
PATIENT PRESENTING CLINICAL SIGNS

Samson Heyes

SPECIES

Canine

BREED

Golden Cross Poodle

SEX

Neutered male

AGE

9 years

WEIGHT

44.5 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Kelly Reshny, RVT

HOSPITAL NAME

 Niagara Vet
 Emergency Clinic

REFERRING VET

Dr. Lawton

INVOICE

94297

DATE

12/6/21

History: vomited once on Friday, seizure at home on Saturday, no further episodes since or prior Anorexia 4 days duration prior to presentation, no PUPD noted at home. panting a bit more than usual
 PHYSICAL EXAM Q, BCS 7/9, MCS 3/3, FAS 0/5 T 40.5, HR 120, RR 30 to panting, MM pink/m1 tacky, CRT ~2s, Hydration 5-7% deh2o LNs - all peripheral LNs within normal limits Ears: m1 hair AU, m1 dark wax AD Eyes: clear corneas bilaterally, normal PLR and menace, m1 scleral hyperemia Oral Cavity: mi gingival hyperplasia CV: no murmur or arrhythmia; normal heart sounds, no pulse deficits, femoral pulses okay Resp: good air movement in all quadrants, no crackles or wheezes Abdominal palpation: m1 doughy and m1 tense, no obvious organomegaly noted Rectal: NE MMSK: Full ortho exam was not performed but no lameness or other obvious abnormalities were noted. Integument: a few sq masses noted, largest is caudoventral thorax ~5cm diameter Urogenital: distended u-bladder Neuro: detailed neuro exam was not performed but no ataxia or proprioceptive deficits were noted. Pain Score (0-5): 1 site/source: abd. Ampicillin, melatonin, dexamethasone, pantoprazole, cerenia and buprenorphine
 Abnormal PE/Chem/CBC/UA Results: Main finding of concern - thrombocytopenia confirmed on manual smear Waiting on Leptospirosis PCR, was lepto witness NEGATIVE 4Dx Negative Please see attached radiographs.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN
Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 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.

The residual prostate was symmetrically normal in size with uniform parenchyma and slight coarse echotexture.

The aortic trifurcation was normal.

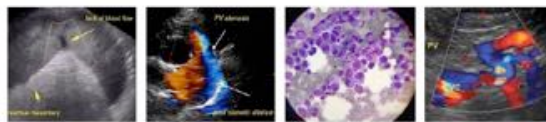
Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney revealed a solitary cortical cyst. The right kidney measured 7.6 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 2.9 cm length x 0.75 cm width at the caudal pole. The right adrenal gland was indistinctly visualized owing to the patient's size and body condition, yet no overt pathology was noted. The right adrenal gland subjectively measured 2.4 x 0.69 cm at the caudal pole.

Spleen

The spleen exhibited primarily finely textured parenchyma, which was hyperechoic to the liver and renal cortical parenchyma. Mild generalized parenchyma heterogeneity was present without evidence of nodular changes. 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. There were



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no overt splenic masses, nodules or obvious neoplastic criteria. The parenchymal heterogeneity is likely consistent with benign changes such as extramedullary hematopoiesis or age related remodeling with minor potential for inflammatory or neoplastic disease.

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Liver

The liver presented enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature was normal in appearance without signs of congestion. The gallbladder was non-distended in size with primarily anechoic luminal content. The cystic and common bile ducts were normal.

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Gastrointestinal

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The stomach presented wall thickening secondary to echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. The gastric body wall measured 0.52 cm width. Mild gastric distension with mild to moderate anechoic fluid was present.

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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 apparent formed feces in lumen.

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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 was evident.

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Free Abdomen

No omental masses, lymphadenopathy or peritoneal effusion was noted.

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ULTRASONOGRAPHIC FINDINGS

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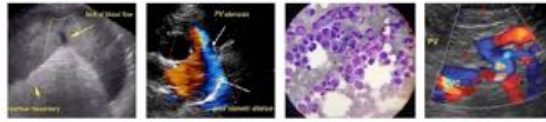
- Mild gastritis pattern exhibiting mild, metabolic gastric stasis.
- Hepatomegaly- subjectively benign.
- Sonographically unremarkable spleen.
- Age related kidneys with left renal cortical cyst.

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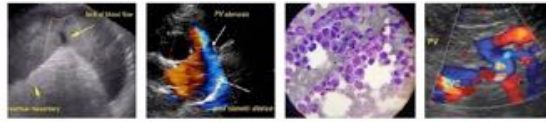
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the lack of reported hepatic enzyme elevations the hepatomegaly was non-specific, yet not overtly consistent with neoplastic criteria. Metabolic/vacuolar/reactive hepatopathy, non-specific inflammation (immune mediated, infectious, etc.) is possible. FNA of the liver is recommended using a 25-gauge needle is to be considered for screening cytology. Continued gastrointestinal support and medical therapy for gastritis is recommended. Overall an obvious cause of the thrombocytopenia was not definitively evident. Expanded infectious disease serology and CBC pathology review can be considered. If persistent anorexia or vomiting then as needed gastrointestinal support and/or some or all of the following protocol can 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.), Sucralfate (0.5-2 g/dog PO) and 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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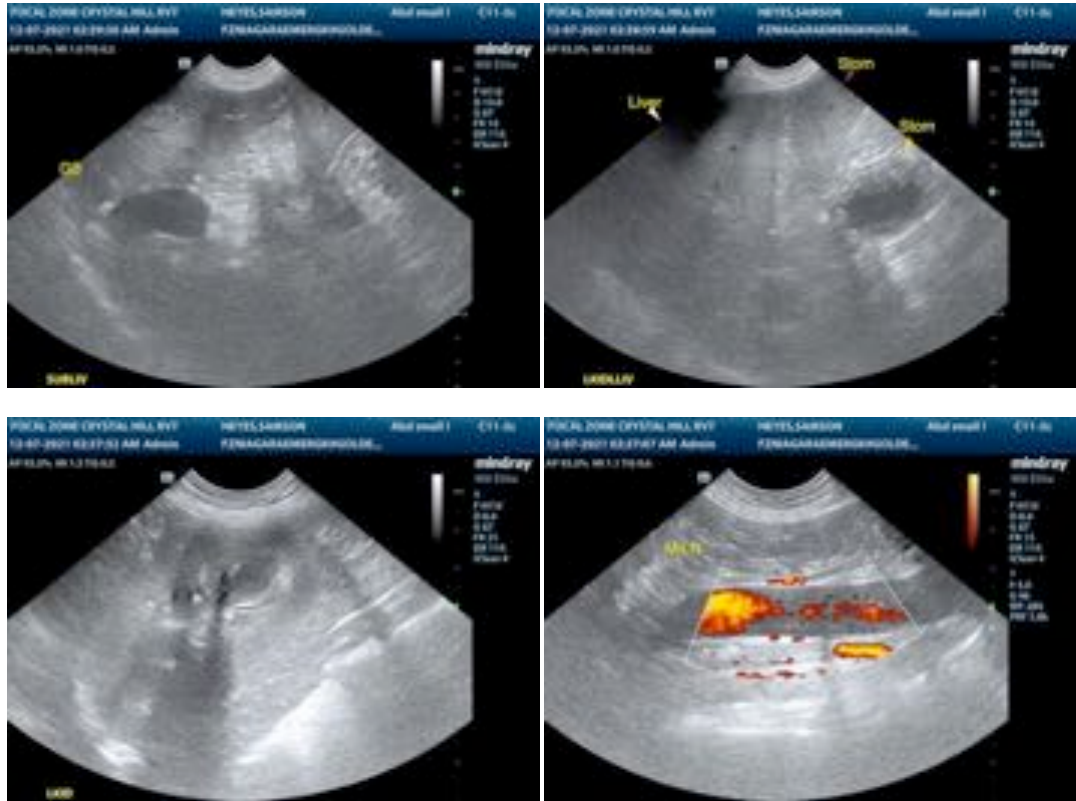
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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