



PATIENT

Millie Elmo

PRESENTING CLINICAL SIGNS

vomiting post prandial, blood hx of IBD

SPECIES

Canine

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 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 were noted.

BREED

Poodle X

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 loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 4.2 cm. The right kidney measured 4.2 cm.

SEX

Spayed Female

The area of the aortic trifurcation was free of pathology.

AGE

11 Years

Adrenal Glands

The adrenal glands were uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.35 cm at the cranial pole and 0.35 cm at the caudal pole. The right adrenal gland measured 0.75 cm at the cranial pole and 0.59 cm at the caudal pole.

WEIGHT

11.8

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.

INTERPRETED BY

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

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 mild, echogenic, nonmineralized biliary sludge. The gallbladder debris is likely incidental and may potentially be owing to decreased food intake or fasting, or indicative of mild non-clinical cholestasis. The cystic duct and common bile ducts were normal without evidence of dilation.

IMAGING PERFORMED BY

Jenn

HOSPITAL NAME

Rockaway AH

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material. Mild luminal gas was present. Pylorus wall measured 0.42 cm.

REFERRING VET

Dr. Maniar

The small intestine presented intact wall layering with subjective propensity for segmental to generalized prominent mucosa layer along with segmental mild mucosal fogging. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material. Jejunum wall measured 0.35 cm. Duodenum wall measured 0.37 cm.

INVOICE

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

DATE

9/30/21



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Pancreas

Millie Elmo

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

SPECIES

Free Abdomen

Canine

No overt lymphadenopathy or peritoneal effusion was present.

BREED

PRIMARY FINDINGS

Poodle X

- Subjective segmental to generalized mild prominent small bowel mucosa with subtle mucosal fogging – consistent with probable IBD.

SEX

- Sonographically unremarkable stomach

Spayed Female

- Mild heterogeneous pancreas – non-specific, age related changes, minor remodeling owing to previous inflammation, or low-grade to chronic inflammation possible.

AGE

SECONDARY FINDINGS

11 Years

- Mild gallbladder debris – incidental.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

WEIGHT

Potential for low-grade to chronic pancreatic inflammation would be suspected if evidence of cranial abdominal or subxiphoid discomfort on palpation. Correlation with spec cPL may be considered.

11.8

No overt evidence of gastric or gastrointestinal ulceration. In addition to current therapy for IBD, some or all of the following protocol may be considered. 3-view chest radiographs suggested to rule out occult thoracic or esophageal pathology as a potential cause of the vomiting.

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Helicobacter/Gastritis protocol

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(Canine and Feline)

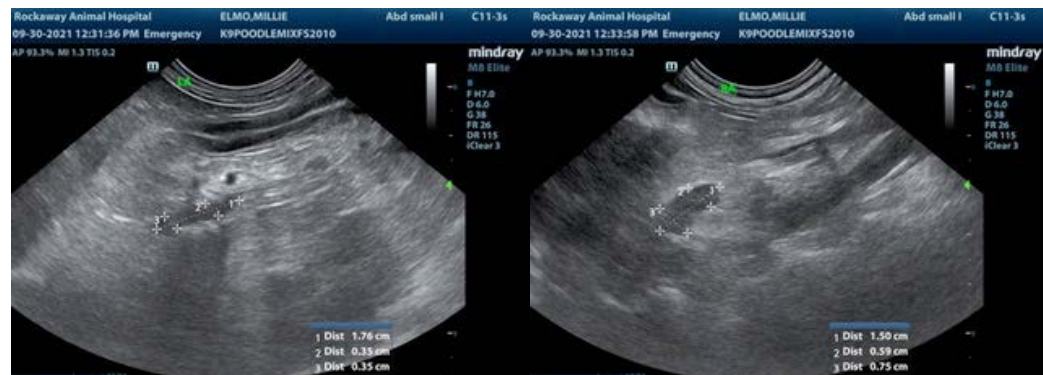
A clinical trial of **Zithromax** (Dogs: 5-10 mg/kg p.o. q24h. May increase dosing interval to q48h after 3-5 days of treatment), **Metronidazole** (10-20 mg/kg p.o. b.i.d.), **Pepcid** (0.5-1 mg/kg s.i.d.) and **Sucralfate** (0.5-2 g/dog PO) or **Omeprazole** (1 mg/kg p.o. s.i.d.) over the next 3 weeks 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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Poodle X

SEX

Spayed Female

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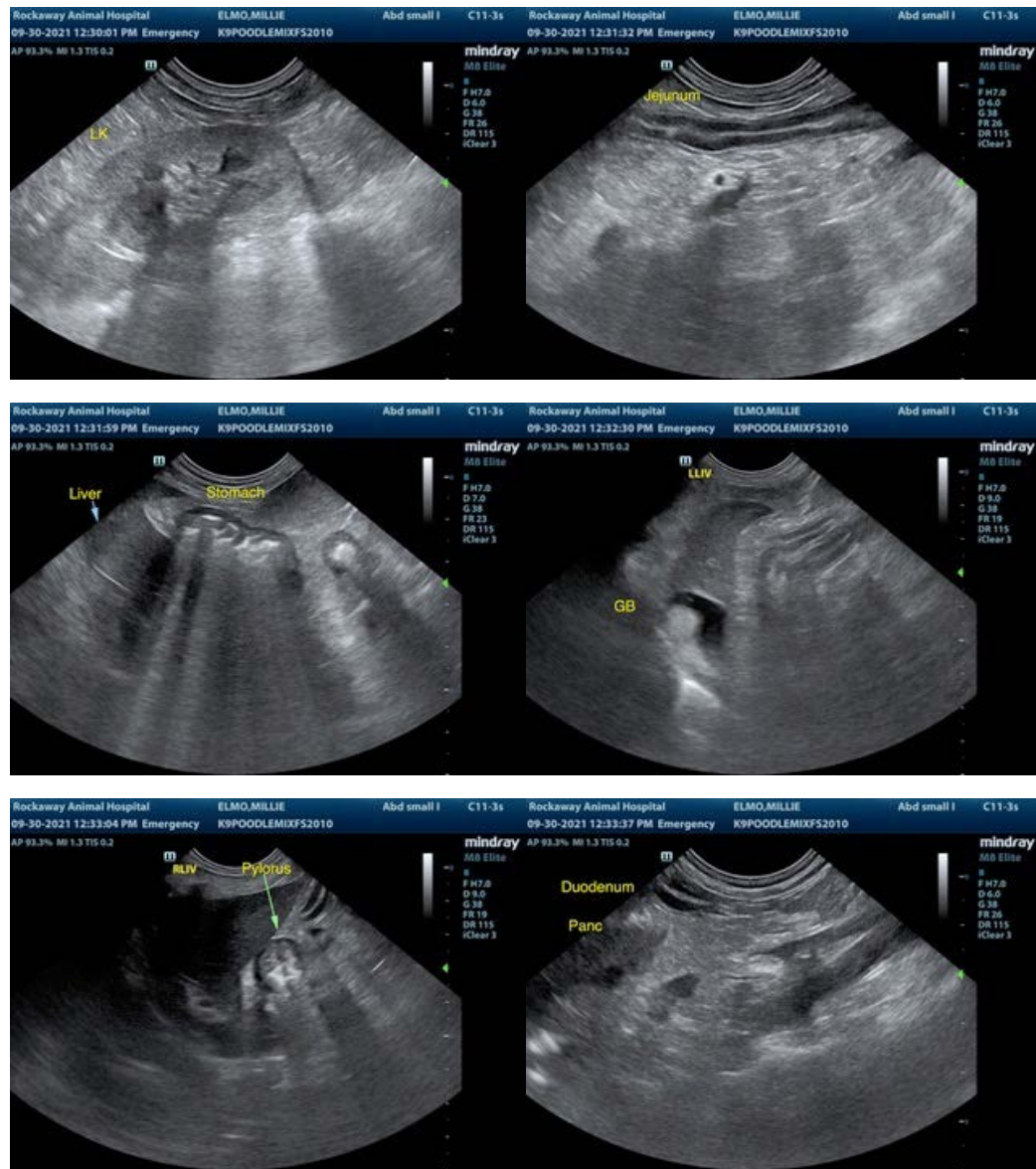
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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