



PATIENT

Oliver Landucci

SPECIES

Canine

BREED

Chihuahua

SEX

MN

AGE

11y

WEIGHT

3.6 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Patti Mayfield DVM

HOSPITAL NAME

Bend Animal
Emergency and
Specialty Center

REFERRING VET

Dr VanLishout

INVOICE

10973ag

DATE

06/26/2022

PRESENTING CLINICAL SIGNS

History: Oliver presented to BAESC on 6/23/22 for vomiting (bilious fluid) and soft stools. Abdominal pain noted. No known dietary indiscretion, although canine housemate had similar clinical signs. -- Over the following 3 days of treatment, no further vomiting noted, but diarrhea developed. -- Patient has improved with no significant vomiting, diarrhea is reducing/improving, however hyporexia and abdominal discomfort persists. PPH: History of pancreatitis x 3-5 years (between 2015 and 2019), requiring biannual hospitalization. This has reduced significantly since patient was started on Royal Canin HP. No hospitalization for pancreatitis has been required until this year. Heart murmur -- echo performed by cardiologist suggests trivial MVI with little to no LAE Current treatments: -- Cerenia (none for 2 days) -- Intermittent buprenex -- Metronidazole -- Ondansetron

Abnormal PE/Chem/CBC/UA Results: PE: Mild dental tartar, slightly overweight. Tensing and bracing on abdomen. Blood work (6/23/22): CBC: -- WBC: 16,790/uL (5050-16,760) -- PMN: 13,910/uL (2950-11,640) CHEM: -- BUN: 4 mg/dL (7-27) -- ALT: 134 U/L (10-125) -- ALP: 293 U/L (23-212) 6/23/22 (abdominal radiographs) -- NSF; no obvious obstruction (gastric/intestinal)

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. A small solitary dorsal trigone polyp measuring 0.36 cm in diameter was present. 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 was 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. Pinpoint to focal nonobstructive medullary mineral primarily in the lateral diverticuli was noted. No evidence of pelvic dilation was present. The left kidney measured 3.6 cm in length. The right kidney measured 3.7 cm in length.

The area of the aortic trifurcation was free of pathology.

No overt pathology in the area of the residual prostate.

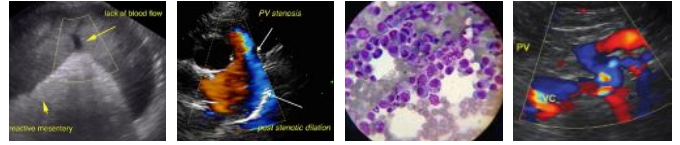
Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.58 cm width at the caudal pole and 0.57 cm width at the cranial pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.47 cm width at the caudal pole and 0.69 cm width at the cranial pole.

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. A solitary non disruptive subtly hyperechoic nodule was present in the cranial spleen measuring 0.44 cm in diameter. 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.

Liver



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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. 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.

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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 measured 0.29 cm in width.

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Chihuahua

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. Minor segmental jejunal mucosal speckling was present. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material. The duodenum wall measured 0.39 cm in width. The jejunum wall measured 0.26 cm in width.

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The descending colon exhibited intact yet thickened wall layering and an empty lumen. The descending colon wall measured 0.42 cm in width. Mild evidence of descending colon reactive mesentery and potential for very scant pericolic free fluid was present.

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Pancreas

The parenchyma of the left limb, body and right limb of the pancreas presented heterogeneous to hyperechoic compared to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct exhibited minor dilation.

WEIGHT

3.6 kg

Free Abdomen

No overt lymphadenopathy was present.

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Mild evidence of descending colon reactive mesentery and potential for very scant pericolic free fluid was present.

ULTRASONOGRAPHIC FINDINGS

- Descending colitis with mild regional pericolic reactive mesentery
- Sonographically unremarkable stomach/SI with minor segmental jejunal mucosal speckling
- Chronic to chronic active pancreatitis pattern
- Low grade benign hepatopathy
- Benign splenic nodule-consistent with a myelolipoma
- Bilateral chronic renal changes with mild nonobstructive medullary mineral
- Suspect small dorsal trigone polyp

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Sonographic monitoring of the dorsal trigone polyp for evidence of progression is recommended. A screening BRAF assay could also be considered. This patient may be having intermittent to chronic flare ups of pancreatitis although the possibility of concurrent structurally insignificant inflammatory gastroenterocolopathy is possible. Continued long term dietary therapy and as needed supportive care for possible inflammatory gastroenterocolopathy and chronic to chronic active pancreatitis is suggested. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended.

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Endoscopic upper and lower GI biopsies are likely ideal given this presentation yet continued supportive care given the recent improvement in clinical signs +/- sonographic reassessment of the GI tract if persistent GI signs for evidence of progressive inflammatory changes would be reasonable.

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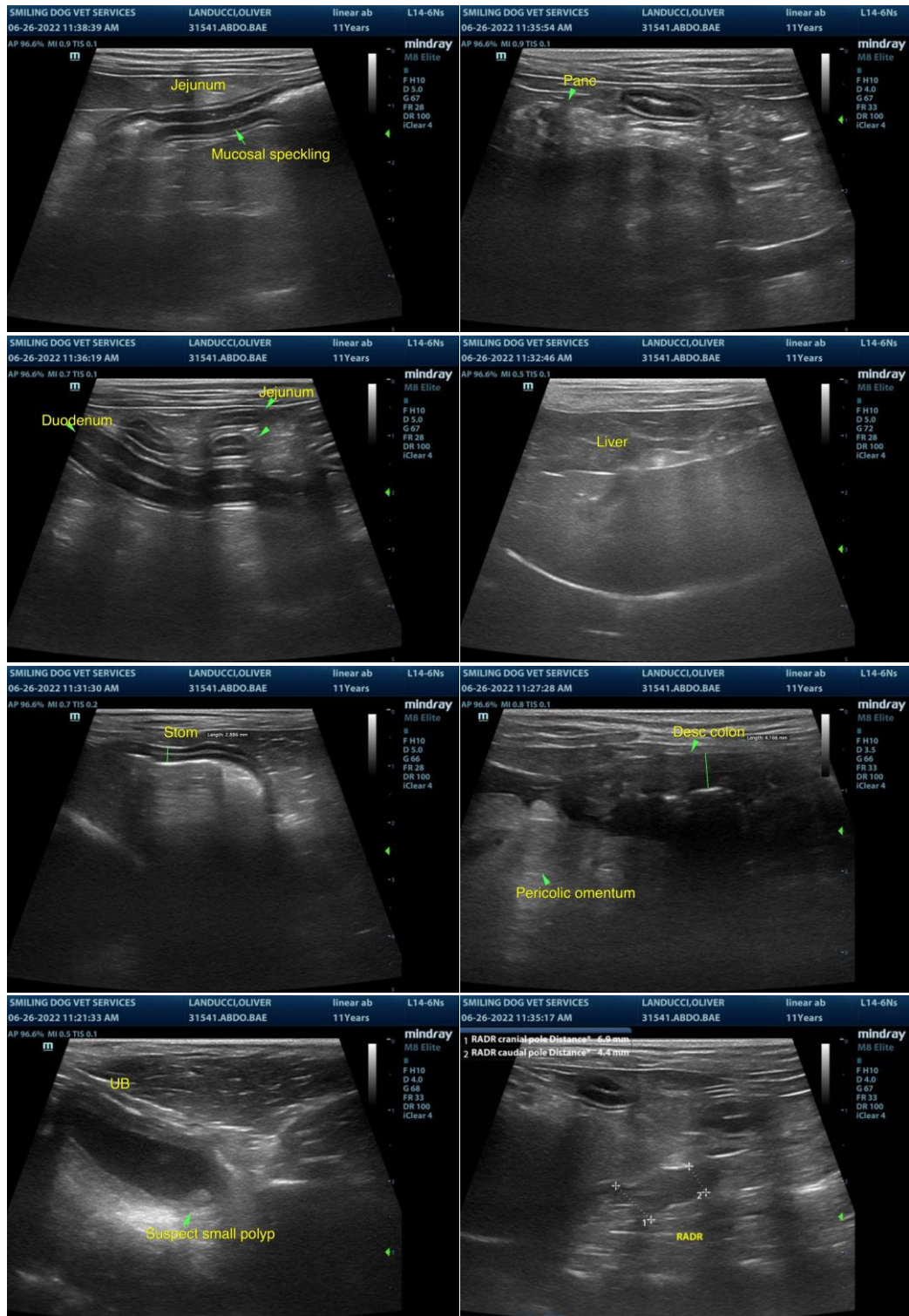
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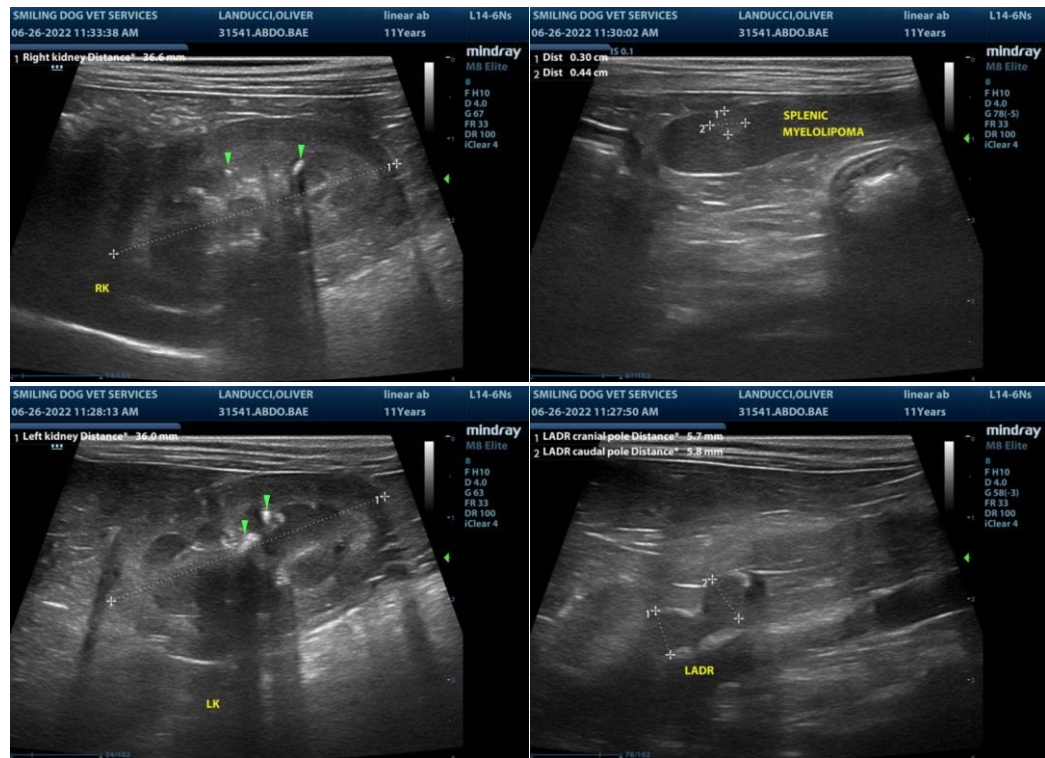
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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