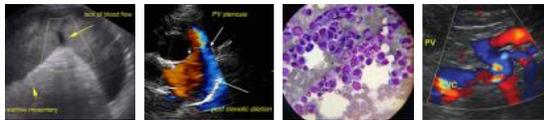


PATIENT	PRESENTING CLINICAL SIGNS
Angus Payne	Starting 08/22/22 - vomiting, dry heaves, drooling, abdominal discomfort. Rads taken - no sign of blockage. Repeat rads taken 12 hours later confirmed no evidence of blockage. P is not improved - poor appetite, drooling, uncomfortable and diarrhea. P has hx of IBD (biopsies taken at a partial bowel resection sx in 2016). Until now, P has had no concerns.
<b>SPECIES</b>	
Canine	
<b>BREED</b>	
Labrador Retriever	Abnormal PE/Chem/CBC/UA Results: ALT 681, ALP 1124, GGT 24 Current Medications Cerenia once daily, Omeprazole 20 mg PO BID and Budesonide 2 mg EOD (long term use) Radiographic Findings Findings: Six radiographs of the abdomen are available for review and compared to previous images dated the same day. There is progressive emptying of the gastric lumen. The small intestines are mildly fluid and gas filled without evidence of pathological dilation. The colon is feces filled. The liver, the spleen, the kidneys and the urinary bladder are within normal limits. There is a small amount of spondylosis deformans in the lumbar vertebral column. Assessment: Progressive emptying of the gastric lumen. No evidence of mechanical ileus. Some degree of enteritis/ IBD flare up etc. might be considered to explain the clinical signs.
<b>SEX</b>	
MN	
<b>AGE</b>	
9 yrs	
<b>WEIGHT</b>	
78.3 lbs.	
<b>INTERPRETED BY</b>	<b>ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN</b>
R. McKenzie Daniel, DVM, DABVP (Canine and Feline)	<b>Urinary System</b>  The urinary bladder, trigone and cystourethral junction 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.  No overt pathology in the area of the residual prostate.  Aortic trifurcation was normal.
<b>IMAGING PERFORMED BY</b>	
Sara Hansen	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 minor loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 7.2 cm in length. The right kidney measured 7.3 cm in length.
<b>HOSPITAL NAME</b>	<b>Adrenal Glands</b>
West Hills AH	The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 3.0 cm in length x 0.65 cm width at the caudal pole.  The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 2.8 cm in length x 0.56 cm width at the caudal pole.
<b>REFERRING VET</b>	
Dr. Remcho	
<b>INVOICE</b>	
17039	
<b>DATE</b>	<b>Spleen</b>
8/26/22	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



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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.

**Liver/ Gallbladder**

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to benign parenchymal remodeling. Subtle increased yet indistinct prominence of portal vascular borders noted.

The gallbladder was non-distended with anechoic content with mild hyperechoic subtly shadowing debris present in the cranial lumen. No evidence of peripheral gallbladder inflammation. The common bile duct was subjectively normal without evidence of posthepatic obstructive criteria.

**Gastrointestinal**

The stomach exhibited generalized moderate yet variable mural thickening exhibiting decreased mural echogenicity and indistinct wall layer detail. Mild retained anechoic to mildly echogenic fluid and chyme were present in the gastric lumen. No overt evidence of mechanical pyloric outflow obstruction or obstructive pyloric mural pathology. The gastric body wall measured 1.0 cm in width. The pylorus wall measured 1.1 cm in width.

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.

Normal visible colon wall layers were present with subjective semi-formed to soft fecal matter in lumen.

**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**

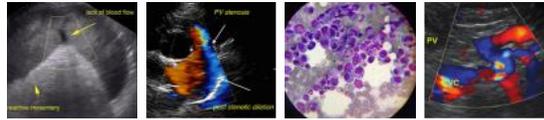
No omental masses, lymphadenopathy or evidence of peritoneal effusion was present.

**ULTRASONOGRAPHIC FINDINGS**

- Thickened hypomotile stomach
- Sonographically unremarkable small bowel
- Hepatopathy- possible acute or acute on chronic
- Hyperechoic subtly shadowing gallbladder debris (non-mucocele)

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Sonographically, the appearance of the stomach may suggest acute hypomotile gastritis. The possibility of early infiltrative gastric neoplasia may also present in the manner and cannot be definitively excluded. Although no evidence of structural small bowel pathology, potential contributing factor to the patients



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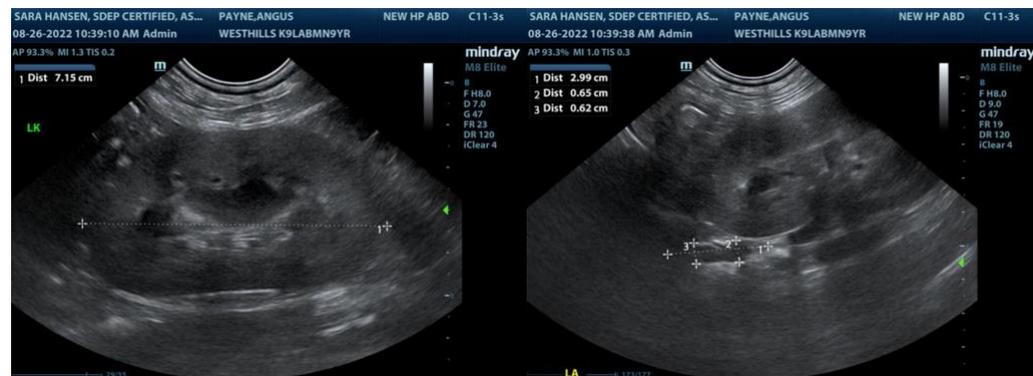
clinical signs, owing to concurrent enteropathy, given the patient history, cannot be definitively excluded. Assessment of serum cobalamin and folate levels may be considered.

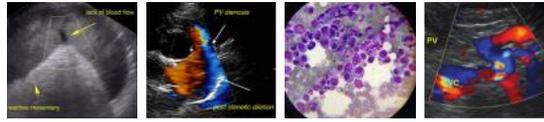
The appearance of the liver was not specific with considerations, including vacuolar hepatopathy, nonspecific hepatitis/cholangiohepatitis (viral, bacterial, leptospirosis, toxin, etc.), nonobstructive cholestasis or other hepatopathy with infiltrative neoplasia considered less likely yet cannot be definitively excluded. Further assessment of the liver may include ultrasound guided FNA cytology +/- Leptospirosis titers/PCR (if potential exposure).

Empirically, medical therapy for acute gastritis and hepatopathy with as needed gastrointestinal and hepatic support with assessment of clinical response and monitoring of liver enzymes would be reasonable. hepatogastric biopsies may be required for a definitive diagnosis. Some or all of the following protocol with as needed hepatic support or similar protocol could be considered.

**Helicobacter/Gastritis protocol**

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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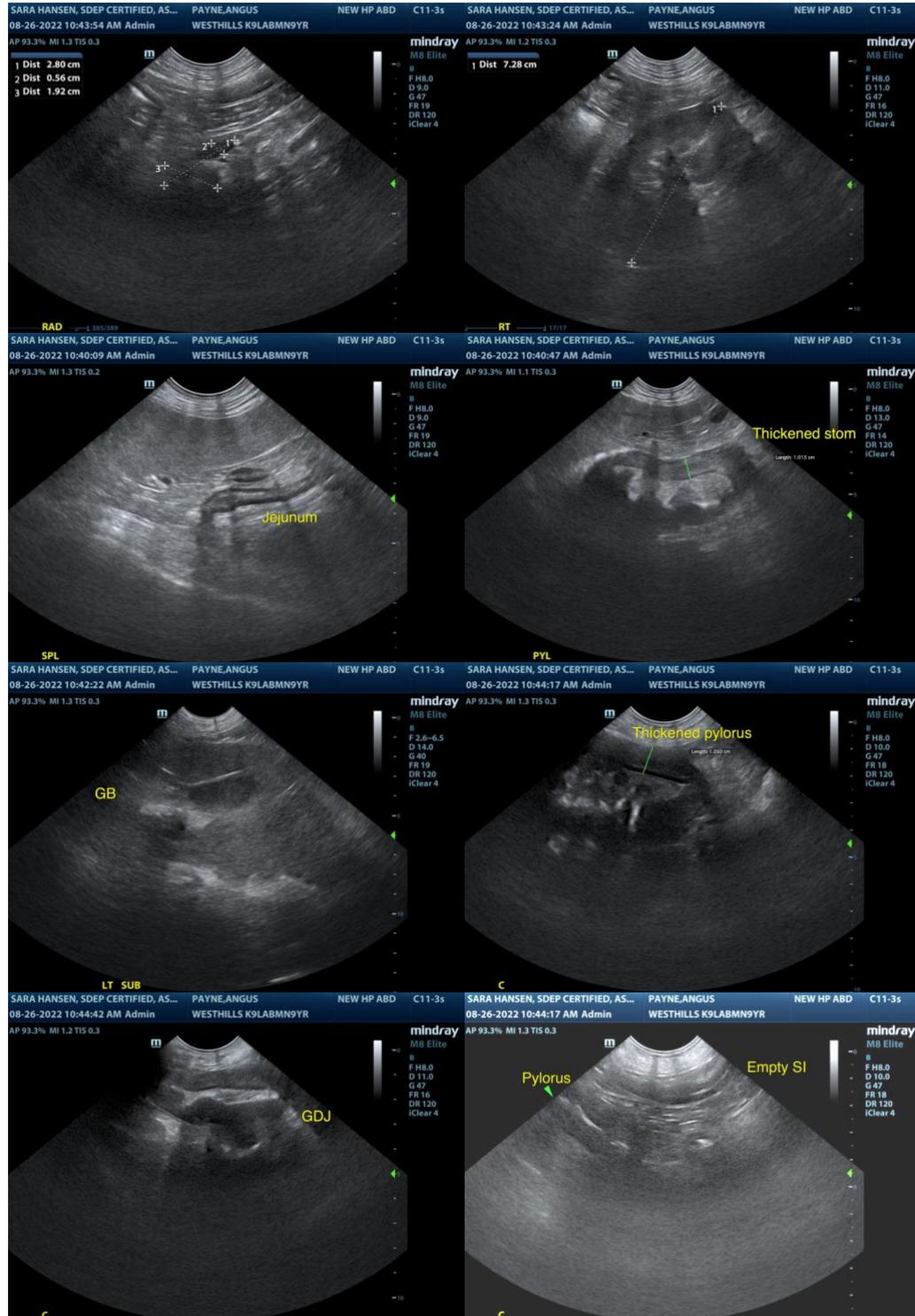
Dr. Remcho

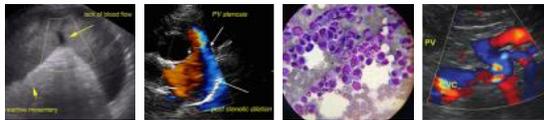
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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