

PATIENT

Missy Brumley

SPECIES

Canine

BREED

Chihuahua

SEX

FS

AGE

12

WEIGHT

8lb

PRESENTING CLINICAL SIGNS

Pt presented for not eating. Pt has been vomiting when O tried to hand feed. Stopped eating or drinking much since Wed and does seem lethargic as on 7/5. Treated with SQ fluids, metronidazole, clavamox and cerenia. By 7/7 pt showed no improvements, pt still not eating and now painful on abdominal palpation. Added on ursodiol, SAME and mirtazipine and ran pt IV fluids throughout the day on 7/8. O thinks Pt is losing weight

BW showed elevated HCT, Chem showed elevated ALT, ALP and GGT on 7/5. tbili also high but sample was hemolyzed. Rads showed empty stomach, larger SI loops than expected and stool in colon and appears to be some gas mixed in.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3 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.

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. Nonobstructive medullary renoliths were present. No evidence of pelvic dilation was present. The left kidney measured 3.8 cm in length. The right kidney measured 0.36 cm in length.

The area of the aortic trifurcation was free of pathology.

INTERPRETED BY

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

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.40 cm width at the caudal pole and 0.46 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 0.53 cm width at the caudal pole.

IMAGING PERFORMED BY

Jonathan Moss

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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Veterinary Hospital

Liver

The liver presented enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion.

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The gallbladder was mildly distended in size with mildly prominent isoechoic to mildly hyperechoic gallbladder walls. Primarily anechoic luminal content with moderate mildly congealed yet nonorganized luminal debris. Subtle evidence of peripheral inflammation noted without evidence of concurrent free fluid. The cystic and common bile ducts were normal.



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Gastrointestinal

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The stomach presented wall thickening secondary to echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. The pylorus wall measured 0.36 cm width. Mild gastric distension with primarily anechoic fluid was present.

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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 0.40 cm in width.

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Normal visible colon wall layers were present with apparent soft to possible non formed feces in lumen.

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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

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No overt evidence of significant lymphadenopathy or peritoneal effusion was present.

WEIGHT

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ULTRASONOGRAPHIC FINDINGS

- Moderate congealed gallbladder debris with subtle peripheral inflammation
- Hepatopathy-subjectively benign
- Mild gastritis/gastroenteritis pattern, soft to non-formed fecal matter in colon
- Bilateral mild chronic renal changes with non obstructive medullary renolithiasis

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The gallbladder presentation was not overtly consistent with a classic gallbladder mucocele yet evidence of cholecystitis and subtle peripheral peri cholecystic inflammation was present. Assessment for cranial abdominal or subxiphoid discomfort on palpation is recommended.

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No overt evidence of sonographically active pancreatitis was present yet low grade pancreatitis could be present and appear sonographically normal. Correlation with a spec cPL to assess for evidence of pancreatitis could be considered.

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If concern for weight loss, a GI panel to include PLI/TLI/Cobalamin/Folate is recommended.

Empirically as needed GI and hepatic support with some or all of the following protocol would be reasonable. If persistent/progressive hepatic enzyme elevations or evidence of cholestasis, a cholecystectomy with hepatic biopsies may be indicated.

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Enrofloxacin 5 mg/kg SID PO & Metronidazole (10-20 mg/kg po bid) over 3 weeks, Ursodiol (10-15 mg/kg p.o. q24h) over 8 weeks and recheck sonogram. Monitor rapid rise in ALT, SAP, Bilirubin, bilirubinuria, leukocytosis, focal cranial abdominal subxiphoid discomfort or progressive anorexia.

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More information regarding clinical emerging mucocele issues may be found with our article and research at <http://sonopath.com/resources/articles>, Defining a GB Mucocele and Clinical Parameters in Dogs with Sonographically Diagnosed Surgical Biliary Disease from ECVIM 2009.

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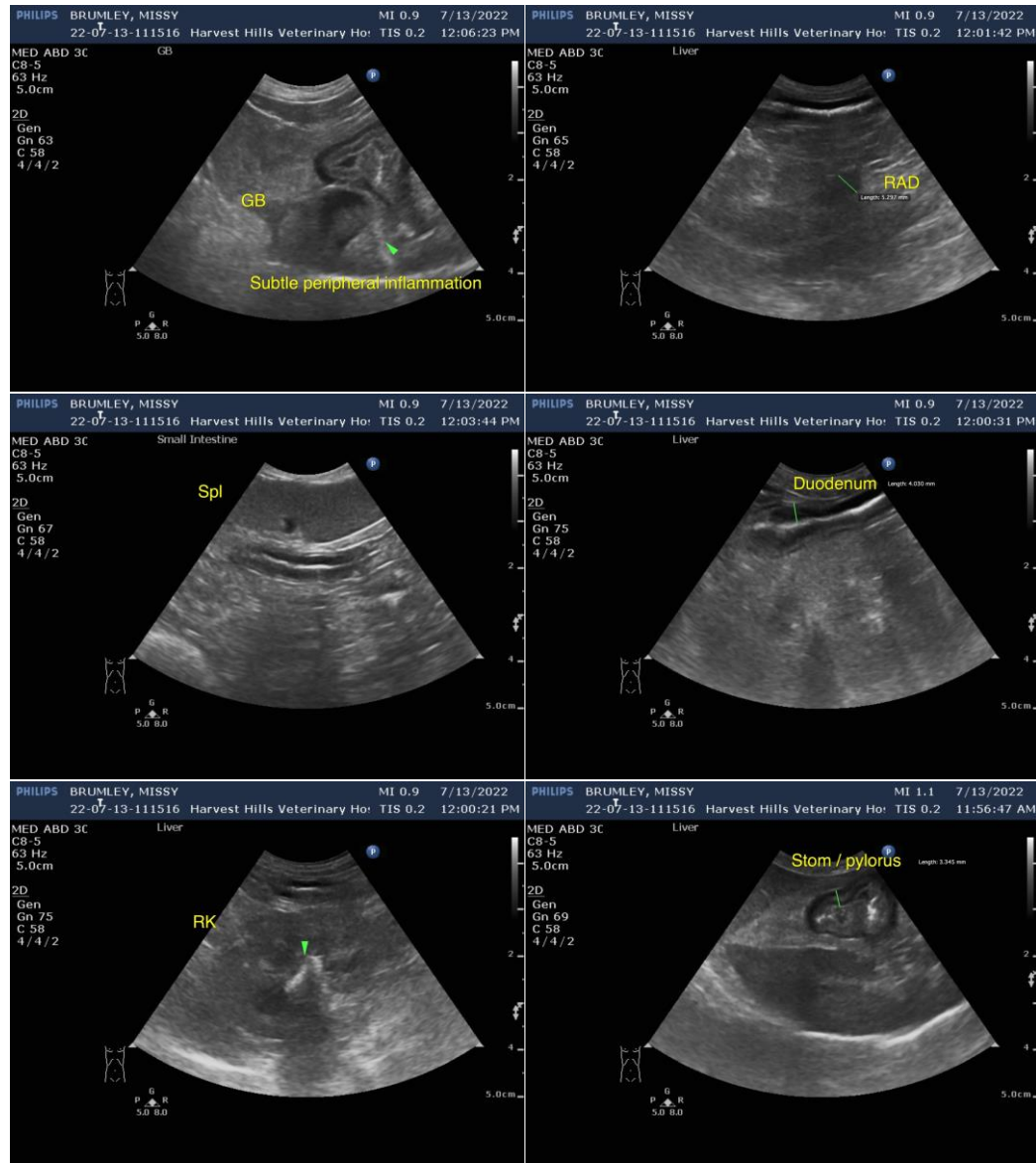
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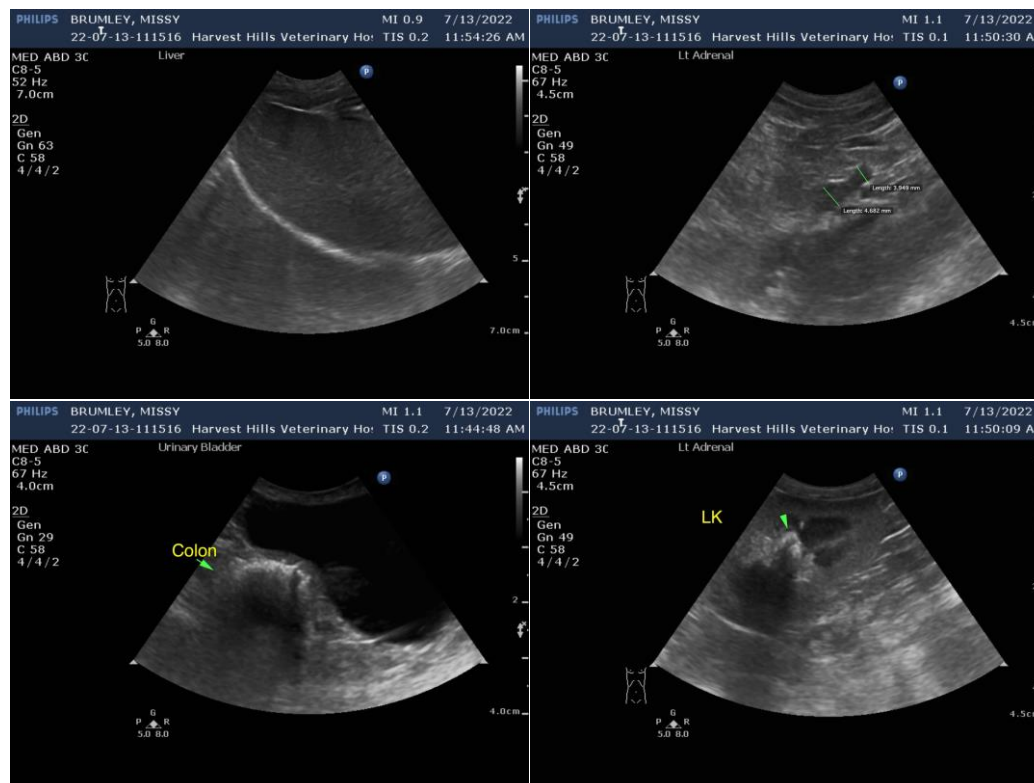
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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