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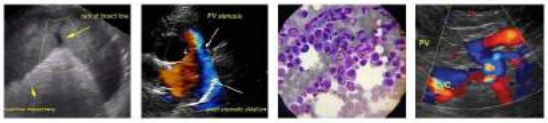

IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Emma Semrad

SPECIES

Canine

BREED

Portuguese Mix

SEX

Female Spayed

AGE

8 Years 8 Months

WEIGHT

42 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT

HOSPITAL NAME

Sierra Pet Clinc

REFERRING VET

Dr. Swalander

INVOICE

11987kk

DATE

10/8/21

PRESENTING CLINICAL SIGNS

History: Emma (71365) Alison Semrad (21892) (530) 807-7007 Canine Water Dog, Portuguese Mix 8 Yrs. 8 Mos. Spayed Female 42.5 pounds (9/7/2021) Presenting Complaint: For about the last month and 1/2 dog has been slowing down on eating morning meal. Then just last week o heard borborigmus that she has not heard before and there was one episode of bilious vomit--was in her crate in the am. She has also been skipping poops. Stools look normal however. _ History: __No diarrhea, coughing, sneezing. Patient drinking, urinating, defecating normally. Diet:__ Current Medications: none T=101 P=70 R=pant Attitude: BARH MM: pink, moist, crt<2sec EENT: no oculonasal discharge, ears clean dent: mild to mod perio dz Peripheral Lymph Nodes: no enlargements Heart/Lung: 3/6 murmur (previous echo in 2017 ATO) Abdomen: no pain, masses or organomegaly Rectal: not performed Musculoskeletal: good tone, no lameness, BCS 5/9 Genitourinary: no abnormalities noted Nervous System: no obvious deficits Skin: clean and healthy Other findings:__ Problems for summary page: Assessment for summary page: Problem list with rule outs:Change in appetite, one vomit, borborigmus r/o primary GI (FB, gastritis, dietary, pancreatitis), metabolic/endocrine, infectious, autoimmune Recommendations: offered bw, rads, aus; rec echo Plan:o ok with monitoring for now and will schedule echo with previous cardiologist

Abnormal PE/Chem/CBC/UA Results: sed dex/torb 0.1ml each

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 left kidney is normal size (5.55 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 (5.14 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 (0.63 cm at cranial pole) (0.56 cm at caudal pole) (2.26 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 (0.67 cm at cranial pole) (0.41 cm at caudal pole) (1.39 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 (1.59 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.

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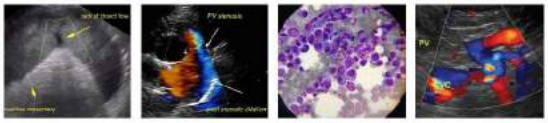

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Liver

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 gastric lumen is moderately fluid-distended and hypomotile. 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 ileocolic junction and colonic wall are normal.

Pancreas

The left and right limbs of the pancreas are 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. The abdominal lymph nodes are normal/not visible.

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 gastric distension is most likely due to functional ileus. However, an intermittent outflow tract obstruction (i.e., due to a small foreign body) cannot be completely excluded. Correlation with the patient's history is recommended.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

1. Baseline lab work including a CBC chemistry panel, urinalysis, and T4 is recommended to assess overall metabolic function.
2. Three-view thoracic radiographs are recommended to assess for occult esophageal disease. Other diagnostic considerations include the following:
    a. A fecal evaluation for ova/Giardia
    b. A malabsorption panel including serum cobalamin, folate, PLI and TLI.
    c. A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended.
    d. A 6-week limited antigen or hypoallergenic diet trial.
    e. Depending on the results of the above diagnostics/therapeutics, endoscopic or surgical gastrointestinal biopsies may be necessary to get a definitive diagnosis.

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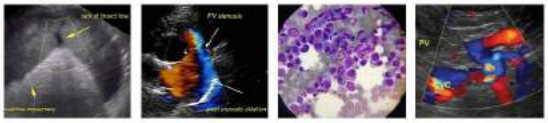

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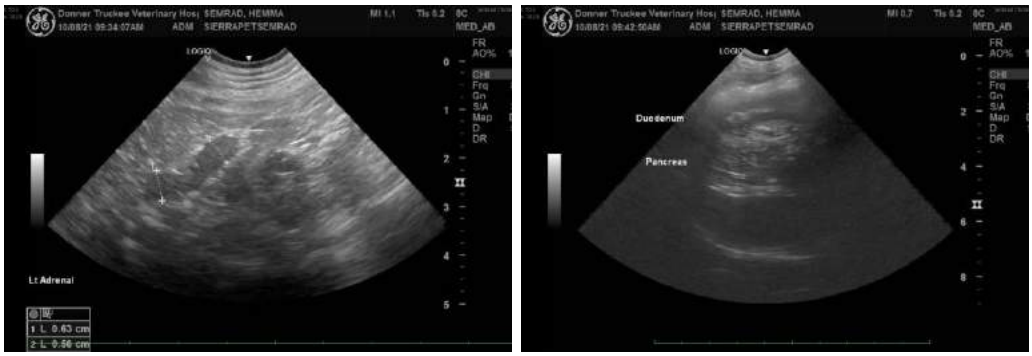

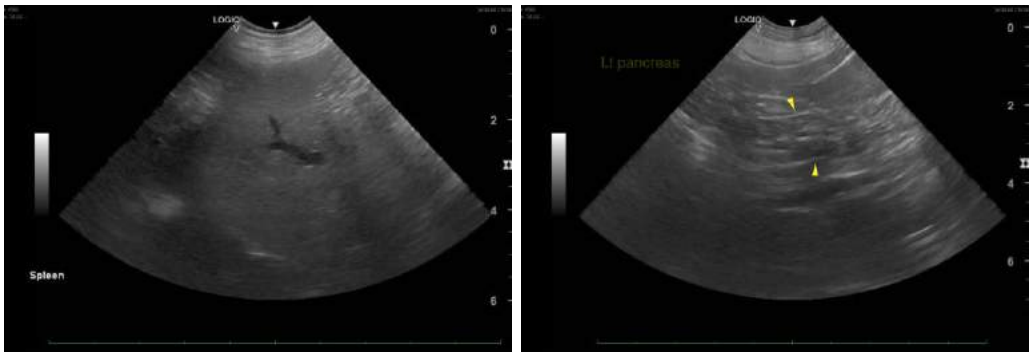

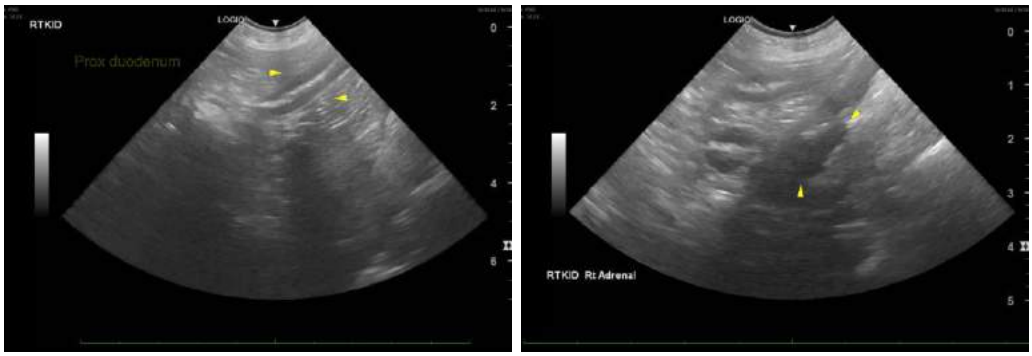

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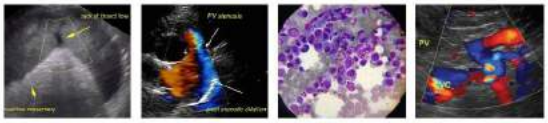

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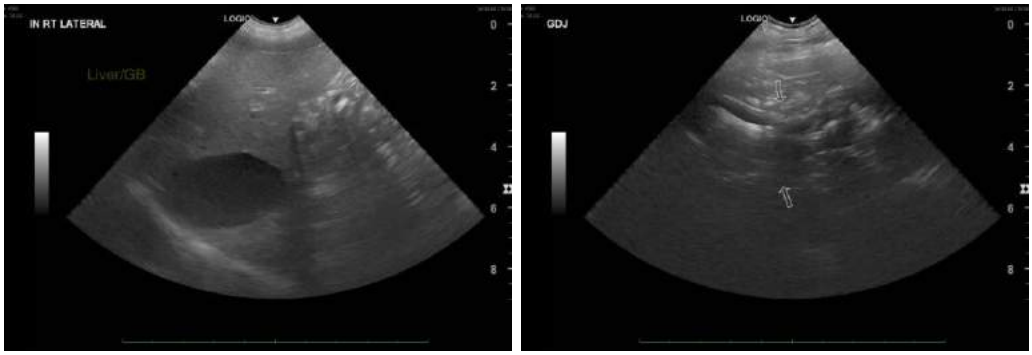

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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