

**PATIENT**

Sevro Zeitler 54133

**SPECIES**

Canine

**BREED**

Pitbull Terrier Mix

**SEX**

Neutered Male

**AGE**

2 years

**WEIGHT**

21.7 kg

**INTERPRETED BY**

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

**IMAGING  
PERFORMED BY**

Tom McNeill

**HOSPITAL NAME**

SVS Imaging CT

**REFERRING VET**

Madison Vet Spec Dr.  
Calhoun

**INVOICE**

11853

**DATE**

10.20.22

**PRESENTING CLINICAL SIGNS**

History: Sevro presented to the MVS Emergency Service on Oct 19, 2022, at 8:45pm, for evaluation of firm abdomen. starting today Sevro began having a firm abdomen this afternoon and has been dry heaving with no production occasionally. Sevro has been E/D/U/D normally and has otherwise been acting normally. Owner reports that he historically has had some soft stool, but it has fluctuated over time. Patient was hospitalized overnight with IV fluids, Cerenia, methadone PRN, and Gabapentin.

Abnormal PE/Chem/CBC/UA Results: Abdominal radiographs 10/19: Stomach: Distended with heterogenous material within lumen Small bowel: Mixed of gas and ingesta; gas patterns interrupted with intermittent loss of luminal gas; proximal duodenum suspicious for increased soft tissue opacity Large bowel: Mixture of gas and fecal material noted

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The **urinary bladder** 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. The region of the trigone and the visible portion of the proximal urethra are normal.

The **prostate** is normal in size (0.83 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 (5.67 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 (5.59 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 (0.46 cm at cranial pole) (0.46 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 (0.44 cm at cranial pole) (0.50 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.

**Spleen**

The **spleen** is subjectively prominent in size (2.37 cm in width at the level of the hilus) with normal curvilinear peripheral contours. The parenchyma is slightly mottled in appearance. No distinct focal lesions are observed. Splenic vasculature appears normal with no evidence of thrombosis.

**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.

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**Gastrointestinal**

The **gastric lumen** is mildly distended with gas and ingesta. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract appears 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 ileocecolic junction and colonic wall are normal. There is no obvious evidence of an obstructive pattern.

**Pancreas**

The **pancreas** is diffusely visible with normal size and normal curvilinear peripheral contours. The parenchyma is mildly hypoechoic relative to surrounding omental fat. No focal lesions are observed. The pancreatic duct is not overtly dilated.

**Free Abdomen**

There is no evidence of free fluid. The medial iliac **lymph nodes** are visualized (left: 2.25 x 0.58) (right: 2.17 x 0.70 cm). The nodes are normal in shape and echogenicity. Several prominent mesenteric lymph nodes are visualized, the largest measuring 2.46 cm in length. One to two of the nodes are slightly rounded and hypoechoic.

**ULTRASONOGRAPHIC FINDINGS****Primary Findings**

- The abdominal lymphadenopathy could be consistent with lymphoid hyperplasia, reactive lymphadenitis or emerging neoplasia (i.e., lymphoma).
- The splenic parenchymal changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis, splenitis or antigenic stimulation or infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).

**Secondary Findings**

- The pancreatic changes may be a normal variant for this patient or could be consistent with mild, chronic pancreatitis. Correlation with clinical findings is recommended.

\*There is no obvious evidence of a gastrointestinal foreign body/obstruction.

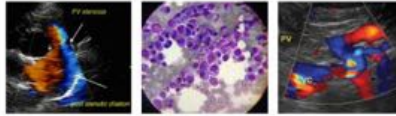
**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

To better assess for round cell neoplasia, consider fine-needle aspirates of the spleen and prominent mesenteric lymph nodes. Also consider a fecal evaluation for ova and Giardia.

While awaiting test results, supportive care for acute gastroenteritis is recommended, including fluid therapy, gastric protectants, antiemetics and pain medication (as needed). Also consider initiation of a probiotic.

Given the history of vomiting, also consider three-view thoracic radiographs to assess for occult aspiration pneumonia.

If the patient's clinical signs do not improve with medical management, a more advanced GI workup may be warranted.



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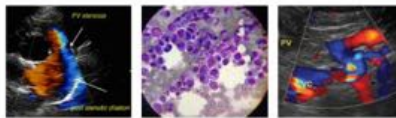
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)**  
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