



PATIENT

Soda Spot Wyke

SPECIES

Canine

BREED

Pug

SEX

Spayed Female

AGE

11.5 Years

WEIGHT

5.2 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Patti Mayfield, DVM
Smiling Dog VS

HOSPITAL NAME

Bend Animal
Emergency

REFERRING VET

Dr. Adam Stone

INVOICE

25341

DATE

9/11/21

PRESENTING CLINICAL SIGNS

Patient has been losing weight (unknown duration) History of bilious vomiting when not fed three times daily Meds: Gabapentin, Galliprant, Metronidazole Patient reportedly fasted prior to US
Abnormal PE/Chem/CBC/UA Results: Weight loss (unknown duration) History of elevated liver values (blood work not provided)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of – 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 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 right kidney measured 4.2 cm. The left kidney measured 4.1 cm.

Adrenal Glands

The adrenal glands were uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.98 cm at the cranial pole and 0.60 cm at the caudal pole. The left adrenal gland measured 0.55 cm at the cranial pole and 0.70 cm 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

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 visualized gastric walls were sonographically unremarkable with intact wall layering and without overt evidence of visualized mural pathology. The lumen of the stomach contained moderate echogenic, nonshadowing ingesta/chyme. No evidence of mechanical pyloric outflow obstruction or foreign material. Gastric body wall measured 0.26 cm.

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. Duodenum wall measured 0.37 cm. Jejunum wall measured 0.34 cm.

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



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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.

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ULTRASONOGRAPHIC FINDINGS

- Sonographically unremarkable gastrointestinal tract with retained gastric ingesta/chyme

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The presence of gastric ingesta is nonspecific and likely indicates post-prandial presentation. Correlation with most recent meal ingestion is recommended. If documented NPO prior to the ultrasound, the presence of gastric ingesta may indicate some degree of gastric hypomotility or metabolic stasis. The sonographic presentation of the ingesta was most consistent with food, without evidence of foreign material.

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Low-grade or chronic pancreatitis (which may present as sonographically normal) may be possible, yet considered unlikely. Concurrently, underlying gastroenteropathy without evidence of mural changes may be considered in this case given the patient's weight loss.

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If not done, full CBC/Chem panel, T4 and urinalysis recommended to assess for underlying metabolic disease. Radiographic monitoring for evidence of gastric emptying is recommended. A GI panel to include PLI/TLI/Cobalamin/Folate as well as three view chest radiographs and neurological examination are recommended to assess for or rule out occult disease which may cause weight loss. Although considered unlikely given the normal sonographic appearance of the bilateral adrenal glands, resting cortisol may be considered to rule out occult Addison's disease. Some or all of the following protocol may be considered empirically.

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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.

IMAGING PERFORMED BY

Patti Mayfield, DVM Smiling Dog VS

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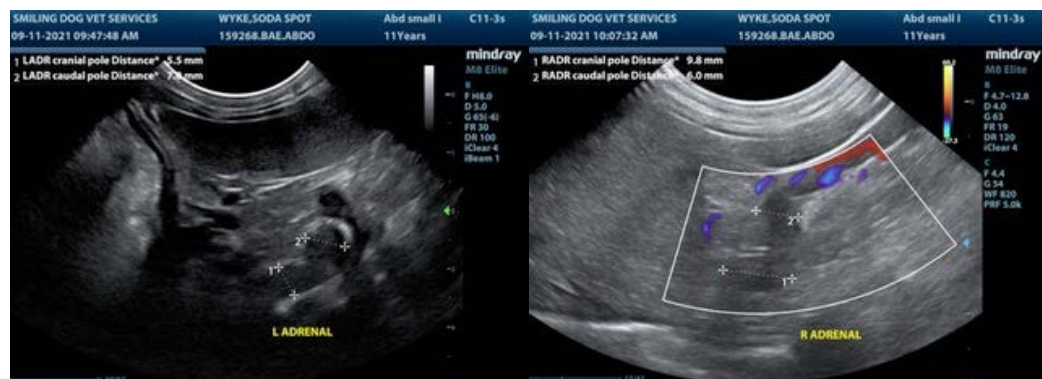
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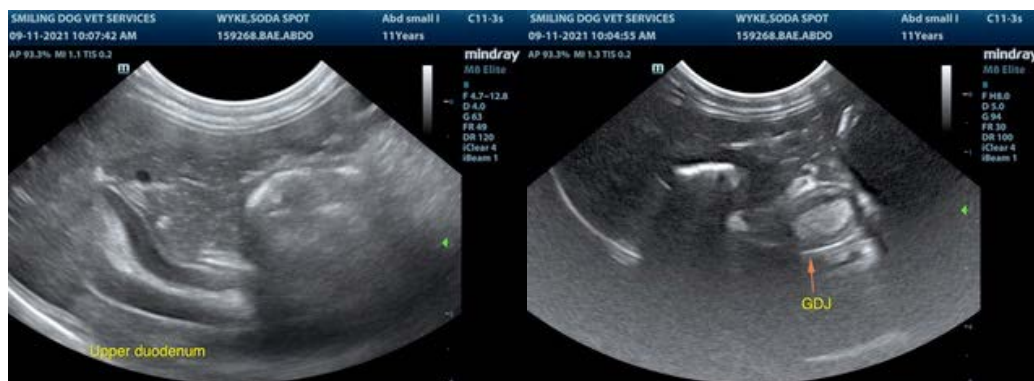
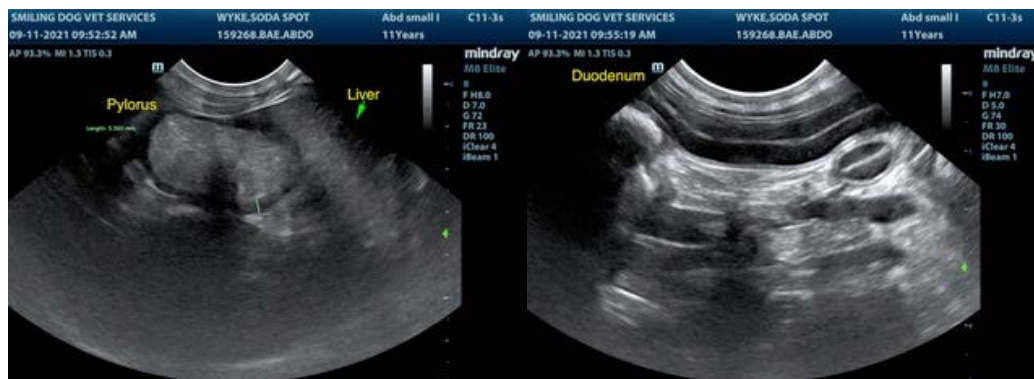
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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Canine

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

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