

**DATE PRESENTING CLINICAL SIGNS**

10/7/2021

Chronic intermittent vomiting over the last year. Owner reports that vomiting happens especially when RJ eats or drinks very quickly but he still has issues keeping things down when he eats slowly too. Has been treated supportively on and off with Cerenia which limits vomiting but symptoms return soon after medication is stopped. Not currently using hypoallergenic or hydrolyzed protein diet.

PATIENT

RJ Brown

SPECIES

Canine

BREED

Mixed breed

SEX

Male, neutered

AGE

2013

WEIGHT

52 lbs.

INTERPRETED BY

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

HOSPITAL NAME

Everhart VH

REFERRING VET

Dr. EK

INVOICE

12309

Current Medications: No current medications

Lab Results: WNL. Hypoglycemia on lab results from other vet hospital likely due to sampling error/blood sitting out. Negative fecal.

Radiographs: Repeated abdominal and chest radiographs show no abnormalities.

Date of Previous IntraPet Ultrasound: No previous.

Sedation: Sedation not required.

Stat Report: Stat report not requested by DVM.

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 mostly 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 (1.29 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 (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.

The right kidney is normal size (6.40 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 (0.70 cm at cranial pole) (0.62 cm at caudal pole) (2.24 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 (0.75 cm at cranial pole) (0.72 cm at caudal pole) (2.96 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

The spleen is normal in size (2.30 cm in width at the level of the hilus) with a normal capsular contour. The parenchyma is subtly mottled in appearance. 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 not 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 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

The peritoneal cavity is normal. There is no evidence of inflammation or effusion. The abdominal lymph nodes are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

- The splenic parenchyma changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis or splenitis with a low possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).

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

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for occult esophageal disease.
- Other diagnostic considerations include the following:
 1. A fecal evaluation for ova/Giardia
 2. Serum cobalamin, folate, PLI and TLI
 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. A 6-week limited antigen diet trial to assess for food allergies
- Depending on the results of the above diagnostics/therapeutics, endoscopic or surgical gastrointestinal biopsies may be necessary to get a definitive diagnosis.
- From a medical management standpoint, Metoclopramide can be used safely long term in most patients. Also consider initiation of a proton pump inhibitor as empirical treatment for gastric reflux.





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*)
Andrea.nicastro@sonopath.com