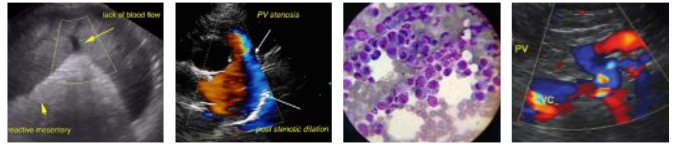

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1-800-838-4268 info@sonopath.com

PATIENT

Milo Shives

SPECIES

Canine

BREED

Chihuahua

SEX

MN

AGE

10

WEIGHT

3.6

INTERPRETED BY

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

IMAGING PERFORMED BY

Schofield

HOSPITAL NAME

Wilvet South

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PRESENTING CLINICAL SIGNS

Milo is a 10 year old MN Chihuahua who presents for anorexia (< 24 hours), hyporexia (1 week), vomiting (several times this morning, even through Cerenia), and severe lethargy. Milo has had a history of these clinical signs and was recently seen with his rDVM, Banfield, where bloodwork (including testing for Addison's and pancreatitis) were found to be WNL. Next steps discussed was an abdominal ultrasound, but they are not able to get Milo in until Monday. Owners are concerned with how lethargic he has become and has dramatically he has declined in the last week and so brought him to the ER. He was seen with us in April where radiographs were found to be WNL. He was seen at this time for crying after eating. Owners feel like this problem resolved when his food was changed from dry food to wet food. A. Schofield, DVM

Abnormal PE/Chem/CBC/UA Results: Bloodwork: PCV/TS: 70%,/8.0 EPOC: HCT = 70%, Na 154 (H), BUN 31 (H), pH 7.242 (L, acidotic), pCO2 53.8 (H), rDVM bloodwork 1/31/23: Snap 4Dx = neg Electrolytes: WNL Chem: WNL CBC: HCT 67% (H) Radiographs Report: NCLUSIONS: The possibility of at least a partial small intestinal obstruction due to a soft tissue opacity foreign body could be considered but is not totally definitive. Stricture, adhesions or neoplasia cannot be excluded. Chronic gastroenteritis , inflammatory bowel disease and or pancreatitis remain possible differential diagnosis, but overall considered less likely with some of the reported history. The distention of the esophagus with gas is most likely due to aerophagia given that this is variable. Megaesophagus cannot be excluded but is considered less likely.

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 were 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. No evidence of pelvic dilation was present. Minor medullary mineral was present. The left kidney measured 3.9 cm in length. The right kidney measured 3.7 cm in length.

The area of the aortic trifurcation was free of pathology.

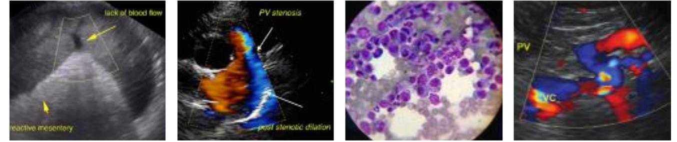
The area of the residual prostate appeared normal and free of pathology.

Adrenal Glands

The left and right adrenal glands were not definitively visualized. No obvious pathology was present in the area of the bilateral adrenal glands.

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



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thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

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. Normal vascular volume. 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 exhibited moderate to marked distention with retained anechoic fluid. The stomach presented intact mildly prominent wall layering in the area of the antrum and pylorus. The pylorus wall measured 0.48 cm in width. Subjectively potentially thickened pyloroduodenal junction and upper duodenum was present measuring ~ 1.3 cm in diameter.

The small intestine presented intact wall layering with minor upper duodenal retained fluid and generalized empty lumen.

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

Pancreas

The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

Free Abdomen

No omental masses, overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

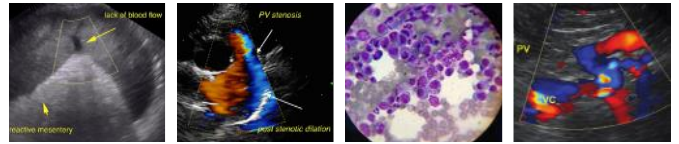
- Moderate to marked fluid dilated stomach with intact mildly thickened antrum/pylorus wall layering.
- Subjective potentially thickened pyloroduodenal junction and upper duodenum.
- Overall empty small bowel-no overt evidence of obstructive pattern.
- Mild pancreatic remodeling-no sonographic evidence of active pancreatitis, age related remodeling or chronic pancreatitis possible.

Secondary

- Mild chronic renal changes with mild medullary mineral.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

General considerations for the fluid distended stomach may include metabolic/functional or mechanical gastric stasis. Given the degree of retained gastric fluid and secondary gastric distention, concern for mechanical pyloric or upper intestinal obstruction which may include obstructive mural



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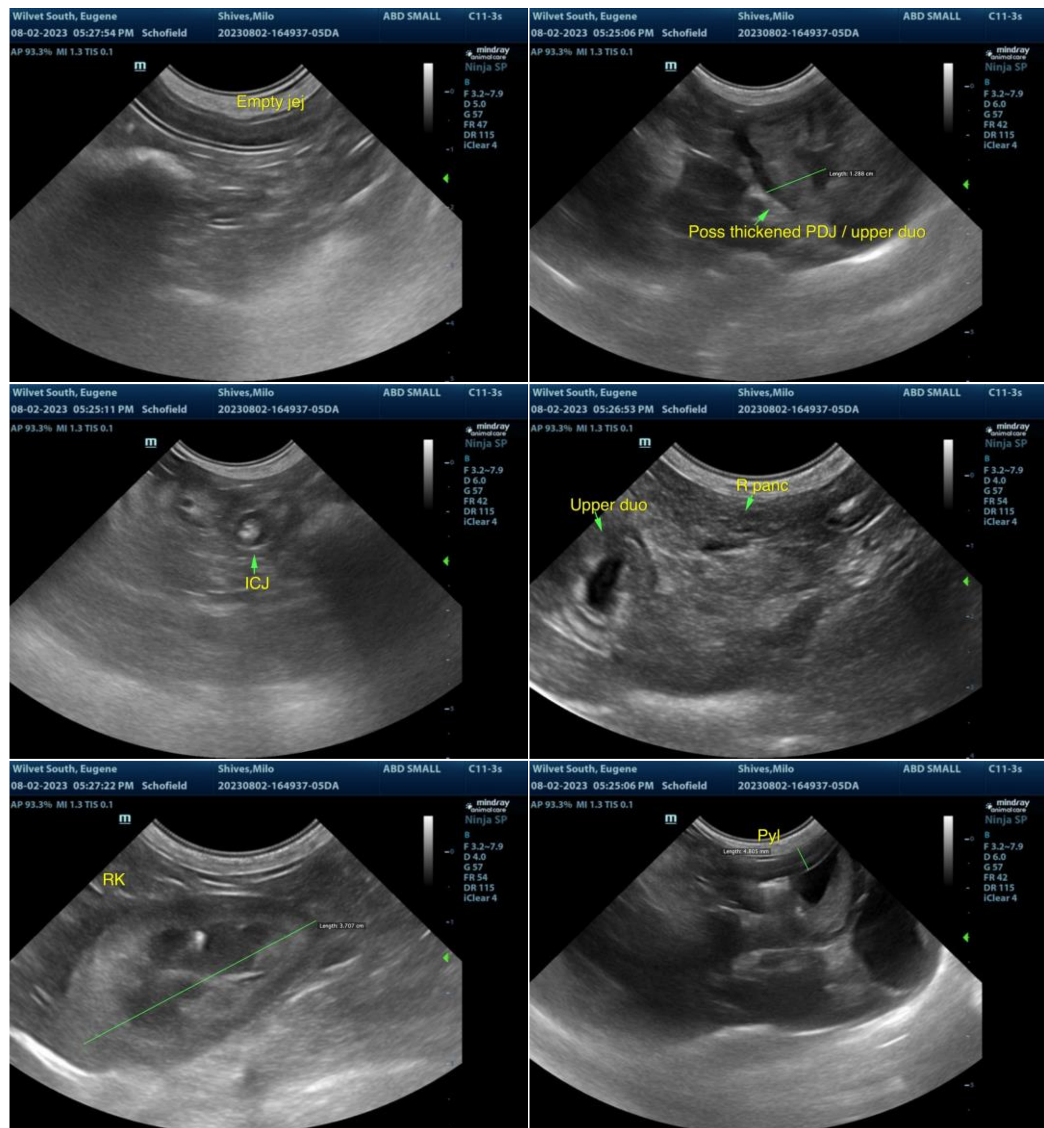
pathology or non-obvious foreign body is warranted. Inflammatory or emerging infiltrative neoplastic gastric or upper intestinal etiologies are possible.

Given previous negative diagnostics and clinical presentation, conservative empirical therapy including gastric evacuation via NG tube with gastroprotectants, canned hydrolyzed diet with avoidance of dry food and empirical therapy for helicobacter with assessment of clinical response and sonographic monitoring may be considered.

However, given the degree of fluid distention, exploratory laparotomy with gross inspection of the upper GI and potential biopsies should be strongly considered.



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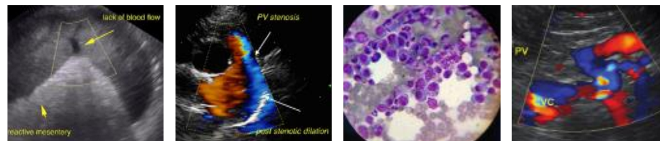

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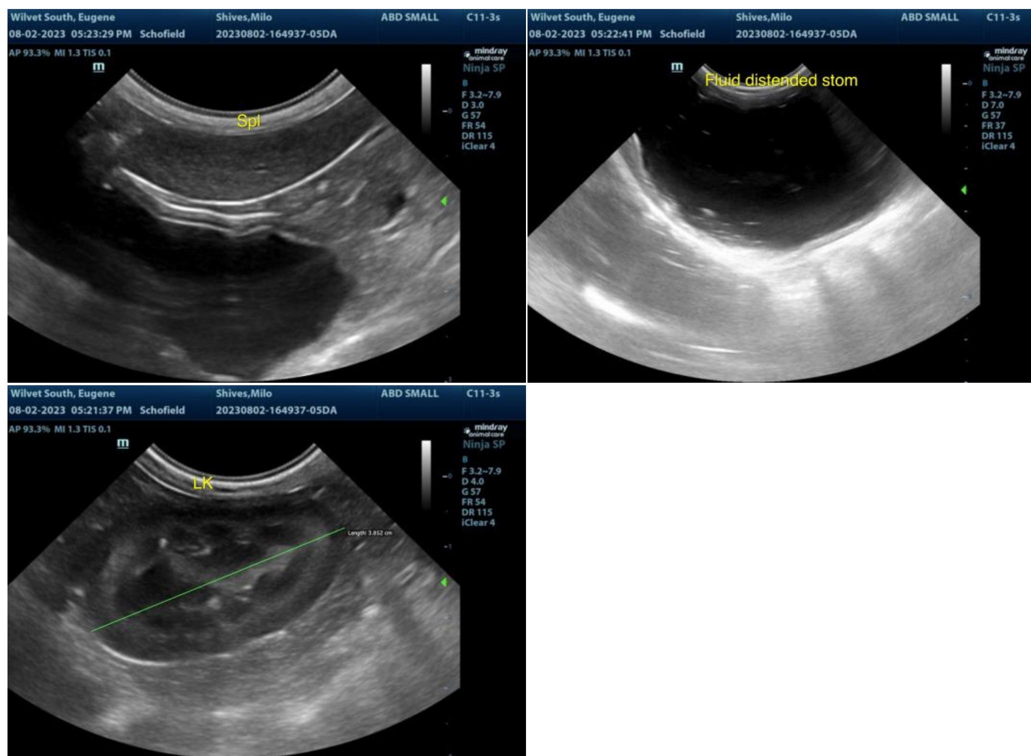

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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