, as well as no overt sonographic evidence of active pancreatitis.

The hyperechoic to linear like gastric luminal echoes were non-specific. However, the possibility of a small amount of non-obstructive foreign material in the stomach could not be excluded. Recommend hospitalization with 24-48 hour IV fluid, gastrointestinal support, and ideally sonographic monitoring of the stomach for evidence of gastric emptying or retained fluid with linear like echoes. Upper gastrointestinal endoscopy may be indicated if persistent evidence of retained linear like gastric echoes or for biopsies if vomiting is persistent despite supportive care. Some or all of the following protocol or similar protocol could be considered empirically, or if clinically indicated.

Helicobacter/Gastritis protocol
A clinical trial of **Zithromax (*Dogs:*** 5-10 mg/kg p.o. q24h. May increase dosing interval to q48h after 3-5 days of treatment)**, Metronidazole** (10-20 mg/kg p.o. b.i.d.), **Pepcid** (0.5-1 mg/kg s.i.d.) and **Sucralfate** (0.5-2 g/dog PO) or **Omeprazole** (1 mg/kg p.o. s.i.d.) over the next 3 weeks along with a **novel-protein or hydrolyzed diet** with slurry feeding b.i.d./t.i.d. over the next 2-4 days and then increase to canned diet bid. Dry food should be avoided over the next 4 weeks. A recheck sonogram to assess GI improvement or progression would be ideal in 4 weeks.

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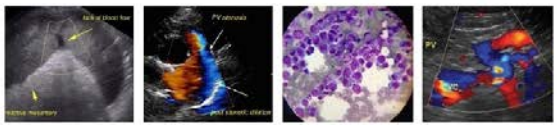

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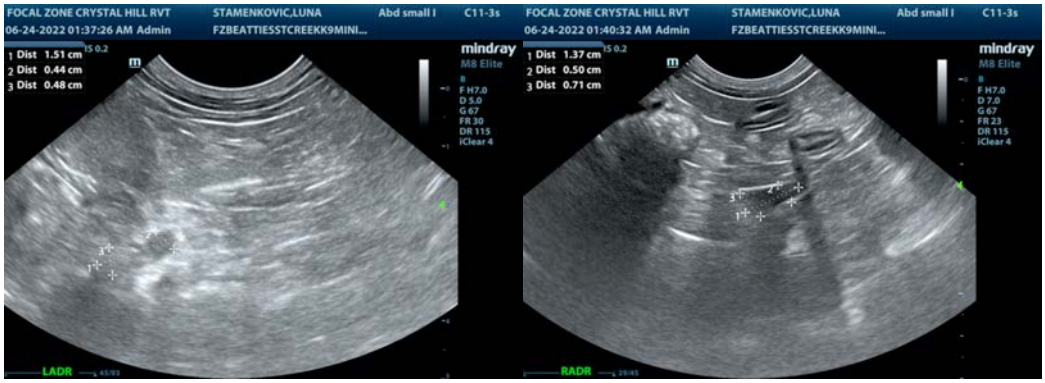

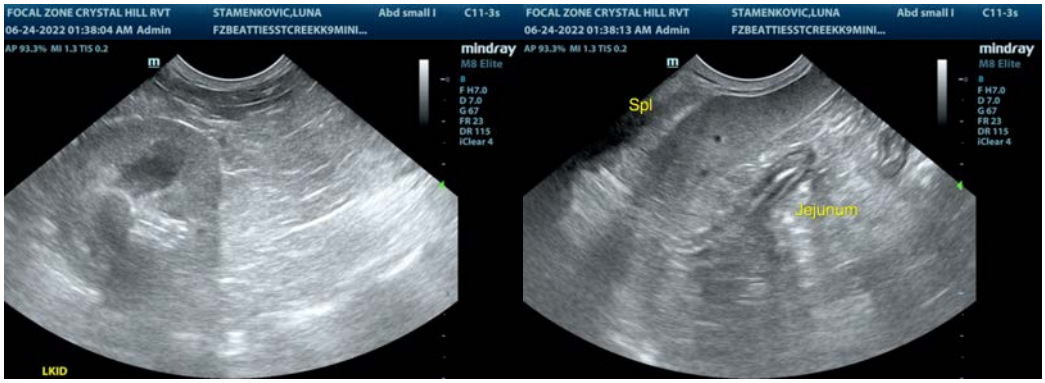

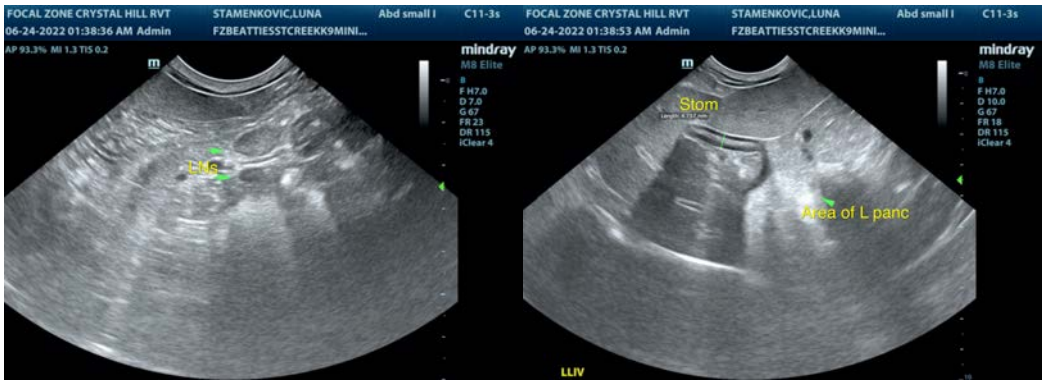

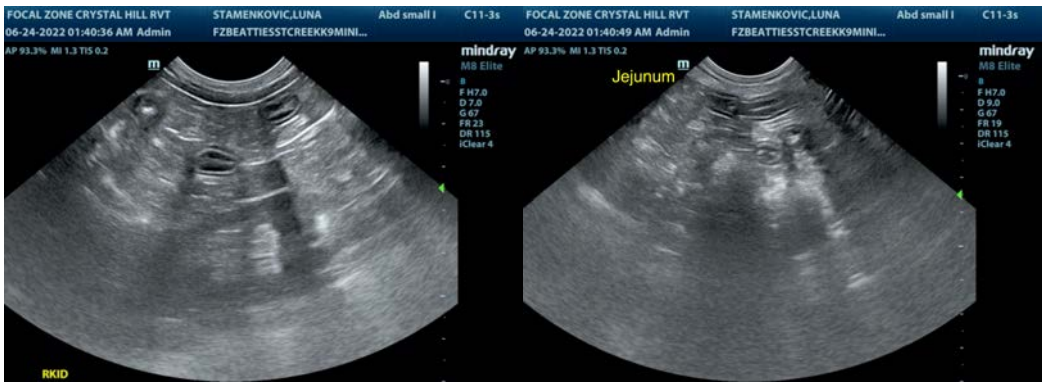

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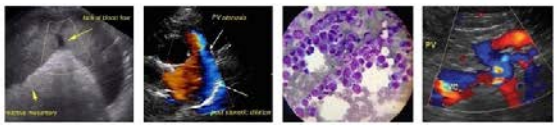

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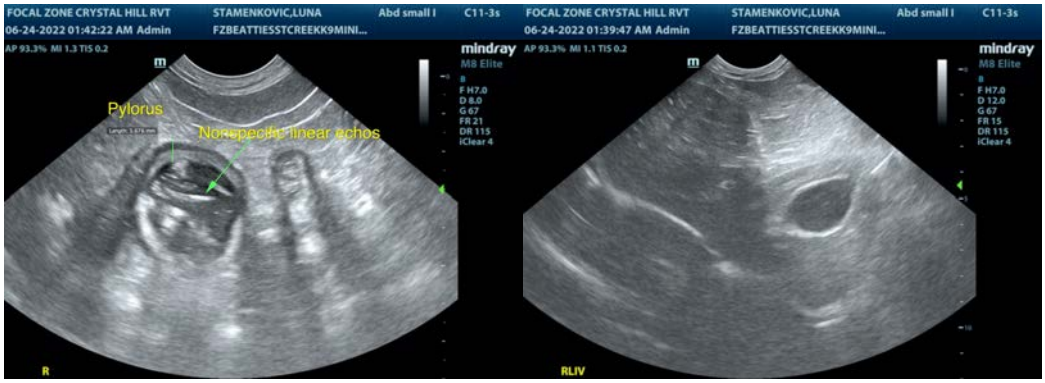

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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