
PATIENT

Charlie Lankin

SPECIES

Canine

BREED

Shetland Sheepdog

SEX

Neutered male

AGE

5 years

WEIGHT

22.7 kg

INTERPRETED BY

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

**IMAGING
 PERFORMED BY**

Crysall Hill

HOSPITAL NAME

Upper Canada AH

REFERRING VET

Dr. Rossi

INVOICE

42978

DATE

2/27/23

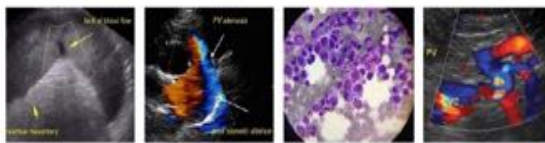
PRESENTING CLINICAL SIGNS

History: His back seemed to flare up recently in the last week or so. Goes to NCCC for this and gets laser. O has started Gabapentin once daily and Metacam once daily for the past 5 days. Has had looser stool for ~ 3-4 days which has progressed to worsening diarrhea, last night was quite mucousy but no blood noted. Then, this morning vomited around 6:30 normal semi-digested kibble appearance. Last night this morning was doing a throat clearing hack/gag/cough as per O but seems okay since vomiting. Has been giving PetLabCo chews for ~ 2-3 months now, and uses proviable probiotic ~ 2-3 times weekly currently. A&P at that appt: PLAN: -Suspected Dx if applicable: Suspect possible indiscretion/colitis - Diagnostic Plans: Fecal antigen for now -Therapeutic Plans: Less suspicious for FB based on history and exam but advised O risks of cerenia without x-ray. Cerenia given Entero-aid sent home (already giving proviable) I told Jacky I'd like her to discontinue metacam and if needed can give gabapentin 2x daily instead of once. Advised O if worsens need to consider diagnostic imaging (xray, ultrasound) Then at NVEC 2/25/2023: Hx: Charlie had some back pain last year, was on Gaba and meloxicam for about 2 weeks. He was fine at this time. He recently went back on pain medication for suspect back pain and then developed diarrhea. o stopped metacam, he went on progut - didn't help. Started metronidazole this past Tuesdays. Diarrhea has started to clear up, small amount noted today but vomiting started this afternoon/ evening. 7x today - vomited up food and bile then clear foam. He proceeded to retching and producing more bile. He's on a gastrointestinal diet. picky eater and o has given him chicken previously to give medications. He doesn't eat FB or chew on things. A&P: A: Vomiting diarrhea improving. decreased appetite. r/o mucocele, hepatitis, pancreatitis, pyelonephritis, neoplasia, other. P: Recommend bloodwork and discussed imaging with abdominal ultrasound vs radiographs. Explained differences between ultrasound and x-rays. O explained that they had talked to their vet about imaging and they may want to proceed with them first. O do consent with bloodwork today. CBC/ Chem17 and lytes. - mild lymphopenia - mildly elevated ALT and increased TBILL although sample was hemolyzed. Possible liver disease/ pancreatitis/ GI inflammation causing this ALT increase Abdominal ultrasound would be the next step for evaluating the vomiting and recent case of diarrhea. O understand. O would like to follow up with primary vet tomorrow to see if they would be able to set up ultrasound as soon as possible. explained sometimes it can't occur on weekend but everywhere different. Recommend cerenia 1 mg/kg SQ if worsening condition have pet reassessed. O understand bloodwork and condition can worsen within a matter of days. Then seen again at NVEC 2/26/2023: Hx: Returned for recheck. Was at rDVM this morning for a recheck a few hours ago. rDVM has booked an ultrasound for Monday (2 days). rDVM dispensed Denosyl and oral Cerenia. Owner gave both of these medications already. Charlie is no longer vomiting but had explosive, watery diarrhea (previously diarrhea had resolved). Eating small amounts of lean ground beef and rice. A&P: ASSESSMENT SECTION NOTES normal physical exam. dog is BAR and running around. no abdominal pain. good hydration PLAN SECTION NOTES Owners are worried that Charlie will become dehydrated. Explained that Charlie is well-hydrated now, typically adult dogs can tolerate some diarrhea without clinical dehydration (has had diarrhea once) Gave subcutaneous PLA 400 ml to compensate for losses. Refilled metronidazole as owners felt it helped initially. Lower dose due to liver concerns. Denosyl 450 mg PO SID due to suspicion of gall bladder disease based on NVEC bloodwork 2/25/2023. Also, Metronidazole refill Rx at NVEC yesterday (Os stated appeared to help after initial Rx by myself and thus was refilled Saturday evening.

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 (3.0) cm.

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,



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cystic change or hydronephrosis. The proximal ureter is not visible (normal). The left kidney is (5.6) cm in length. The right kidney is (5.9) cm in length.

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Adrenal Glands

The left adrenal gland is identified in its normal location. It is of normal size and shape with appropriate parenchymal echogenicity and normal phrenic vasculature. The left adrenal gland height is 7.1 mm at the cranial pole and 4.8 mm at the caudal pole.

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The right adrenal gland is not specifically visualized, but the region appears unremarkable.

SEX

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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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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.

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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.

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Gastrointestinal

The stomach is empty. The gastric wall is normal with deviations due to rugal folds, and exhibits appropriate wall layering. The pylorus is of normal appearance.

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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 (3.7) mm. The jejunal wall measures up to (3.3) mm. Intestinal motility appears normal.

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The visible portions of the colon are of normal thickness, up to (1.7) mm, with intact wall layering. The ileocecal junction is visualized and appears normal.

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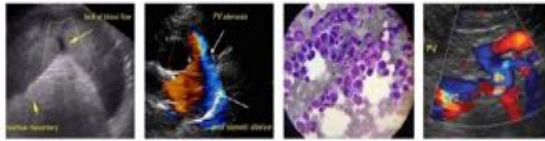
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Pancreas

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.

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Free Abdomen

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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

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PRIMARY FINDINGS:

- Unremarkable canine abdomen.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There are no changes on today's ultrasound to explain the history of vomiting and diarrhea. Given the mildly elevated liver values, pancreatitis is a consideration and does not always appear on ultrasound. Inflammatory bowel disease and a food allergy may also cause similar signs with an unremarkable ultrasound. Additional recommendations include:

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The changes in the gastrointestinal tract are consistent with gastroenteritis of unknown etiology. Recommendations include:

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- ❖ fecal parasite testing and empiric fenbendazole treatment
- ❖ probiotic therapy
- ❖ bland diet
- ❖ treatment with parenteral fluids, antiemetics, antacids and gastroprotectants as clinically indicated.
- ❖ If signs persist, trials with a novel protein or hydrolyzed diet, a resting cortisol level and a GI panel could be considered.

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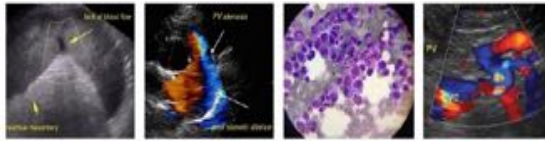
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

info@SonoPath.com