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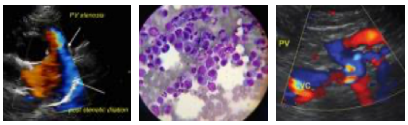

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DATE

10/26/21

PATIENT

Arwin Phillips

SPECIES

Canine

BREED

Labrador Retriever

SEX

Male, neutered

AGE

8/18/2012

WEIGHT

75 lbs.

INTERPRETED BY

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

HOSPITAL NAME

Perry Hall AH

REFERRING VET

Dr. Baer

INVOICE

12427

PRESENTING CLINICAL SIGNS

History: Recurring episode of vomiting and hyporexia on 10/23, no known FB ingestion or dietary indiscretion, episode like this also happened in 06/21. PE: 5% dehydration, abdomen slightly tense on palpation.

Current Medications: 10/25 Unasyn 20mg/kg IV q 12hr, Ondansetron 0.5mg/kg IV q 12 hr, vit b12 1000mcg/ml, 0.15ml SC, Famotidine 0.5mg/kg SC BID.
Lab Results: 10/23 CPL (H) 1267, otherwise chem 27, cbc, T4 wnl.
Radiographs: Not provided by the veterinarian.
Date of Previous IntraPet Ultrasound: No previous IntraPet scans.

Sedation: dexdomitor 0.0075mg/kg IM butorphanol 0.2mg/kg IM

Stat Report: not requested

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are 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 not definitively visualized due to its pelvic location.

The left kidney is normal size (7.04 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. Renal vasculature is normal.

The right kidney is normal size (6.56 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. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.57 cm at cranial pole) (0.57 cm at caudal pole) (2.83 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.

The right adrenal gland is normal size (0.76 cm at cranial pole) (0.76 cm at caudal pole) (3.31 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

The spleen is normal in size (1.75 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 gallbladder is of normal contours and contains some dependent

echogenic debris. The wall is normal in thickness. No choleliths are observed. The cystic and common bile ducts are normal.

Gastrointestinal

The gastric lumen is distended with ingesta and soft shadowing material. The gastric wall is normal in thickness with a normal layering pattern. The small intestinal lumen is segmentally dilated with chyme. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. A portion of the ileal lumen contains hyperechoic shadowing material. The ileocecal colic junction and colonic wall are normal. The colonic lumen contains shadowing fecal material. No obstructive disease is noted. However, a partial obstruction cannot be completely excluded.

Pancreas

A portion of the pancreas is obscured by the gastric distention. In the visualized portion (right limb) the pancreas is prominent in size with slightly irregular peripheral contours. The parenchyma is hyperechoic relative to surrounding omental fat and mottled in appearance. The pancreatic duct is not overtly dilated. There is no evidence of peripancreatic effusion.

Free Abdomen

There is no evidence of free fluid. A few prominent mesenteric and sublumbar lymph nodes are visualized (the largest measuring 1.91 cm in length). Surrounding mesentery is mildly hyperechoic.

ULTRASONOGRAPHIC FINDINGS

- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The presence of ingesta in the gastric lumen despite fasting is suggestive of delayed gastric emptying.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

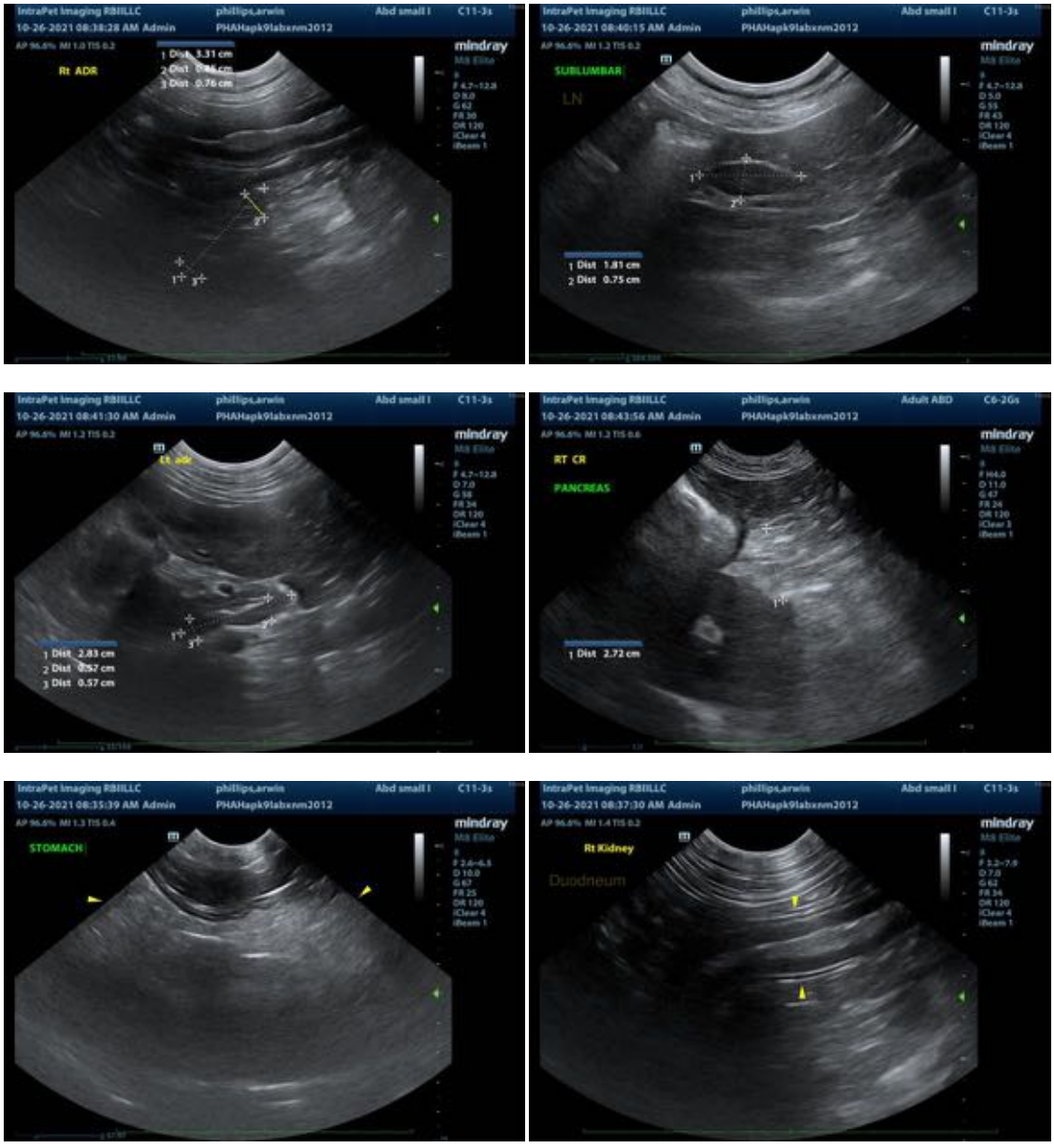
*An obvious cause for the patient's clinical signs is not identified in this study. Considerations include recurring pancreatitis, primary gastrointestinal disease (i.e., food allergy, inflammatory bowel disease, infectious/parasitic, motility disorder), underlying metabolic issue, other.

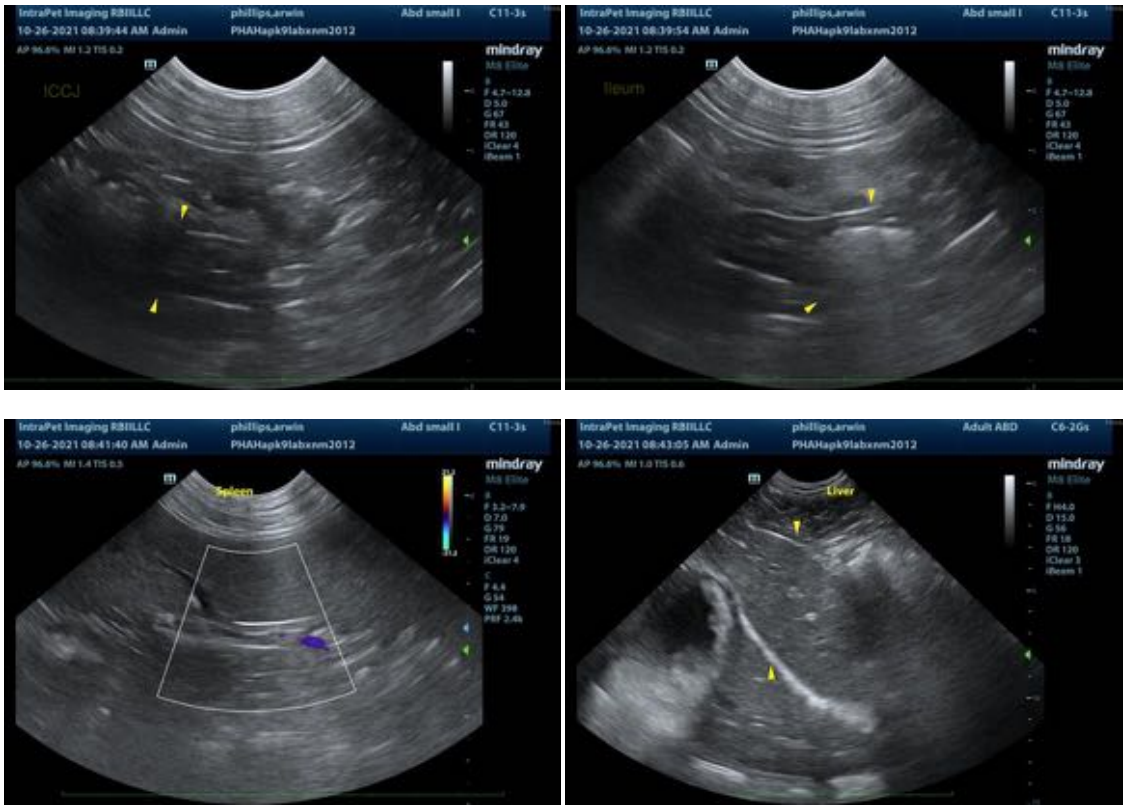
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for occult esophageal disease.
- Other diagnostic/therapeutic considerations could include the following:
    1. Serum cobalamin, folate, PLI and TLI
    2. A fecal evaluation for ova/Giardia
    3. A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended
    4. 6-week limited antigen diet trial

5. +/- endoscopic or surgical gastrointestinal biopsies

6. If patient's clinical signs do not improve with supportive care and if the above diagnostics are inconclusive, a repeat ultrasound can be considered to reassess for partial small intestinal obstruction.





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.

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