PATIENT

Oreo Nimmers

SPECIES

Canine

BREED

Cocker Spaniel

SEX

Spayed Female

AGE

6 years

WEIGHT

21.6 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Sarah Pender, CVT

HOSPITAL NAME

SVS Imaging QC

REFERRING VET

Dr. Narske

INVOICE

12148

DATE

9/1/21

PRESENTING CLINICAL SIGNS

P presented with vomiting food and runny diarrhea. Decreased appetite. Lethargic.
Abnormal PE/Chem/CBC/UA Results: tacky membranes, CRT prolonged. moderate tartar, doughy, intestinal loops prominent, mild discomfort, Low: crea, ca, tp, alb, glob, alkp, chol Elevated: retic, neu, mono, mpv, pct Abdominocentesis at time of ultrasound: Colorless, cloudy, SpGr 1.010, WBC 43/hpf, RBC 2/hpf, no bacteria

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder exhibited subnormal size yet normal tone. Mild dependent to non-dependent mineral was present in primarily anechoic urine. The urethra exhibited normal thickness and tone to a depth of 3.0 cm.

The area of the aortic trifurcation was free of pathology.

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 5.0 cm in length. The right kidney measured 5.7 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 2.2 cm length x 0.49 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 2.3 cm length x 0.49 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.

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 thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact yet subjective prominent wall layering. The stomach appeared to be mildly distended with luminal gas, without evidence of retained ingesta, fluid, or overt foreign material. The gastric body wall width measured 0.30 cm.

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The small intestine exhibited intact wall layering with a generalized propensity for prominent to hypoechoic mucosa along with generalized subtle mucosal fogging. Segmental jejunal nonobstructive ileus pattern was present without evidence of mechanical obstruction, foreign material, or loss of intestinal wall layering. The duodenum wall width measured 0.45 cm. The jejunum wall width measured 0.37 cm.

Normal visible colon wall layers were present with segmental non-formed to liquid feces, consistent with diarrhea and luminal gas.

Pancreas

The pancreas was mildly prominent In size with mildly swollen contour and heterogeneous parenchyma.

Free Abdomen

Generalized reactive mesentery and mild subjectively acellular peritoneal free fluid were present. Likely, intermittent, mild omental lymphadenopathy was present, yet no overt evidence of significant omental lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Enteropathy with segmental nonobstructive ileus pattern and subtle mucosal fogging
- Pancreatic edema, possible concurrent mild pancreatitis
- Mild urinary bladder mineral
- Generalized reactive mesentery and mild peritoneal free fluid

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

In light of the panhyperproteinemia and without evidence of hepatic pathology, presence of gastrointestinal signs, and assuming no evidence of proteinuria, intestinal protein loss consistent with protein-losing enteropathy is probable. Considerations may Include IBD, lymphangiectasia, or infiltrative enteropathy i.e., neoplasia, less likely fungal, or other enteropathy. Intestinal biopsies are required for a definitive diagnosis yet likely contraindicated if albumin levels are less than 2.0.

Urine culture and sensitivity on a sterile urine sample may be considered. Empirically, some or all of the following protocol would be appropriate.

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.

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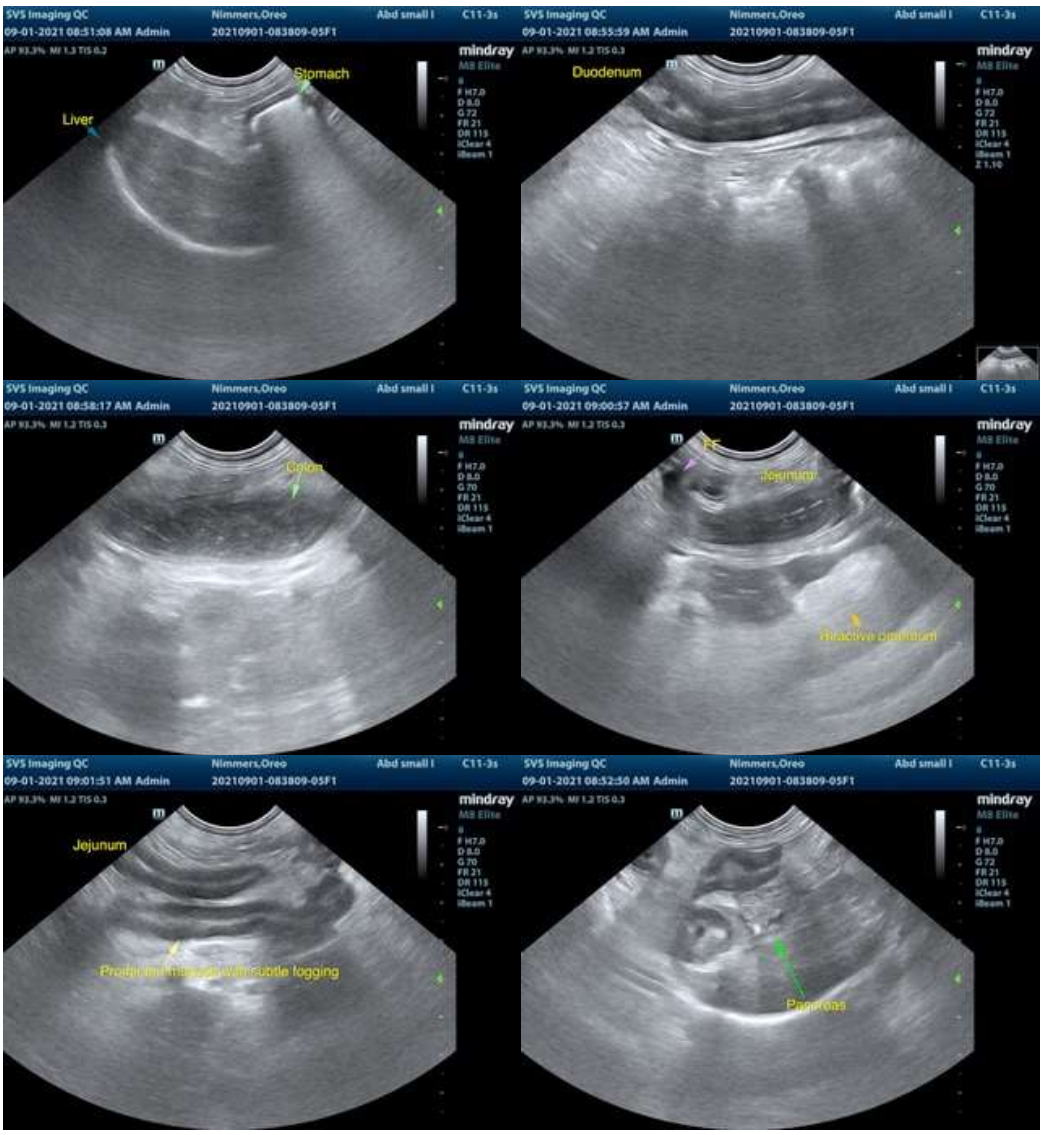
Metronidazole (10-20 mg/kg po bid)
Famotidine 1 mg/kg Iv Im po dc Sid /bid
Sucralfate 0.5-1 g po tid dogs, 0.5 g bid cats in slurry **Or Misoprostol** 1-5 ug/kg po tid
Diet: Highly digestible high quality protein, low fiber, low fat diet (< 15% of dry matter). Hydrolyzed protein or novel protein. Purina 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.



IMAGING PERFORMED BY

SVS IMAGING

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EDUCATIONAL TELECONSULTATION SERVICES™
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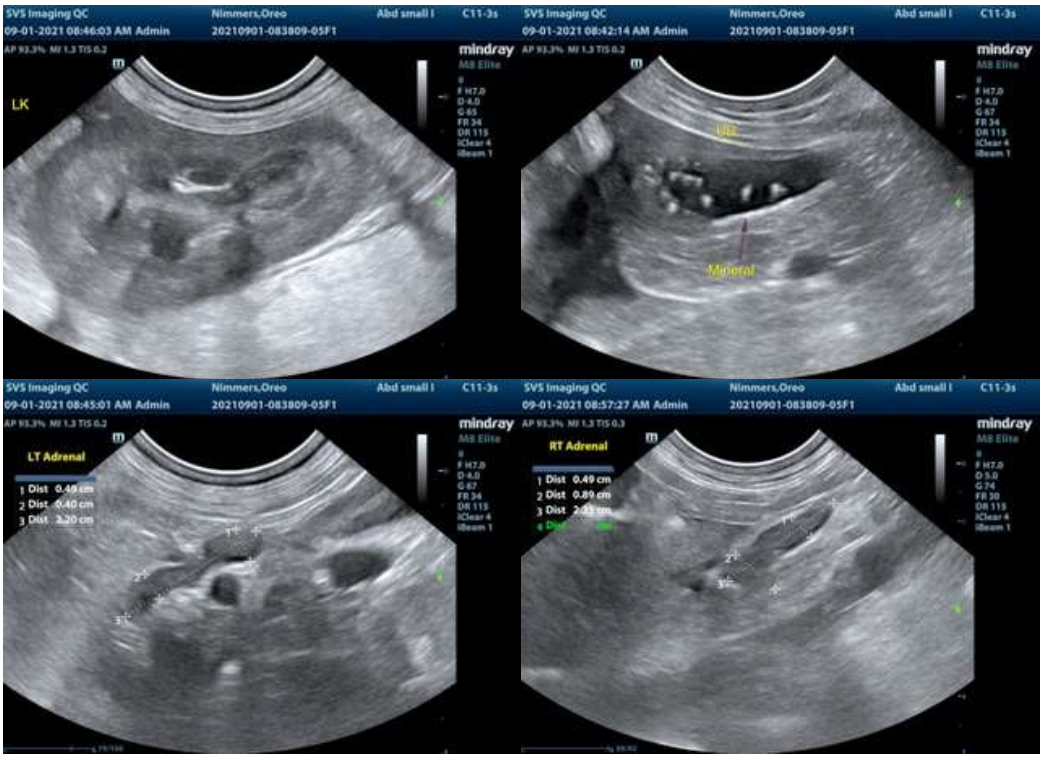

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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