SonoPath
Clinical Sonography & Telecytology

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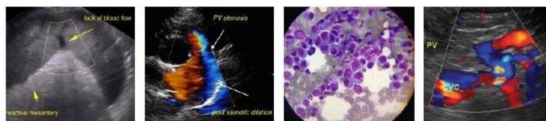


THE FOCAL ZONE

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

PATIENT
Popo Carlucci

SPECIES
Canine

BREED
Weimaraner

SEX
MN

AGE
6yr

WEIGHT
67lb

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

IMAGING PERFORMED BY
Kelly Reschny

HOSPITAL NAME
Dog and Cat Clinic of Niagara

REFERRING VET
Dr. Nick

INVOICE
11181ag

DATE
07/26/2022

PRESENTING CLINICAL SIGNS

History: fluid in abd, marked weight loss, muscle atrophy meds: baytril

Abnormal PE/Chem/CBC/UA Results: elevated neut low glob, Ca, TP, alb,

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

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.

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 to moderate loss of corticomedullary symmetry and definition expected for the age of the patient. Focal areas of asymmetrical renal margination suggestive of cortical infarcts were noted. No evidence of pelvic dilation was present. The left kidney measured 6.4 cm in length. The right kidney measured 7.1 cm in length.

The area of the aortic trifurcation was free of pathology including no evidence of medial iliac or sublumbar lymphadenopathy.

No overt pathology in the area of the residual prostate.

Adrenal Glands

The left and right adrenal glands were not definitively visualized owing to peritoneal free fluid.

Spleen

The spleen was not definitively visualized owing to displacement secondary to free fluid or volume contraction.

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 with hyperechoic luminal debris. The cystic and common bile ducts were normal.

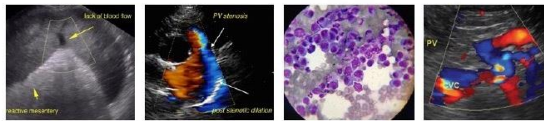
Gastrointestinal

No overt pathology in the area of the stomach.

The small intestine presented intact yet prominent wall layering with mild increased mucosal echogenicity to mucosal fogging. Segmental areas of mild small intestinal stasis were present. The small intestinal wall measured 0.53 cm in width.

Normal visible colon wall layers were present with apparent formed feces in lumen.

Pancreas



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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

Generalized mild hyperechoic mesentery was present. No overt lymphadenopathy was present.

Marked volume peritoneal free fluid exhibiting mild echogenic changes which may indicate mild fluid cellularity.

ULTRASONOGRAPHIC FINDINGS

- Intact yet prominent small bowel walls with segmental to generalized increased echogenicity/mucosal fogging
- Marked volume peritoneal free fluid
- Overtly normal liver
- Non specific chronic renal changes with suspect cortical infarcts

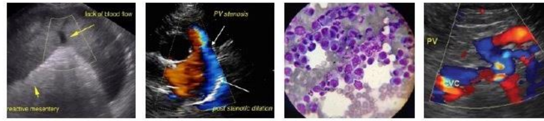
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

In light of the abdominal sonographic presentation combined with the marked weight loss, PLE is considered a top differential diagnosis in this case. Chronic IBD, lymphangiectasia or less likely infiltrative intestinal neoplasia given the lack of overt intestinal masses or loss of intestinal wall layering could be possible. A full urinary workup including a urine C/S and baseline UPC level to rule out proteinuria as a contributing factor is suggested. Three view chest radiographs to assess for thoracic pathology as well as cardiopulmonary status is suggested. Correlation with fluid analysis cytology +/- C/S if evidence of inflammatory cells is suggested. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended.

Pending additional diagnostic some or all of the following protocol could be considered.

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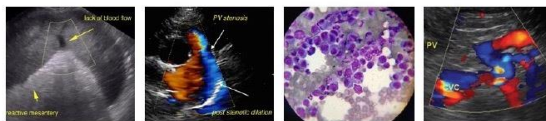
The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.



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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