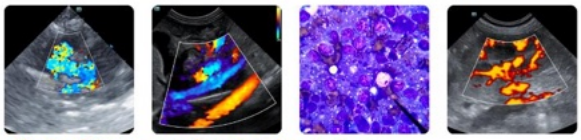


DATE

11/25/25

PATIENT

Porter Raco

SPECIES

Canine

BREED

Staffordshire Bull Terrier mix

SEX

Male, neutered

AGE

7/7/2021

WEIGHT

61.5 lbs.

INTERPRETED BY

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

HOSPITAL NAME

Animal Emergency Hospital

REFERRING VET

Dr. Ruby

INVOICE

13376

PRESENTING CLINICAL SIGNS

Patient History: Adopted at 1.5 yo; chronic GI disease since adoption. - Initial weight at adoption: 20 lbs (expected: 60 lbs). - Persistent diarrhea and weight loss before and after adoption. - Treated previously with metronidazole and powdered medications; diarrhea improved only with tylosin. - Multiple prescription diets (Hills, hydrolyzed protein) trialed; persistent diarrhea and poor appetite. - Severe reaction to chicken (food trial confirmed). - Currently eating beef, rice (homemade, soupy texture), and Merrick kibble (chicken-free). - History of bloat before adoption; meals split in half as precaution. - Recent dietary intake: beef, rice, Merrick kibble. - GI signs since August: weekly vomiting (retching), alternating diarrhea and constipation, worsened overnight. – Recent vomiting (15–20 episodes overnight, non-retching/regurgitation and some with food or mucus). - Not drinking well; prefers "muck water" during hikes. - Supplementing with additional water via soupy meals. - Recent visit at Swan Creek: radiographs suggested gastritis; famotidine prescribed PRN, minimal improvement. - Tylosin dose increased to 0.25 tsp BID. - Last week: diarrhea despite beef/rice, no medication; given DiaGel, subsequently producing small, firm fecal pellets ("rabbit-sized"). - Yesterday: told by RDVM to resume normal
diet after no vomiting/diarrhea for a week. - Last night: refused food, vomited after administration of cerenia and omeprazole; unable to retain medications. - Six to seven lbs. weight loss reported, chronic clinical decline.

Current Medications: Protonix, Ondansetron, Cerenia.
Labwork Results: Chem panel WNL
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: STAT requested.
Imaging Performed by: Rachel Brilhart, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The prostate is normal in size (1.22 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal in size (6.70 cm in length) with a normal shape, architecture and 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 in size (6.25 cm in length) with a normal shape, architecture and 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 in size (0.65 cm at cranial pole) (0.65 cm at caudal pole) with a normal shape and 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 in size (0.79 cm at cranial pole) (0.64 cm at caudal pole) with a normal shape and 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 prominent in size (2.34 cm in width at the level of the hilus) with smooth peripheral 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.

The gall bladder lumen is moderately distended. The wall is thin and smooth. A small amount of mobile echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is mildly to moderately distended with fluid and gas. The gastric wall is normal in thickness with a normal layering pattern. The small intestinal lumen is segmentally distended with fluid and chyme. The small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. The proximal colonic lumen is mildly fluid distended. The descending colonic lumen is empty. There is no obvious evidence of an obstructive pattern.

Pancreas

A portion of the pancreas is obscured by the gastrointestinal distention. In the visualized portion, no obvious abnormalities are seen.

Lymph nodes

1-2 prominent mesenteric lymph nodes are visualized, one of the nodes measuring 1.15 x 0.53 cm.

Free Abdomen

A small amount of anechoic free fluid is present.

Other

A brief echocardiogram reveals no evidence of pericardial effusion or obvious right atrial/auricular mass.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- Gastrointestinal ileus, the cause of which is unclear. It may be secondary to infectious/parasitic disease, inflammatory bowel disease, food allergy/intolerance, other.

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

- Mild ascites

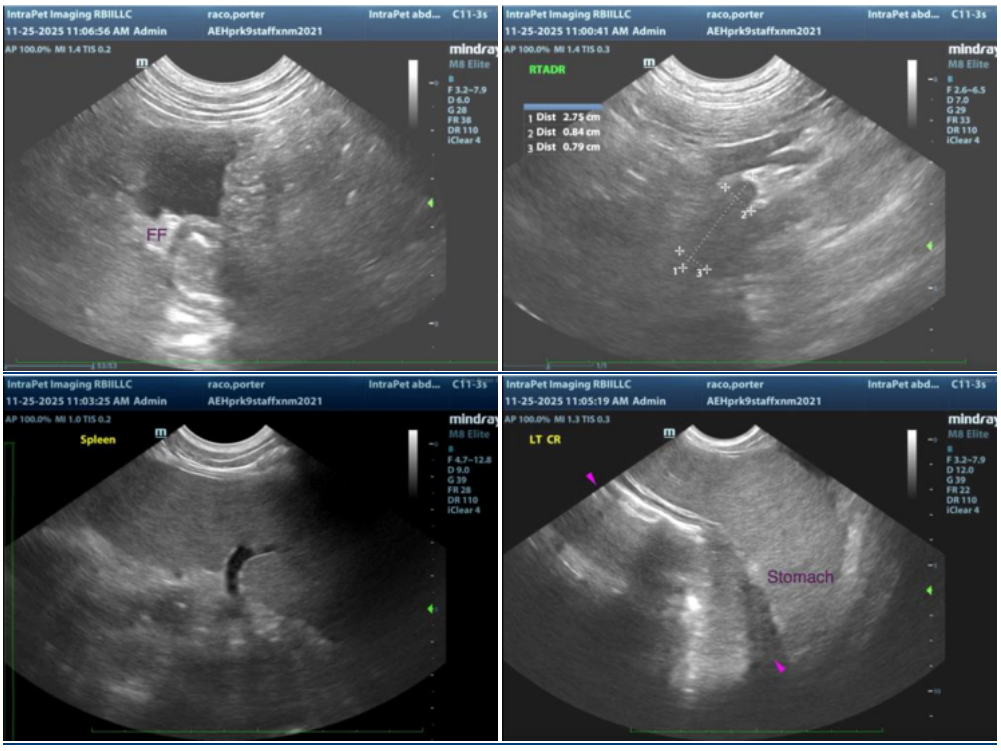
Secondary Findings:

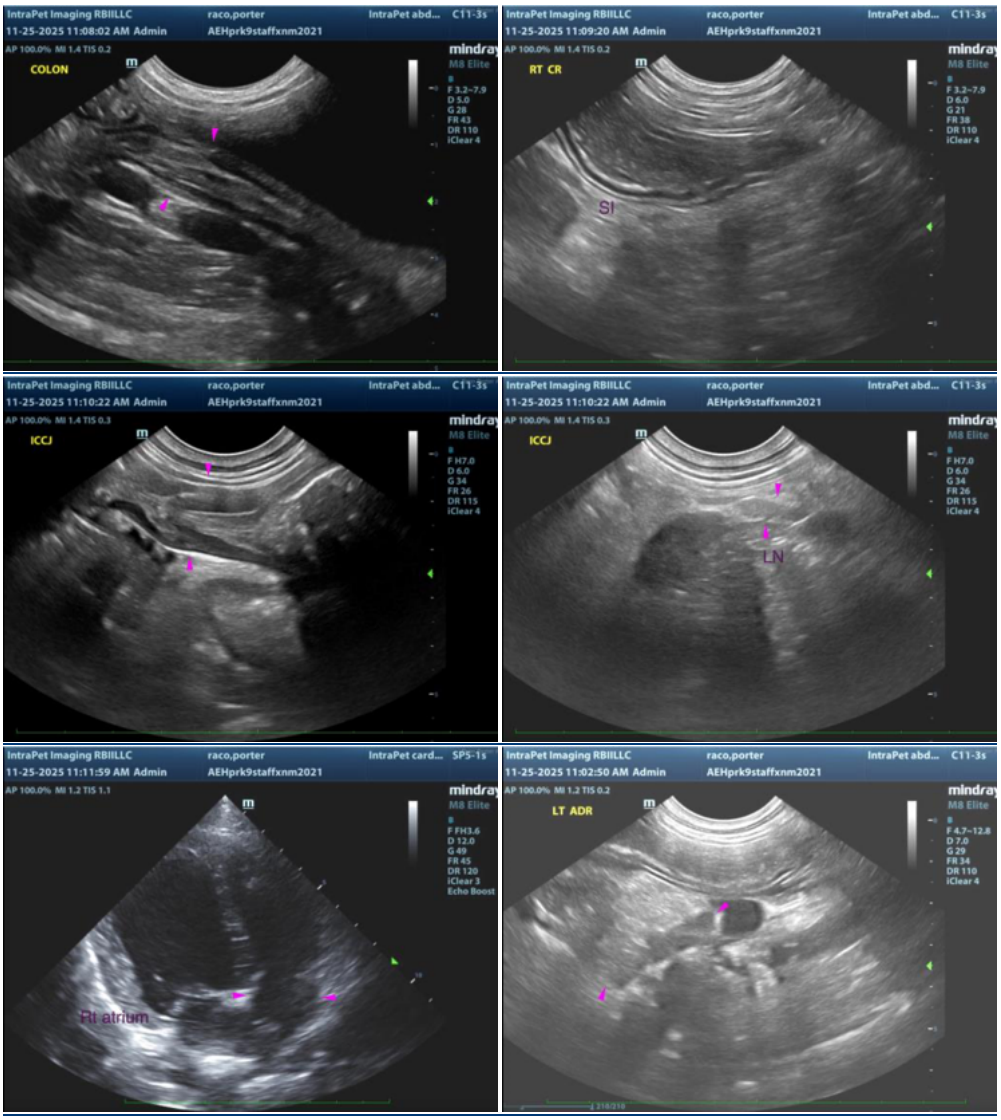
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Regarding the splenic changes, consider fine needle aspiration (to assess for round cell neoplasia) assuming normal clotting status. A 25-gauge needle should be used.
- Also consider submission of the abdominal fluid for cytologic evaluation, if accessible.
- Regarding the chronic GI changes, consider the following:

1. Texas GI panel including serum cobalamin, folate, PLI, TLI and resting cortisol level
2. Fecal evaluation for ova/Giardia
3. Prophylactic deworming with Fenbendazole.
4. 3-4 week hypoallergenic or hydrolyzed protein diet trial
5. Initiation of a probiotic with a high colony count +/- fiber supplement (i.e., psyllium).
6. Depending on the results of the above diagnostics/therapeutics, endoscopic or surgical gastrointestinal biopsies may be warranted. Three-view thoracic radiographs should be performed prior to any anesthetic event.





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