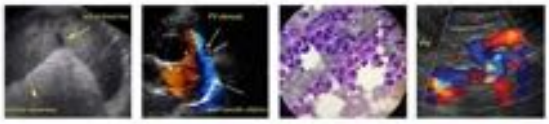


PATIENT

Gus Warren

SPECIES

Canine

BREED

Dachshund

SEX

Male, neutered

AGE

2 Yrs.

WEIGHT

15.9 lbs.

INTERPRETED BY

Andrea Nicastro, DVM, Diplomate ACVIM (*Small Animal Internal Medicine*)

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

Desert Hills AH

REFERRING VET

Dr. Michelle Caldwell

INVOICE

14404

DATE

1/2/2023

PRESENTING CLINICAL SIGNS

History: Intermittent vomiting and bloody diarrhea x 2 weeks duration. P's symptoms have resolved with supportive care, however O is proactive and wants to ensure that P is ok.-On 12/28 - O called and stated that P was doing better but was crying when trying to defecate. Unsure if this was referred back pain, as P was not experiencing vomiting or diarrhea. P again treated symptomatically with cerenia, rimadyl pain injection, entyce, and i/d. Since then, P has been doing well.
Abnormal PE/Chem/CBC/UA Results: 12/23/22: cbc - rbc 9.66 (5.5-8.5), hgb 21.4 (12-18), hct 65.11, cpl 561 (<200 is considered normal), chem - amylase 1277, glu 136 RADS: 12/23/2023
:CONCLUSIONS: The granular material identified within the stomach may be reflective of ingested dependent upon when the patient may have last eaten. The possibility that this may represent foreign material also cannot be excluded. However, no evidence of a gastric outflow obstruction can be seen nor is there indication of an intestinal obstructive pattern. Other differentials for the vomiting and diarrhea could include gastroenteritis (bacterial, viral, parasitic, dietary indiscretion, other) or pancreatitis. RECOMMENDATIONS: Conservative/supportive treatment for gastroenteritis and suspected pancreatitis would be recommended at this time.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder lumen is moderately distended with anechoic urine. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The prostate is normal in size (0.51 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal size (4.48 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

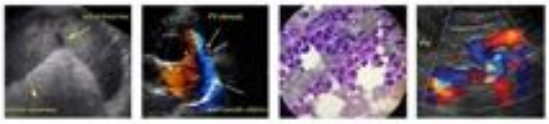
The right kidney is normal size (4.59 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is normal size (0.45 cm at cranial pole) (0.49 cm at caudal pole); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.58 cm at cranial pole) (0.47 cm at caudal pole) (1.96 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen



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The spleen is normal in size (1.20 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed. The gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is mildly fluid distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. No obstructive disease is noted.

Pancreas

The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely isoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Free Abdomen

The peritoneal cavity is normal. There is no evidence of inflammation or effusion. 1-2 prominent mesenteric lymph nodes are visualized, the largest measuring 2.03 cm in length.

Other

A brief echocardiogram reveals no evidence of pericardial effusion or obvious right atrial/auricular mass.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The pancreatic changes in the right limb are suggestive of a prior episode of +/- resolving pancreatitis with parenchymal remodeling +/- fibrosis.

Secondary Findings:

- The lymph node changes are most consistent with reactive lymphadenitis or lymphoid hyperplasia.

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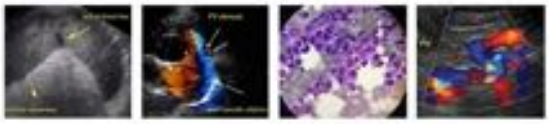

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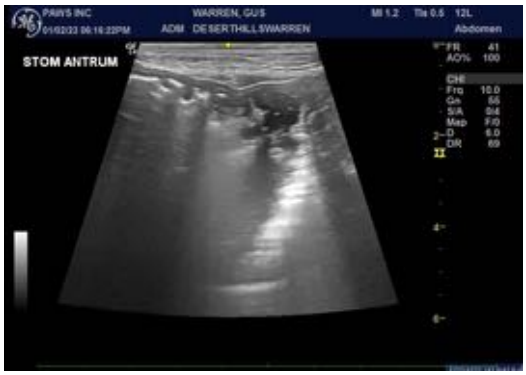
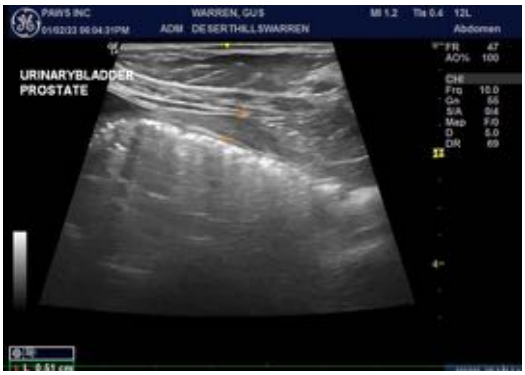
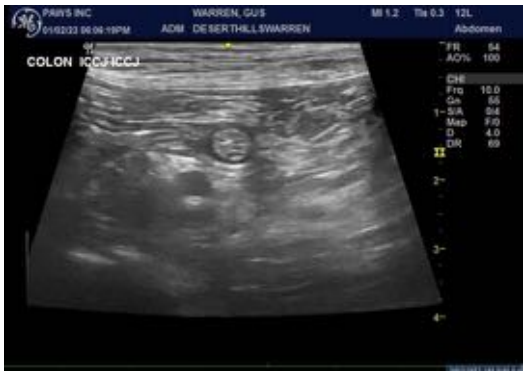
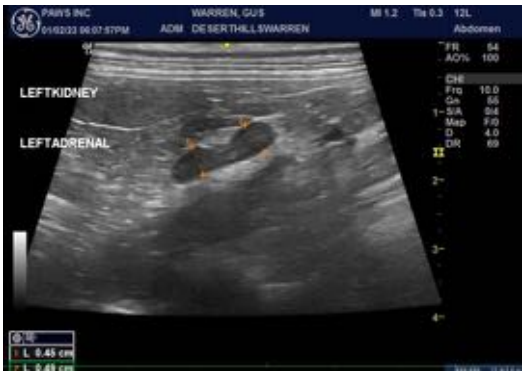
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

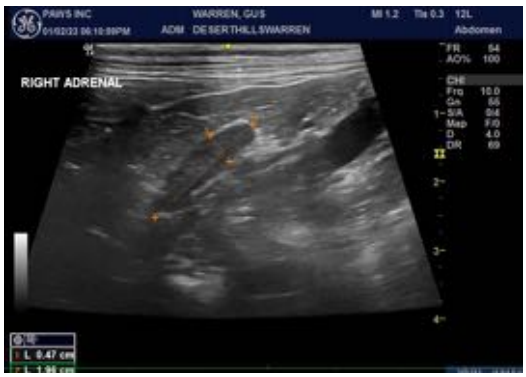
Given the concern for a previous episode of pancreatitis, consider transitioning to a prescription low fat diet for long term maintenance.

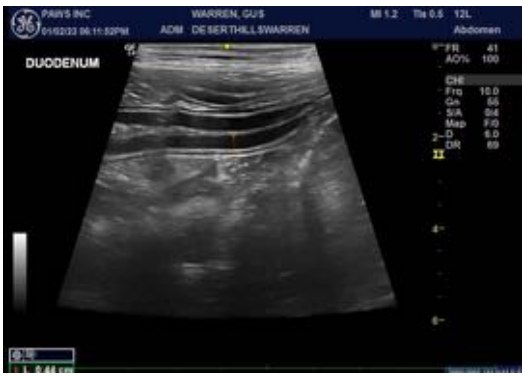












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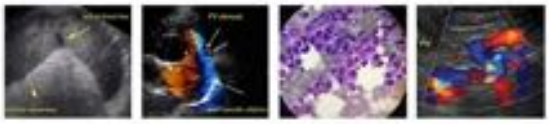

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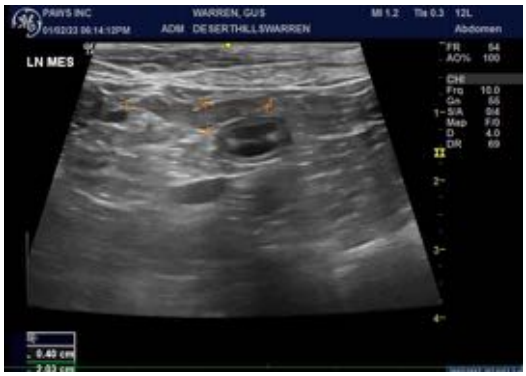

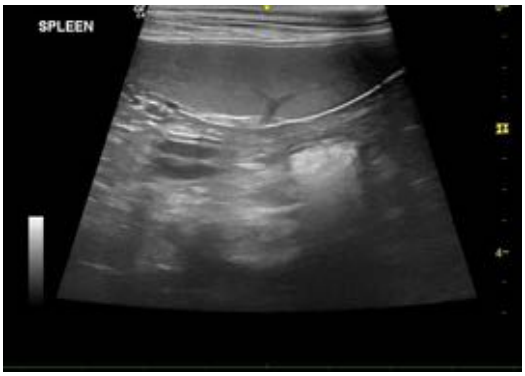

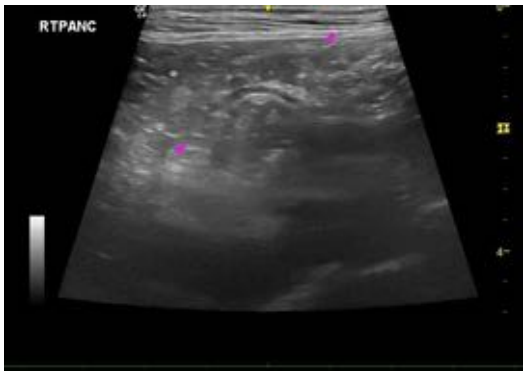

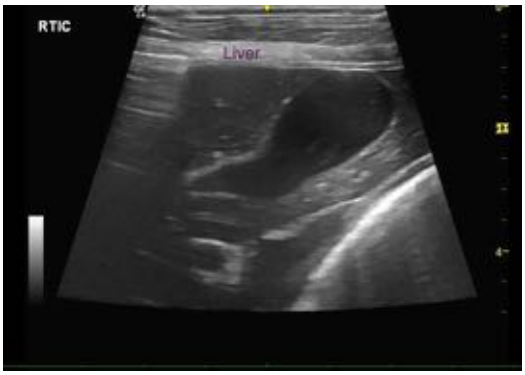

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)

info@SonoPath.com