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Clinical Sonography & Telecytology
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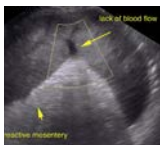
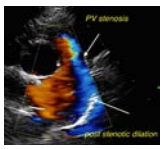
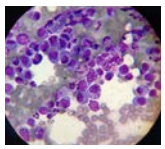
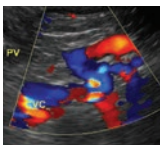





SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Brady Creighton

SPECIES

Canine

BREED

Shih-Poo

SEX

Neutered Male

AGE

14.5 Years

WEIGHT

14 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Tam Mengine

HOSPITAL NAME

Stoney Creek VH

REFERRING VET

Dr. Tam Mengine

INVOICE

39439

DATE

7/12/22

PRESENTING CLINICAL SIGNS

One month history of vomiting several times a week, regurgitating and having intermittent soft stools. CBC / Chem - Cl- low (100), Na+ low normal, ALP 333. U/A - unremarkable, SpGr 1.024. Thoracic rads unremarkable. No response to empiric ondansetron, famotidine and metronidazole

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is 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.

The prostate is of appropriate size for patient age and neutering status, with a homogenous parenchyma and smooth capsule. The prostatic urethra is non-dilated with normal margins).

The kidneys are hyperechoic, and exhibit mildly decreased cortico-medullary differentiation. There is no evidence of nephrolithiasis, mineralization, pyelectasia or hydronephrosis. The proximal ureter is not visible (normal). The left kidney meaursed 3.4 cm. The right kidney measured 4.1 cm.

Adrenal Glands

The adrenal glands are both identified in their normal locations. They are normal in size and shape with appropriate parenchymal echogenicity and normal phrenic vasculature. The left adrenal gland measured 4.9 mm at the cranial pole and 6.9 mm at the caudal pole. The right adrenal gland measured 3.5 mm at the cranial pole and 4.4 mm at the caudal pole.

Spleen

The spleen is of appropriate size and has a normal, homogenous parenchyma with a smooth, continuous capsular surface. A small hyperechoic nodule is present, consistent with a benign myelolipoma. The splenic vasculature is normal with no evidence of congestion or thrombosis, and blood flow through the splenic hilus appears normal.

Liver

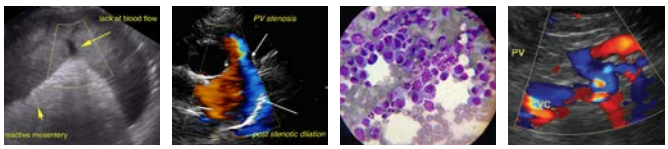
The liver is diffusely hyperechoic and subjectively enlarged. The portal and hepatic vasculature are of normal size and appearance with no evidence of congestion or thrombosis.

The gallbladder is distended with anechoic contents. A moderate amount of dependent echogenic sludge is noted. The wall was thin and continuous with no focal lesions. The cystic and common bile ducts are normal / not visible.

Gastrointestinal

The stomach is markedly distended with fluid contents. The pyloric wall is mildly thickened at 2.6 mm. The reset of the wall is within normal limits and has normal wall layering.

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. The duodenal wall measures 0.46 cm. The jejunal wall measures up to 0.30 cm. . Intestinal motility appears normal.



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The visible portions of the colon are of normal thickness, up to 3.1 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 omentum and intra-abdominal fat are of appropriate echogenicity. Enlarged abdominal lymph nodes are not observed. The aortic trifurcation has normal blood flow with no evidence of thrombosis.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS:

- Fluid distended stomach, consistent with gastritis

SECONDARY FINDINGS:

- Chronic renal changes
- Reactive hepatopathy

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Recommendations for the chronic vomiting include continued aggressive treatment for gastritis with antiemetics, antacids, and gastroprotectants. The addition of a promotility agent such as Metoclopramide should be considered. A GI panel could also be considered. Endoscopic gastric biopsies may be necessary if there is no response to empiric treatment.

The changes in the kidneys are consistent with chronic renal disease. Recommendations include:

- a CBC, chemistry panel, urinalysis, urine protein creatinine ratio and blood pressure measurement are recommended
- urine culture should also be considered, particularly if urine sediment is active
- dietary and supportive care recommendations can be made, based on the staging of the disease as outlined in the IRIS guidelines

Given the minimal elevation in liver values, no additional diagnostics are recommended for the reactive hepatopathy changes, but liver values should be monitored over time.

Consider the following helicobacter protocol and recheck scan in 3 weeks.

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.

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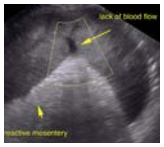
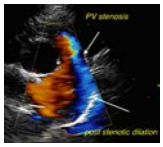
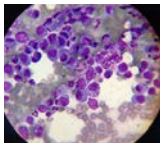
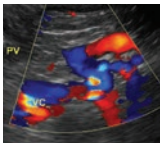

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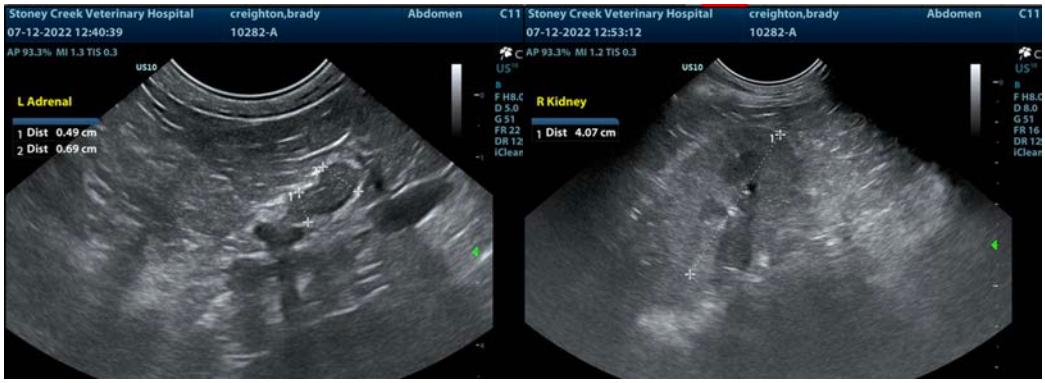

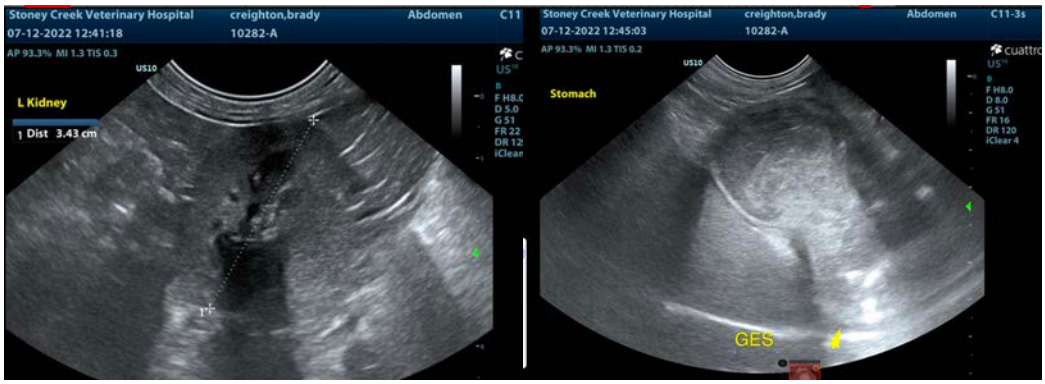

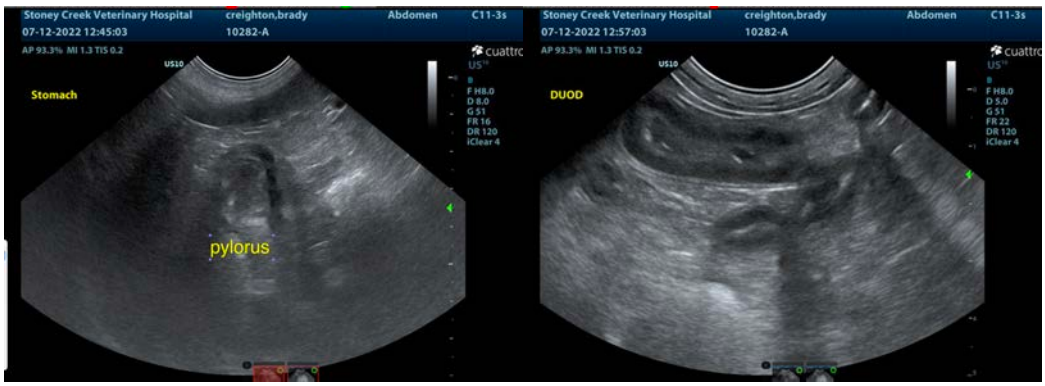

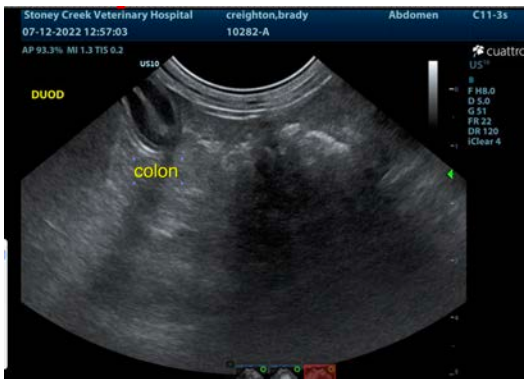

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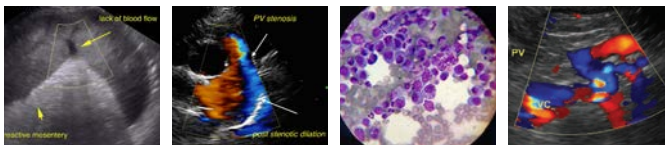

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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