



PATIENT

Rascal DeFiore

SPECIES

Canine

BREED

Bichon

SEX

Neutered Male

AGE

16 Years

WEIGHT

9.8 Pounds

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

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

HOSPITAL NAME

Stoney Creek VH

REFERRING VET

Mandy Becker, DVM

INVOICE

17210

DATE

9/8/22

PRESENTING CLINICAL SIGNS

History: Several weeks of poor appetite, diarrhea, weight loss and occasional vomiting. CBC / Chem unremarkable except mild azotemia (BUN 44, Creat 1.8), urinalysis pending

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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

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 right kidney is hyperechoic and exhibits poor cortico-medullary differentiation. There is no evidence of nephrolithiasis, mineralization, pyelectasia or hydronephrosis. The proximal ureter is not visible (normal). The right kidney measures 5.2 cm in length.

The left kidney displays a complete loss of normal architecture. There are large stones in the region of the pelvis, but no evidence of ureteral obstruction. The left kidney measures 3.3 cm in length.

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 height is 4.6 mm at the cranial pole and 5.2 mm at the caudal pole. The right adrenal gland height is 5.9 mm at the cranial pole and 4.0 mm at the caudal pole.

Spleen

There are multiple hyperechoic masses within the splenic parenchyma measuring up to 1.0 cm in size, with no visible deviation of the splenic capsule. 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 minimally 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 normal ingesta. The gastric wall is thickened up to 6.5 mm. There is an increased muscularis to mucosal ratio. There is a 1.0 cm in diameter soft tissue mass arising from the mucosal layer in the region of the antrum, and wall layering in this area is not distinct.

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 5.0 mm. The jejunal wall measures up to 4.0 mm. Intestinal motility appears normal.



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The visible portions of the colon have increased thickness, up to 2.4 mm, with intact wall layering. The ileocecal junction is visualized and appears normal.

Pancreas

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The left limb and right limbs of the pancreas are hypoechoic, but of normal size and with no changes to the surrounding mesenteric fat. There is no evidence of peripancreatic inflammation. The pancreatic duct appears normal.

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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.

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ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Gastritis with a small mural mass that may represent either a polyp or neoplasia
- Severe degenerative renal changes bilaterally, with large nephroliths in the left kidney

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Secondary Findings

- Splenic myelolipomas
- Reactive hepatopathy
- Colitis
- Enlargement of the left ureteral papilla

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Endoscopy with biopsy would be necessary to differentiate neoplastic from benign disease in the stomach. In the absence of a biopsy, empiric treatment for gastritis could be performed.

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The changes in the stomach are consistent with chronic gastritis. Recommendations include:

- ❖ Empiric treatment with antiemetics, such as maropitant and ondansetron, and antacid therapy, such as omeprazole or famotadine, and gastroprotectants such as sucralfate.
- ❖ Dietary therapy with either a highly digestible, low fat diet, or a hydrolyzed or novel protein diet is recommended. Feeding frequent small meals is preferred if feasible.
- ❖ Fecal parasite testing and empiric fenbendazole treatment
- ❖ Endoscopic biopsies are recommended for definitive diagnosis, and to determine whether corticosteroid therapy would be indicated.
- ❖ Empiric treatment for helicobacter gastritis could be considered. Repeat ultrasound at the end of therapy can assess response, along with monitoring for resolution of clinical signs. Treatment protocol is as follows, for a duration of 28 days :

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- Azithromycin 5mg/kg PO once daily for 5 days, then every other day thereafter
- Metronidazole 10mg/kg PO BID

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- Amoxicillin 20mg/kg PO BID
- Omeprazole 0.7 - 1 mg/kg q24h

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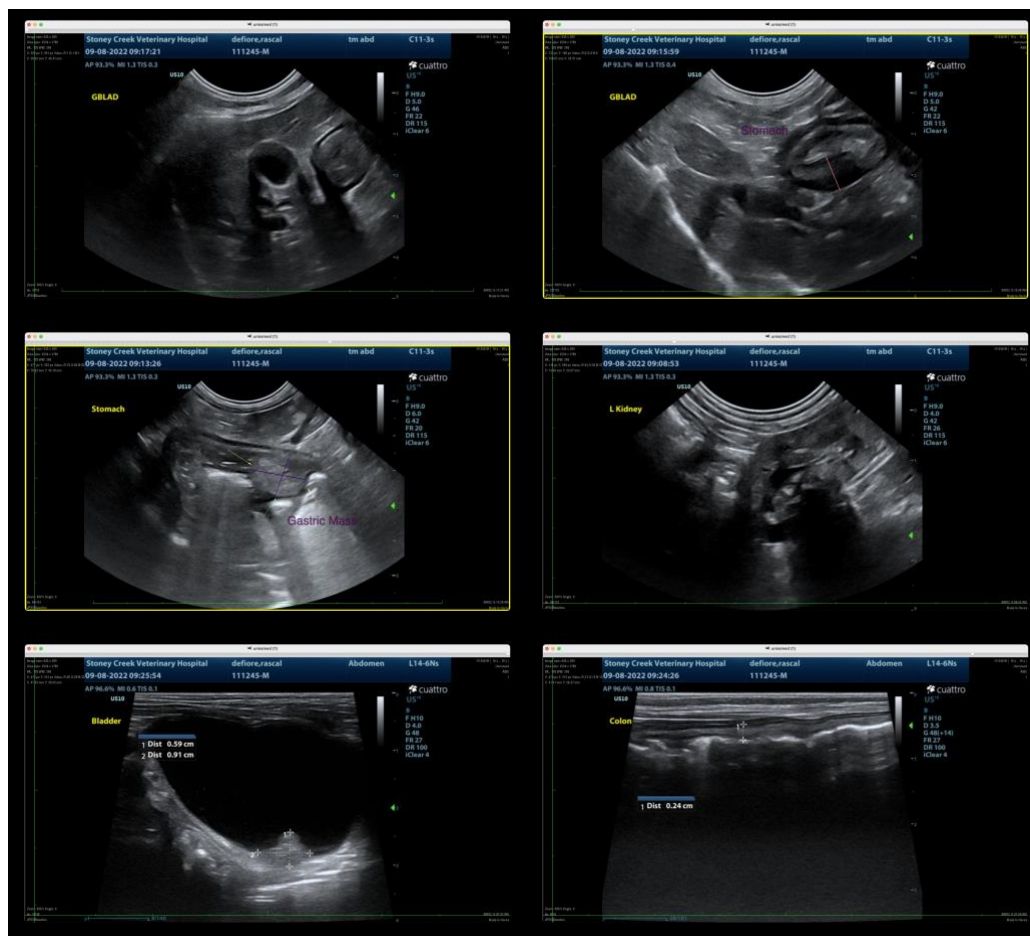
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The changes in the kidneys are consistent with chronic renal disease. Recommendations include:

- ❖ 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

The changes to the ureteral papilla are likely inflammatory secondary to chronically passing nephroliths. However, periodic monitoring should be considered to rule out early neoplastic disease.

If endoscopy is performed, the colon could also be biopsied to rule out neoplastic disease, however, the changes are most typical of benign colitis. Empiric therapy with probiotics, fiber, and perhaps tylosin or metronidazole are recommended.





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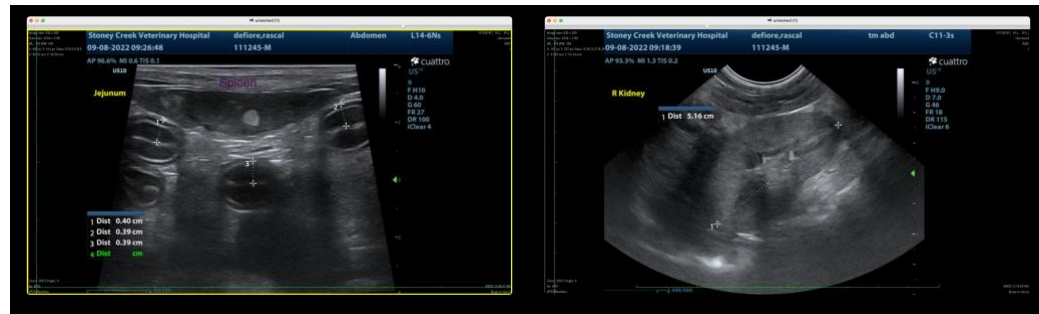
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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