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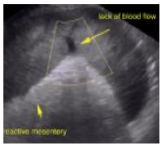
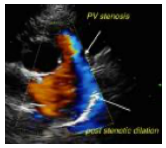
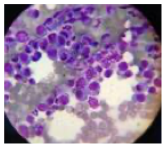
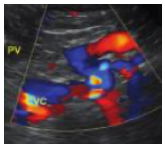

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1-800-838-4268 info@sonopath.com

PATIENT
Lux Kaye

SPECIES
Canine

BREED
Aussie

SEX
Neutered Male

AGE
7 years

WEIGHT
15.45

INTERPRETED BY
Tam Mengine, DVM, DABVP (canine/feline practice)

IMAGING PERFORMED BY
Dr. Laura de Cordone

HOSPITAL NAME
Mason Dixon Animal EH

REFERRING VET
Dr. Laura de Cordon

INVOICE
12910

DATE
4.30.23

PRESENTING CLINICAL SIGNS

History: Was seen at MDAEH in March for a Lyme flare up. Sent home doxy, v+ during those 30 days, mom did not stop meds. Took to rDVM for a recheck, nsf. Doxycycline finished about 2 weeks ago. Changed food to royal canine sensitive stomach. Since changed food, P has not been wanting to eat, v+ white foam. Mom states that since being on the doxy, P has been more clumsy. O thinks P is losing weight. This week, P has been very lethargic, not himself. Walking with a hunched back. Loose stool in the last 24hrs. Transitioned to new food on Wednesday.

Abnormal PE/Chem/CBC/UA Results:
CBC: Mild neutrophilia
CHEM12/LYTES: mild hypocalcemia, moderate hypoalbuminemia, moderate hypoglobulinemia
Cortisol 2.3
PCV 50 TS 5.0
Recheck PCV 42% TS 4.0
Recheck albumin: 1.9 (was 2.0)
Cortisol: 2.3 normal

Urinalysis:
Trace protein
RBCS (occ- from cysto)
USG 1.048
No evidence of bacteria

Radiographs
Thorax: unremarkable
Abdomen: gastric wall thickening, stomach is fluid filled, colon is very large and distended with soft stool

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System
The urinary bladder is moderately distended with anechoic urine, and no luminal sediment is present. The ureteral papillae, trigone and pelvic urethra are of normal appearance, and the ureters are not visible (normal). No masses, calculi or mucosal irregularities are noted. Urethra visualized to 1.0 cm.

The prostate is not seen, presumably due to an intrapelvic location.

The kidneys are of normal size and shape and exhibit appropriate corticomedullary differentiation with a normal 1:3 cortex to medulla ratio. There is no evidence of nephrolithiasis, mineralization, pyelectasia, cystic change or hydronephrosis. The proximal ureter is not visible (normal). The left kidney is 4.0 cm in length. The right kidney is 4.9 cm in length.

Adrenal Glands
The adrenal glands are not distinctly visualized, but the regions appear unremarkable.

Spleen
The spleen is of appropriate size and has a normal, homogenous parenchyma with a smooth, continuous capsular surface. The splenic vasculature is normal with no evidence of congestion or thrombosis, and blood flow through the splenic hilus appears normal.

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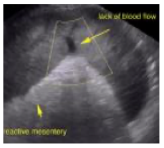
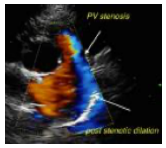
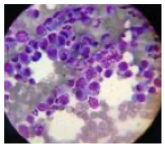
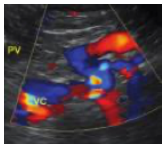

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Liver

The liver is of appropriate size and shape, with sharp borders and a mildly coarse parenchymal echotexture that is hypoechoic to the spleen. The portal and hepatic vasculature are of normal size and appearance with no evidence of congestion or thrombosis.

The gallbladder is moderately distended with anechoic contents and a small amount of freely-moveable echogenic sludge. The wall was thin and continuous with no focal lesions. The cystic and common bile ducts are normal / not visible.

Gastrointestinal

The stomach is moderately distended with hypoechoic fluid and ingesta. The gastric wall is 6.1 mm with normal deviations due to rugal folds and exhibits appropriate wall layering, with the exception of a focal areas or the fundus (which measures 8.8 mm) with loss of normal layering. The pylorus is of normal appearance.

The visualized portions of the duodenum, jejunum, and ileum are of normal thickness with intact wall layering that exhibits the appropriate 1:3 muscularis to mucosa ratio. There are diffuse mucosal striations throughout the small intestines. The duodenum is diffusely corrugated. The duodenal wall measures 4.2 mm. The jejunal wall measures up to 4.6 mm. Intestinal motility appears adequate.

The visible portions of the colon are of normal thickness, up to 1.6 mm, with intact wall layering. The ileocecal junction is visualized and appears normal.

Pancreas

The areas of the limbs and body of the pancreas are isoechoic to the surrounding mesenteric fat, with normal capsular appearance. There is no evidence of peripancreatic inflammation. The pancreatic duct appears normal.

Free Abdomen

There is no evidence of free fluid within the peritoneal cavity. The mesenteric lymph nodes were mildly enlarged, up to 1.5 cm, with normal short to long axis ratio and appropriate echogenicity. The aortic trifurcation has normal blood flow with no evidence of thrombosis.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Mucosal striations within the small intestine, typical of lymphangiectasia
- Fluid- and ingesta-filled stomach, which should be correlated with fasting history. If the patient was fasted, then this may indicate delayed gastric emptying.

Secondary Findings

- Focal area of thickened gastric wall with decreased layering.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes in the small intestines, along with the history of panhypoproteinemia are consistent with a protein-losing enteropathy. While there are no definitive neoplastic criteria on today's ultrasound, the small abnormal area within the wall of the stomach could indicate a neoplastic change but may also be secondary to gastritis. Gastric and intestinal biopsies would be necessary for definitive diagnosis. Additional recommendations include:

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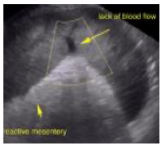
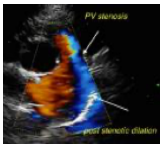
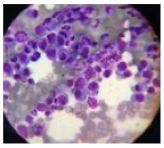
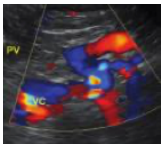

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- Fecal parasite testing and empiric fenbendazole treatment
- Trials with an ultra-low-fat diet. Some patients may require a hydrolyzed diet, if not responding to initial therapy.
- A complete GI panel, or empiric cobalamin supplementation
- Empiric therapy with prednisolone at 2-4mg /kg initial dose should be instituted if biopsies are not pursued.
- Clopidogrel at 1-2mg/kg once daily if albumin levels are <2.0
- Plasma or colloid therapy if clinically significant pleural effusion is present.








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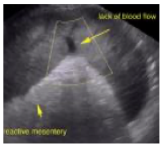
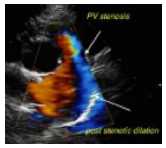
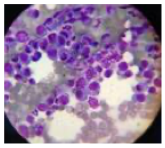
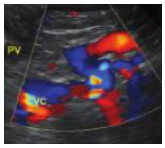

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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