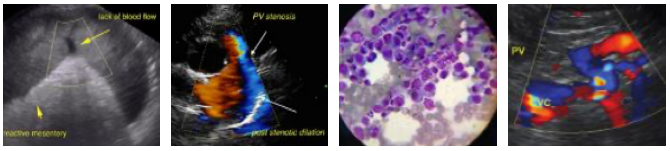

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1-800-838-4268 info@sonopath.com

PATIENT
Petey Freymiller

SPECIES
Canine

BREED
Pitbull Terrier

SEX
Male, neutered

AGE
2 Yrs.

WEIGHT
34 kg.

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

IMAGING PERFORMED BY
Tom McNeill

HOSPITAL NAME
SVS Imaging CT

REFERRING VET
Dr. Maller

INVOICE
14153

DATE
10/26/22

PRESENTING CLINICAL SIGNS

History: Petey presented to the MVS Emergency Service on Oct 25, 2022, at 10:30pm, for evaluation of vomiting. Owners note that Petey has been acting off all day. He vomited this morning around 11:30am, has been acting slightly lethargic, and vomited up rice immediately after being fed around 3pm. This evening after owners ate dinner, he began vomiting more frequently. He vomited ~5 times on the ride here and once in lobby on presentation. Yesterday Petey was playing and doing some training in a family member's yard and did get a treat he wasn't used to. He also sometimes gets dehydrated chicken strips/jerky.
Abnormal PE/Chem/CBC/UA Results: Rectal: Mucous, no anatomic abnormalities - later after admit had blow-out hematochezia diarrhea Abdominal radiographs: Irregular mineral opacity and nearby heterogeneous possible textile material superimposed w/ SI vs LI at level of L1-2 in the left abdomen; suspect gastric foreign material; diffuse SI fluid dilation. Bloodwork was WNL.

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 (1.38 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 (7.34 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 (7.61 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 (0.57 cm at cranial pole) (0.68 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 (0.84 cm at cranial pole) (0.57 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 normal in size (2.04 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

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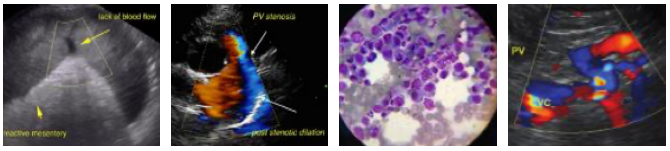

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The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts 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 gastric lumen is mildly gas 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 segmentally fluid distended (mild). The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The cecum and colon are fluid distended. A few small linear hyperechoic shadowing structures are observed within the fluid. No obstructive disease is noted.

Pancreas

The region of the pancreas is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional inflammation or effusion.

Free Abdomen

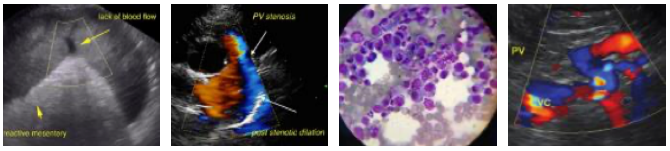
There is no evidence of free fluid. The medial iliac lymph nodes are visualized (left 2.83 x 0.76 cm; right 2.63 x 0.75 cm). At least one sublumbar lymph node is visualized measuring 2.22 cm in length. A few prominent mesenteric lymph nodes are visualized, the largest measuring 4.14 cm in length. Prominent gastric and colic lymph nodes are also seen. All nodes are normal in shape and echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Suspected diffuse gastrointestinal ileus, likely secondary to gastroenteritis/typhlitis/colitis. There is no obvious evidence of a gastrointestinal foreign body/obstruction. However, a partial obstruction cannot be completely excluded.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Baseline labwork including CBC chemistry panel and urinalysis is recommended, if not already performed.
- Fecal evaluation for ova and Giardia.
- Prophylactic deworming with Fenbendazole at 50 mg/kg once a day for 5 days is recommended. Repeat above protocol in 3 weeks.
- A resting cortisol level to screen for hypoadrenocorticism.



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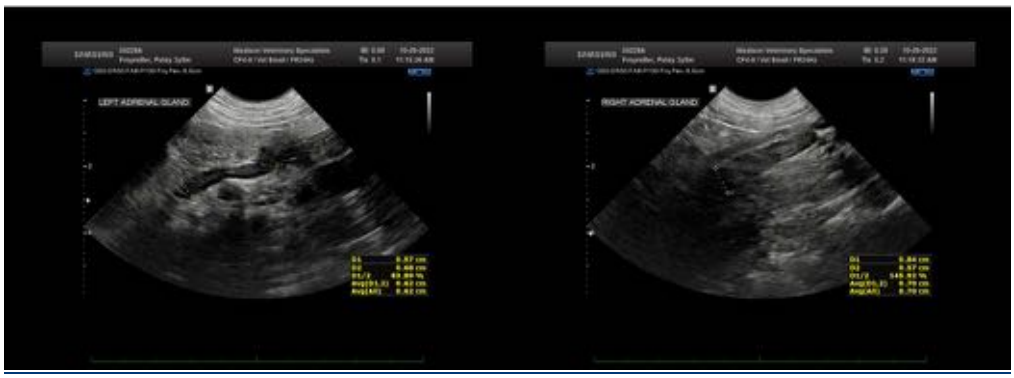
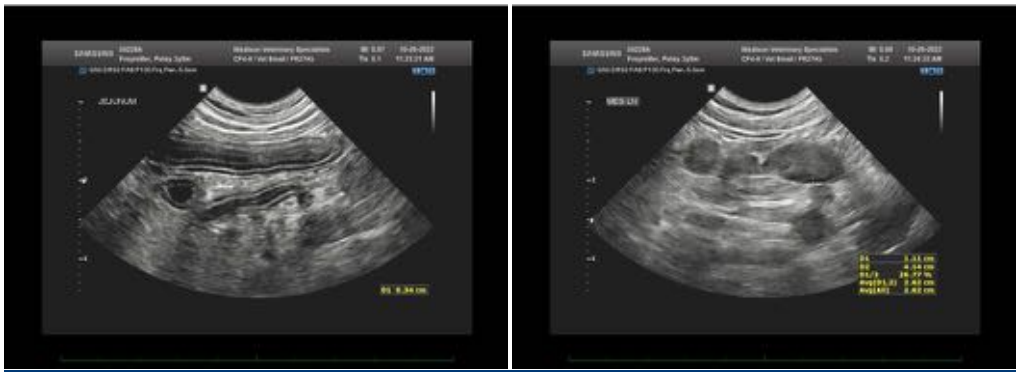
- Supportive care for acute gastroenteritis/colitis is recommended, including fluid therapy, gastric protectants, anti-emetics, probiotics +/- fiber supplementation.
- If the patient's clinical signs do not begin to improve within 48-72 hours of medical management, a more advanced GI workup (i.e., repeat abdominal imaging, GI panel (send to Texas A&M) +/- GI biopsies) may be warranted.





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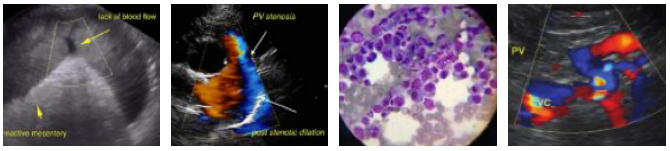

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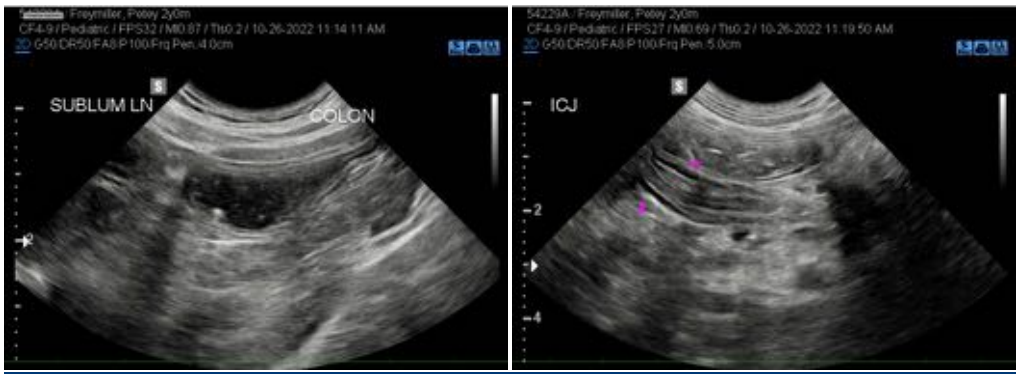

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@SonoPath.com