

**PATIENT**

Jake Mamo

SPECIES

Canine

BREED

Large Mixed Breed

SEX

MN

AGE

10 years

WEIGHT

95 lbs.

INTERPRETED BYR. McKenzie Daniel,
DVM, DABVP (Canine
and Feline)**IMAGING
PERFORMED BY**

Amy Mayhew LVT

HOSPITAL NAME

SVS imaging MI

REFERRING VETTown Center
Veterinary Associates**INVOICE**

14567

DATE

8/10/22

PRESENTING CLINICAL SIGNS

O notes P has not gotten any better since the original visit 3 weeks ago, P still having the same symptoms as last visit. O notes the medications (Metronidazole & Provable) did not seem to help with the diarrhea or overall sickness even while on them. P has since stopped eating dry food and will only eat wet food, feeding 2-3 cans of wet food daily. O still noticing pt sleeping most of the day, very low energy. Stool is still very soft and has not hardened at all, urinating well. O did note pt vomited 2X since last visit, was mostly dry food and saliva. Prior to couple of months ago, had a very good appetite. Some belching.

Abnormal PE/Chem/CBC/UA Results: Exam findings and abnormal lab values: Assessment: open-occult FB/parasitic/dietary Diagnostics: previous BW wnl Xray right lateral and VD abdomen-gas with pronounced rugal folds, ingesta vs. foreign material in pylorus, questionable linear material in stomach Tx: none Plan: Bland diet, Tylan/Panacur trial, baseline cortisol /barium if still not improving and possible US, hydrolyzed diet trial Rx: Rx for Omeprazole 40mg #10 (1 SID) Rx's for Hill's ID or RC GI lowfat Tylan 10tsp 1/8tsp TID Panacur x 3 days

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 was noted.

The area of the aortic trifurcation was free of pathology. Visualized medial iliac lymph nodes were sonographically normal without evidence of inflammatory or neoplastic criteria.

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 7.8 cm in length. The right kidney measured 8.3 cm in length.

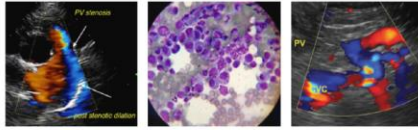
Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.67 cm width at the caudal pole and 0.74 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 0.60 cm width 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.

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Liver/ Gallbladder

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 mild nondependent nonorganized gallbladder debris. The gallbladder or peripheral gallbladder were sonographically normal. No evidence of gallbladder or peripheral gallbladder inflammatory criteria was noted. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach exhibited mild to moderate yet irregular wall thickening with potential areas of gas artifact noted within rugal folds or potentially within the gastric wall. Indistinct gastric wall layering was present within the areas of variable gastric wall thickening. A mild amount of retained anechoic fluid was present in the gastric lumen. No evidence of gastric distention as with mechanical pyloric outflow obstruction. The gastric body wall width subjectively measured 0.6 - 0.7 cm, but potentially thicker.

The small intestine presented intact wall layering and primarily maintained a 1:3 muscularis/mucosa ratio with subjective propensity for potential mildly prominent generalized small intestinal mucosa. Intermittent nonspecific jejunal mucosal speckling was noted. The duodenum wall measured 0.43 cm width. The jejunum wall measured 0.29 cm width.

The colon exhibited intact yet mildly prominent wall layering. Primary empty descending colon with minor semi-formed to soft descending colon fecal matter was present. The descending colon wall width measured 0.2 cm.

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 were evident.

Free Abdomen

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

ULTRASONOGRAPHIC FINDINGS***Primary Findings***

- Variably thickened to irregular gastric walls with mild retained anechoic gastric fluid - chronic potentially hypomotile gastritis, possible infiltrative gastric neoplastic criteria
- Mild enterocolitis pattern - potential for inflammatory bowel

Secondary Findings

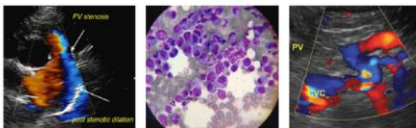
- Minor gallbladder debris (non-mucocele) - suspect secondary to fasting

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No obvious evidence of gastrointestinal foreign material or mechanical gastrointestinal obstructive pattern. Blanket deworming i.e., Panacur 50 mg/kg PO SID for at least 5 consecutive days with

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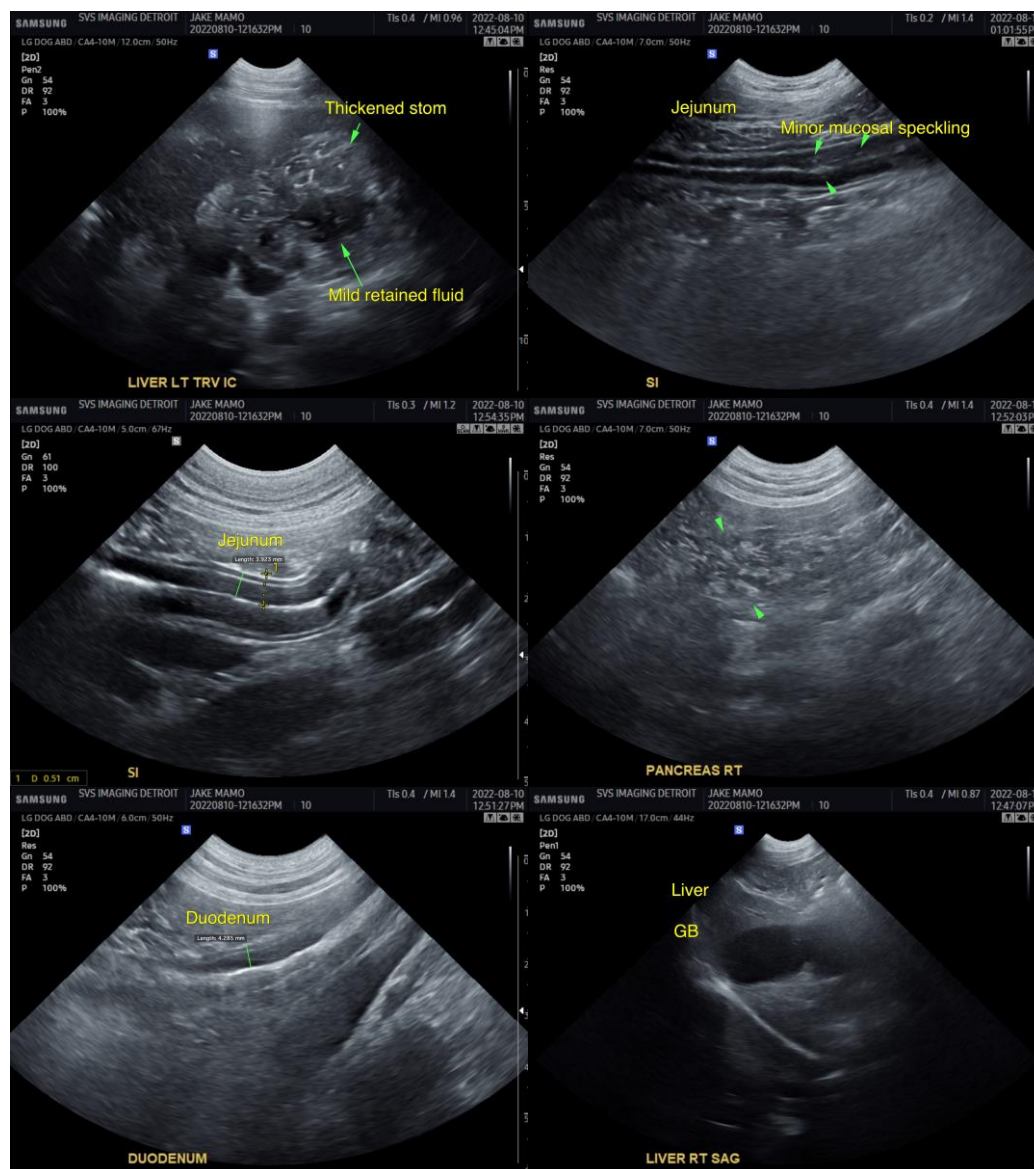
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potential repeat protocol in 3 weeks, as well as resting cortisol level to rule out occult Addison's Disease as a contributing factor even with overall normal adrenal presentation is suggested.

Given the lack of positive response to previous empirical therapy, some or all of the following protocol could be considered. However, given the gastrointestinal presentation, specifically, irregularly thickened gastric walls and evidence of gastric hypomotility, endoscopy for further assessment and potential biopsies are strongly recommended if possible and pending additional therapy / diagnostics.

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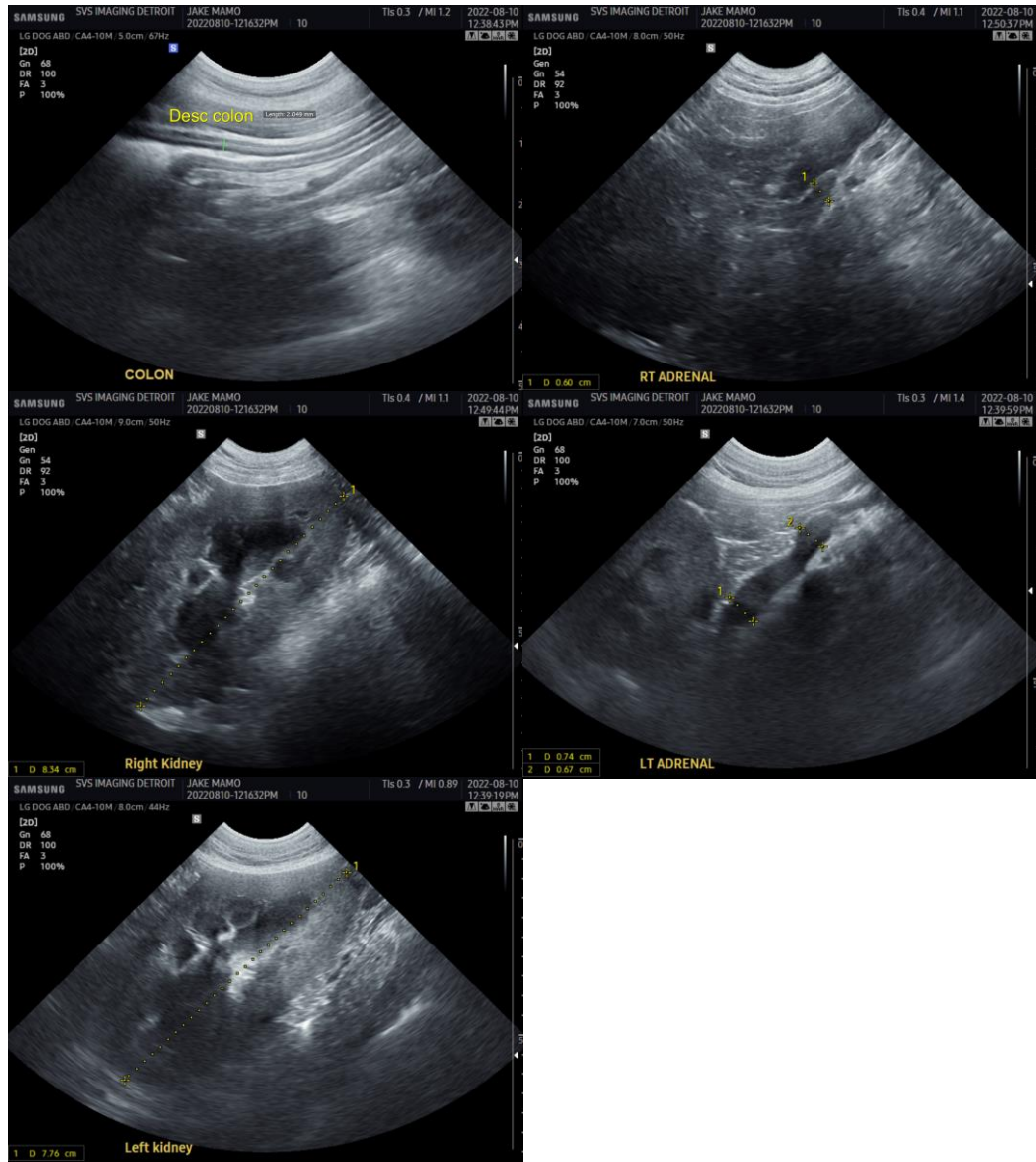
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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